

TABLE 1—Monthly Summary of Quality Control Sample Results for the Radon Project

M-Y	Sets	Cans	LS	Av % SD		Av cans/ monitors	Av LS/ monitors	No. LS	
				Cans	LS			50%-75%	<50%
12-88	22	85	158	6.4	7.5	.99	.99	1	0
1-89	14	56	96	5.7	5.3	1.02	.98	1	0
2-89	19	76	140	5.8	6.7	1.01	.99	2	3
3-89	21	84	162	4.9	5.6	.95	1.03	0	1
4-89	20	80	142	5.5	4.9	1.01	1.00	1	0
5-89	23	92	170	4.5	5.3	1.00	.98	1	1
6-89	21	84	99	4.9	5.3	.99	1.05	0	0
7-89	15	60	59	5.0	4.7	.95	1.03	0	0
8-89	22	86	88	5.5	4.6	.92	1.00	0	0
9-89	20	80	76	6.1	3.9	.97	.97	0	0
10-89	22	88	83	5.2	3.6	1.02	1.01	1	0
11-89	21	84	83	5.1	5.1	1.01	1.00	0	0
12-89	18	72	70	5.7	3.9	1.08	1.02	0	0
1-90	9	35	32	6.3	3.3	1.00	1.02	0	0
2-90	8	32	31	5.8	4.5	1.00	1.08	1	0
3-90	9	34	33	5.3	6.0	.98	1.02	0	0
4-90	9	34	34	5.8	4.7	.99	1.01	0	0
5-90	10	40	36	5.2	6.4	.99	1.00	0	0
6-90	8	32	32	5.5	5.6	1.01	.94	0	0
Total	311	1234	1624					8	5
Average				5.48	5.10	.994	1.006		

^a3 measurements results of 0.1 and 0.2 pCi/L were ignored under the assumption that detectors were not exposed.

^bA total of 70 LS were used for other experiments and thus were never measured.

^c3 cans and 3 LS were lost and never measured.

^d5 outliers rejected in data on cans.

avoid this problem, there have been virtually no failures in the past year.

From the bottom line of Table 1 we see that the average percentage standard deviation is slightly lower for LS than for cans. This is contrary to the conclusion by Field and Kross that the LS give poorer precision. At least on this 19-month average, columns 7 and 8 indicate that the agreement with chamber monitor data was equally good for LS and cans, and the month-to-month fluctuation was comparable for the two.

In summary, our data, based on over 100 times as many measurements, contradict the conclusion by Field and Kross that LS performance is inferior to that of cans. □

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Homicide Trends in New York State, 1980 to 1988

Homicide continues to be a major health problem in the United States, and is the 12th leading cause of death. In some groups, such as Black males aged 15 to 24

years, homicide is the number one cause of death.¹ Rapid increases in homicide rates nationwide have been noted recently, particularly among young Black males.² Ongoing homicide surveillance in New York State has detected a rapid increase in homicide rate since 1985 that is greatest among Black males and among residents of New York City.

Data on homicides among New York State residents from 1980 through 1988 were obtained from death records from the New York State Department of Health, Bureau of Production Systems Management. Overall, homicide rates declined from 12.5 per 100 000 in 1980 to 10.0 in 1985, followed by an increase to 12.5 in 1988. Breakdown of trends by sex, region, ethnicity, and specific cause of death yielded interesting results. There has been no significant change in female homicide rates over time as judged by a chi-square test of trend in rates. Male rates changed significantly over time, dropping from 21.7 in 1980 to 16.6 in 1985 and increasing to 21.7 in 1988. The increase in male homicide rates from 1985 to 1988 is greater in New York City (31%) than in the remainder of the state (20%). The increase from 1985 to 1988 was greatest in Black male residents of New York

City (63%), followed by Black male residents elsewhere in the state (36%), White male residents of New York City (12%), and White male residents elsewhere in the state (10%). Overall, the highest homicide rate was found among Black male residents of New York City aged 15 to 24 years; in 1988 the rate was 220.6 per 100 000.

