

## ‘# 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 Qantas 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.



## 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.



## 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

was important enough to warrant an exception. In part this was because it calls attention to the need for such a measure for children, and to the fact that to date, there have been few attempts to construct one. As is all too often the case, the needs of children lag behind those of adults. (It is analogous to pharmaceutical companies who first test a new drug on adults, where the market is larger, and only belatedly, if at

all, do so for children.) The associate editors also advised that the paper be accompanied by an editorial commenting on where it fits in the array of measures in this domain. We welcome the guest editorial that follows, written by an internationally renowned expert in this field.

IB PLESS  
Editor

*Editor's note:* the following is a statement reached by consensus of those attending the Third International Conference on Injury Prevention and Control in Melbourne. Readers are urged to publicize it widely in their own communities and work towards its full implementation.

### **The Melbourne Declaration**

Injury is a threat to health in every country in the world and is currently responsible for 7% of world mortality. This proportion is predicted to rise. In high income countries, such as the United States of America, injury is the leading cause of premature death. In many low income countries, such as India, injury is the leading cause of death and morbidity in the middle of the age spectrum (from age 4 or 5 years to 35 years and older). Injury deaths and trauma can be significantly reduced through a strategic mix of education, environmental and design changes, community and organisation-based action, regulation and enforcement. Improved treatments and rehabilitation would also reduce the long term individual, social and economic burden of injury.

**The international injury prevention community calls on global organisations, government and government agencies together with industrial, commercial, labour and other non-government organisations and the public that share responsibility for the SAFETY of the citizens of the world to work in partnership to:**

- Allocate sufficient monetary and human resources to implement strategies to reduce injury rates from all causes in all settings
- Establish departments in all appropriate government ministries to provide the leadership, coordination and resources that are necessary to develop policies and programs which promote a culture of safety
- Provide resources to indigenous peoples to determine and implement programs to reduce the high incidence of injury among groups in their communities
- Involve government, trade, industry and labour in global action to reduce injuries that result from the manufacture and dumping of unsafe products and technologies, the manufacture of products in unsafe conditions and the exploitation of cheap and child labour
- Implement programs to reduce intentional injuries: suicide and attempted suicide, interpersonal violence and assaults with weapons, particularly guns and land mines

**The international injury prevention community agrees to a worldwide partnership to act immediately on current knowledge to reduce injuries and the attendant social and economic costs by:**

- Placing injury prevention and control higher on the agenda of the World Health Organisation, the World Health Assembly, the United Nations, and the World Bank and global trade, labour, consumer safety and transport forums
- Creating world networks and coalitions which bring together the professions, sectors and disciplines (and the technologies to support them) that enable cooperative action to reduce injury at the community, national, regional and international levels and the rapid transfer of data and information
- Securing a budget allocation for injury prevention and control from all governments
- Securing from trade, industry and labour the commitment and resources to create safer products and environments by technical solutions and organisational measures
- Establishing regional, national and international lead agencies and task forces with appropriate financial resources to coordinate and drive intersectoral injury prevention efforts
- Including the safety of the population in all strategic plans and operational activities at all levels in all organisations
- Improving the availability of accessible and linked data (which includes the cause of injury) and information on effective interventions, and increasing research which supports the design of new interventions