'# Clavicle — ? etiology'

This is what the emergency room physician scribbled after seeing me. But, I swear, this time there could be no question of injury proneness. After a 10 hour flight that left Honolulu at 1 am, and a 1½ hour wait in Sydney, I was descending a flight of stairs to board the flight to Melbourne. Two steps from the bottom, I was gently encouraged by an over eager passenger behind me. As I was carrying a backpack and a small case, I guess I was a bit top heavy. I fell down the remaining stairs and landed on the tip of my shoulder. After the shock of the excruciating pain passed, I realized I had probably fractured my clavicle — the usual result of this type of force (*x* rays a few hours later in Melbourne showed I was correct).

After persuading Quantas I did not need to see a doctor I proceeded to Melbourne, with a huge ice pack dripping all over me. On arrival I was whisked off to the Royal Melbourne for confirmation and treatment. The latter consisted of nothing more than a sling, some pain killers, and a touch of sympathy. Visions of humiliation floated around my head: 'No, not again, Barry!', days in the hospital, possible surgery, and above all, the prospect of not swimming during a precious week of preconference vacation.

Remember now, this is what most physicians would classify as a minor fracture and, of course, relative to a femur, a hip, or even a forearm, I suppose it is. But it is salutary to be reminded that when pain and dysfunction are taken into account, for the victim the notion of 'minor' is pretty meaningless.

What can't you do with a fractured clavicle without sudden 'lancing' groan-making pain? Roll over in bed; dress or undress yourself without assistance; brush your teeth; walk up or down stairs quickly; cut your food; get up or down off the beach; swim (I managed a gentle backstroke); soap yourself in the shower. The list goes on and on ...

And for a right handed person with a left sided fracture, that's the good news! No need for more of this: I trust my point about 'minor injuries' is understood: it is all in the eye of the beholder. And I was lucky and recovered much more quickly than I had anticipated, although I'm told it will be six weeks before the pain is gone and I will be forever deformed.

What puzzles me is how this sort of injury should be classified: *intentional* or *unintentional*? On balance, not intentional in the sense that most would mean. Clearly, the person behind me did not intend that I be injured. But not typically unintentional either, because no other person is usually involved in the latter except in the case of sport injuries, where the grey zone is often even wider.

Morals of the story

The aircraft is not going to leave without you. So take it easy on the person in front, especially when boarding involves going downstairs. A second lesson is that injuries are rarely minor when seen from the perspective of the victim.

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Melbourne

Melbourne was marvellous. Melbourne was mild. Melbourne stimulated the mind — and the gastric juices. The wine was wonderful. Most importantly, child and adolescent issues were extremely well represented; in many sessions, they dominated. I chaired one on evaluation and all but one of the 11 papers presented were focused on children. Moreover, over 150 people gathered for the special child and adolescent session jointly sponsored by Kidsafe and ISCAIP on the afternoon of the day the conference ended. I had predicted that only a small fraction of that number would be willing to give up what, for many, was the last chance to soak up the sunshine or to visit Victoria market. Wrong! As important as the numbers, the content of that meeting was stimulating, lively, and valuable — a great tribute to the hard work of Angela Seay, Ian Scott, Peter Vulcan, and Fred Rivara. I had anticipated it would be boring. Wrong again! Abundant congratulations are also due to Terry Nolan for making the scientific program as a whole such a success. Many of us would have preferred more aggregation of child and adolescent issues, and I was disappointed there were so few randomized trials or rigid program evaluations. But that probably reflects the state of injury prevention at present. The Haddon Memorial Plenary was a welcome addition to the conference format and two of the top six papers presented in the plenary dealt with childhood injury. In short, Melbourne was magnificent. Start saving for Amsterdam in 1998.

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The SF-36: not suitable for children

A surprising paper appears in this issue. In it, Branko Kopjar provides data to support the validity of a measure of health status (the SF-36) after injury. For many, being able to measure post-injury disability accurately and to assess changes over time, is a holy grail. Unfortunately, this paper is only a small part of that vessel — the handle, perhaps. What makes it incomplete is the fact that, at present, the SF-36 applies only to adults and older adolescents.

So how is it that a journal whose focus is children and adolescents decided to publish this paper? The decision was not taken lightly. The associate editors were consulted and agreed — with varying degrees of enthusiasm — that it

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