Of all the homicides investigated, firearms were the means for the majority of deaths (59%), followed by cutting/piercing instruments (23%). All other means of homicide each accounted for less than 5% of the total. Only firearms homicides showed a significant temporal trend. Here, the rate of increase among males from 1985 to 1988 was greatest in Black residents of New York City (105%), followed by Black residents elsewhere in the state (66%), White residents of New York City (34%), and White residents elsewhere in the state (6%). Thus, the rapid increase in homicides in New York state is confined to firearms deaths and is related primarily to ethnicity and secondarily to place of residence. □

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Suicides at Niagara Falls

There are several famous suicide venues to which people come to kill themselves, such as the Golden Gate Bridge in San Francisco and Mount Fuji in Japan. One of the less well-known suicide venues in North America is Niagara Falls. The present research was designed to ascertain what type of person commits suicide at Niagara Falls.

Data were collected on suicides identified by the police on both sides of the falls from 1978 to 1988.

During the 11-year period from 1978 to 1988, 60 suicides jumped from the American side and 81 jumped from the Canadian side. This total of 141 suicides and average of 12.8 each year represents an increase over the average of 7.1 re-

ported by Lester and Brockopp for the period from 1958 to 1967.¹

Of those whose sex was known, 59% were male and 41% female. Thus the percentage of women is higher than it generally is for suicides in the United States (24%) or Canada (25%). The mean age of the women was 38.0 years (SD 14.9) and of the men, 39.5 years (SD 15.4).

The most popular points for entering the water (Prospect Point on the American side and Table Rock on the Canadian side) are the points where a typical visitor first encounters the water. The majority of the suicides occurred during the summer months (May to August) and during the day (from 10 AM to 8 PM), in other words, at times when most tourists are visiting the falls and intervention by bystanders is most likely. Perhaps some of the suicides wish to be observed going over the falls to their death, and this is part of the mystique of committing suicide by this method. The distance from home was within 10 miles, and so it seems that Niagara Falls is a popular suicide venue for those living nearby.

Since the incidence of suicide at Niagara Falls is quite high, thought should be given to making the water of the falls less accessible to potential suicides without reducing the tourist potential of the area. □

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Workers' Compensation Data Add to Fatal Injury Census

In February 1990, an article was published in the *American Journal of Public Health* concerning sources of data for fatal occupational injury surveillance in New Jersey.¹ Sources of data included death certificates, medical examiners' reports, and fatality reports from the Occupational Safety and Health Administration (OSHA). We would like to provide an update to that report adding a fourth source of data, workers' compensation data, for the years 1986 through 1989.

Three hundred eighty-six deaths were identified from all sources of data combined. Death certificates identified a total of 286 (74%); state medical examiners' data identified 217 (56%); OSHA investigation data identified 133 (34%), and workers' compensation reports identified 53 (14%). These data continue to point out that no single data source can be used to provide a complete census of fatal occupational injuries.

Recently we joined with other states in an initiative from the Bureau of Labor Statistics (BLS) to develop a nationwide census for fatal occupational injuries using multiple sources of data.² The BLS will provide additional data sources and will standardize fatal injury reporting procedures and coding with all participating states. Results of this project will be critical in directing efforts to reduce these preventable deaths. □

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Let's Not "Blame the Victim"—Exercise Does Protect against Heart Disease

Dr. Marantz in his October 1990 editorial, "Blaming the Victim: The Negative Consequences of Preventive Medicine,"¹ shows a reluctance to accept sedentary behavior as a risk factor for cardiovascular disease. Yet, the very case he presents illustrates the relevance of exercise: the patient had a low count of high-density lipoprotein (HDL), which is often a function of inactivity.

The resident Dr. Marantz scolds for "intolerance" actually showed a laudable sensitivity to life-style issues. Physicians often overlook health promotion in general² and exercise in particular. This insensitivity is regrettable because compared with other accepted therapeutic interventions for coronary heart disease (CHD), exercise is cost-effective.³ The US Preventive Services Task Force

has given it high marks not only for CHD prevention, but also for the management of hypertension, obesity, and mental health.⁴

Yet, physician surveys show exercise is not thought to be very important,^{5,6} and therefore it is not mentioned to patients.⁷⁻⁹

Sadly, inactivity remains the most prevalent cardiovascular risk factor; the CDC's 1988 Behavioral Risk Factor Surveillance System put the prevalence at 58%. (Interestingly, the percentage of academic physicians engaging in an adequate exercise program ranges from 33% to 49%).¹⁰⁻¹² Because of this high prevalence, physical inactivity imposes twice as much external cost onto others as does cigarette smoking.

Let us not "blame the victim" but, surely, if we know that exercise could possibly raise a low HDL count, we should share this information tactfully with a patient already stricken and forcefully with our asymptomatic patients at risk. □

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