The World We Live in Can Be Hazardous to Our Health

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Over the years, the *WMJ* has published a number of articles that describe the relationship of the environment where we live and possible risks to our health.[1] Anyone who has bought a house in recent years knows of the potential for radon exposure that exists in certain parts of the state.[2] A study of the environmental health measures of water, air, and the built environment (housing quality, transportation, safety, etc) showed dramatic variances in the state's counties;[3] and the county health rankings, developed in Wisconsin but now a national program sponsored by Robert Wood Johnson Foundation, are used by public health and state and local governments to address the larger social determinants of health that affect their communities.[4]

Two articles in this issue highlight, again, the realities that where our patients live, work and play affects their health as much as anything we do in our offices. The public seems to be aware of the increasing frequency of falls in older patients and the serious consequences of those falls for the general health of individuals; effective interventions to decrease their likelihood are widely known.[5] Less attention is paid to another environmental hazard, automobile-pedestrian accidents, which have ominous consequences, particularly for older people.

The article by McElroy and colleagues[6] points out that the mortality rate for people over 65 is twice that of younger patients who are admitted to an urban regional level 1 adult trauma center. Older patients require more intensive and longer hospital stays and longer term rehabilitation and skilled nursing care after discharge. Most city streets are not built for people whose vision is low and who cannot hustle away from oncoming vehicles, or, if they try to hustle, often fall. I remember my parents instructing me to stop at crosswalks, look both ways, and then keep looking as I crossed the street. The same advice, coupled with admonitions NOT to go for a walk in the dark, are ones I and my aging cohort should follow. What, exactly, older people are doing crossing streets between 6 PM and midnight, the peak time for automobile-pedestrian accidents, is not clear, but we should be talking with our patients and ourselves about a preference for taking walks in the daylight. Recently, I saw an older man walking across a busy street looking at his cell phone, not at the traffic. The only thing he lacked that younger people use is ear buds, which assure that they neither hear nor see warnings. "No texting while driving" should also be "no texting while walking," in my opinion, and I hope that McElroy and colleagues are doing the research to support my opinion.

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The image of a guy sitting on a bucket on the ice in the middle of a lake has, for many people, come to characterize winter in the Upper Midwest. Even in May this year there were guys on buckets in Northern Minnesota and the Upper Peninsula of Michigan. Regardless, fishing is good for the soul and retains its remarkable popularity across age and gender. But we have managed to make something dangerous out of an activity that has fed our ancestors for millennia. Years of freshwater pollution have made warnings about heavy metals and polychlorinated biphenyls (PCBs) necessary for everyone, particularly women of reproductive age and children. Imm and her colleagues[7] surveyed older Wisconsin fishermen—perhaps the Wisconsin equivalent of Norwegian bachelor farmers and, probably in many cases, both—about their knowledge of the hazards of eating too much of what they caught. They report that, of those men who have seen Health Department advisories about the possible dangers of consuming too many lake fish, some will change their behavior and decrease the number of affected fish, change the types of fish they eat, or fish in safer locations. The attraction of a nice fish fry can sometimes override advice, so the need to keep information in front of anglers is important. That we occasionally do pay attention to warnings should reinforce the idea that public information and public health can work together effectively. And I haven't heard about folks pan frying their trophy muskie, so the top-of-the-food-chain fish are more likely to be returned or hung on a wall.

Depression is a risk factor for worse outcomes for almost any chronic illness, so managing it well is essential. However, as Gallimore and Kushner point out,[8] the guidelines for followup of patients on antidepressants are often poorly met. Their study reports on a process that tripled the success rate of monitoring patients in a family medicine population. They used collaboration between pharmacy, clinical psychology, and a team nurse to manage a registry of patients with the diagnosis of depression on antidepressive medications. This team approach took place within and related to the primary care clinicians at their clinic. The careful chart review to identify patients who were selected for the study was necessary to make sure registries that identify patients solely from being on a particular class of medications correctly identify them for depression as well. While electronic health records can do a lot to integrate data, processes outlined in Gallimore and Kushner require experienced, clinically trained personnel who work together. Such collaboration will positively affect patients and primary care systems. Their method also could be applied to a wide variety of health problems that require close monitoring as part of management. The key to their study is not simply the phone call; it is learning how to manage the entire process together.

Finally, a case study from Magness[9] points out what most of us have learned in our careers, which is that skin lesions often are the manifestations of either more systematic illnesses or clues to deeper problems—in this case tuberculosis. The burgeoning area of online atlases of skin diseases that should make it easier to make diagnoses in practice likely don't include a once-in-a-lifetime diagnosis such as empyema necessitans.

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