

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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