show that the Eddie Eagle curriculum reduces gun-related trauma.

In his letter, Dr. Cowan proposes that public health department officials may be well informed regarding the vast array of research and refereed journal articles on gun-related trauma and have rejected them all as being of poor quality, overtly political, and disparaged by criminologists and sociologists alike. Our personal experience with dozens of city and county health commissioners is that they have limited knowledge of the professional literature on gun-related trauma. Dr. Cowan goes on to note that we did not discuss the protective effects of firearm ownership as identified in, among other sources, books by Kleck[5] and Lott books.[6] Again, the data are of questionable quality in these non-refereed publications.

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Self-Reported Swimming Ability in US Adults, 1994

In 1997, more than 4,000 Americans drowned.[1] The drowning rate for males was four times that for females, African-Americans had twice the rate of whites, and young adults had higher rates than older people (up to 75 years of age). Although these differences in drowning rates may be related to differences in swimming ability, we found no published studies assessing the swimming abilities of these groups. Accordingly, we analyzed data on self-reported swimming ability that were gathered during a national random digit dialed telephone survey conducted from April through September 1994.[2]

A consenting, randomly chosen, English- or Spanish-speaking adult respondent reported on a variety of injury risk factors. Among the questions were: "If the standard pool length is 24 yards, how many pool lengths can you swim without stopping? None, less than one pool length, 1–2 pool lengths, more than 2 pool lengths?" We defined swimming ability based on the distance that respondents said they could swim without stopping. We classified respondents as having "limited swimming ability" if they answered "none" (n = 1,361), "less than one pool length" (n = 386), or "don't know" (n = 122). The question was answered by 5,234 adults (2,681 males, 2,553 females). Because the sampling strategy involved oversampling members of minority groups and equalizing the sex balance, the data required weighting to be representative of the US population. Each respondent was assigned a weighting factor, which was equal to the inverse of the selection probability weight multiplied by a post-stratification weight.[2] We used SUDAAN[3] to generate national estimates and percentages.

Self-reported swimming ability declined with increasing age and increased with increasing educational level (see Table). As a group, those who self-identified as African American reported the most limited ability. For all education levels, ages, and "racial" groups, higher weighted percentages of women than of men reported limited ability despite lower drowning rates in women.

While reported drowning rates in members of minority groups[1] correspond with our findings on self-reported swimming ability, drowning rates by gender or age[1] do not. This apparent contradiction may be explained by exposure to aquatic activities; males and younger people may spend more time in or on the water, or in higher risk situations. A 1996 survey of aquatic skills and behaviors found that men not only have greater exposure to aquatic settings, but also spend more time in higher risk aquatic activities where submersion may occur.[4] Men also report drinking more alcohol than women while in aquatic settings and may overestimate their swimming ability.[4]

While our survey has many limitations, including a 56.1% response rate[2] and reliance on self-report, the data suggest that a substantial percentage (37%) of the US adult population has limited swimming ability. Little is known about the influence of swimming lessons on self-reported ability or the resultant effects on drowning rates. Drowning prevention strategies will differ for people with differing swimming abilities; therefore, it would be of great interest to know if the drowning problem, especially among males, primarily occurs among those with limited swimming ability or among better swimmers with either greater exposure or exposures associated with greater risk.

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Weighted percentages of US adults reporting limited swimming ability, 1994

Self-reported demographic characteristic	*Total*	*95% CI*	*Men*	*95% CI*	*Women*	*95% CI*
Age group						
18–24	22	18–27	16	10–21	30	23–37
25–34	25	22–27	14	11–17	35	30–39
35–44	28	25–32	16	13–20	40	35–45
45–54	35	31–40	20	15–25	51	45–58
55–64	50	44–55	29	23–36	68	61–75
≥65	68	64–72	42	36–48	86	82–90
Educational level						
<high school graduate	60	55–65	40	33–47	76	70–82
High school graduate	44	41–47	27	23–31	58	53–62
Some college	31	28–33	16	13–19	43	38–47
College graduate	22	18–26	11	8–15	36	29–42
>college graduate	22	18–26	14	10–19	33	26–41
Racial/ethnic identification						
White	32	30–34	17	15–19	45	42–48
African American	62	58–67	44	36–51	77	72–83
Asian	47	35–58	26	12–40	63	48–78
Hispanic	44	39–50	31	24–38	57	49–65
Total	37	35–38	21	19–23	51	48–53

CI = confidence interval

National Center for Injury Prevention and Control
Centers for Disease Control and Prevention

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Cultural Competence

Dr. Chin's "Viewpoint" article on culturally competent health care addresses issues in health care access and delivery that are not new but have become more visible only recently. The Issue Brief from which Dr. Chin's article was adapted was published by the Massachusetts Health Policy Forum in May 1999. That very comprehensive and informative Issue Brief, prepared for the Forum by Dr. Chin, served as both the background and springboard for an informed discussion among public and private health policy makers who attended the Forum last May.

The Forum brings health care leaders in Massachusetts together for discussions of timely policy issues to identify where action may be brought about by public-private collaboration. We had hoped that the Forum on cultural competence would have such an impact. Indeed, the presence of federal and state health officials, community health center workers, and patient advocacy groups contributed to a productive discussion. The issues discussed included the recruitment and training of culturally competent providers, improved data collection methodologies, and pending state legislation to provide interpreter services in hospital emergency departments.

Dr. Chin's contribution both to the Forum and to *Public Health Reports* offers an ongoing resource for information related to cultural competence and health care, while the Forum continues in its role of bringing together health policy leaders and stakeholders to address such critical issues.

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