PEDNET

The internet pedestrian issues chatlist, PEDNET, continues to have discussions of interest to *Injury Prevention* readers. Reflecting the international character of the internet, comparisons between countries are frequent. Charles Komanoff (kea@igc.org) noted that despite Tokyo, London, and Paris having populations within 10% of those of New York City, Tokyo and Paris have half as many pedestrian fatalities as New York, and London has two thirds as many. Komanoff noted that New York may be pedestrian friendly by dint of land use, but it isn't in terms of endangerment created by aggressive drivers, vehicular oriented road design and traffic laws, and lax law enforcement.

Pedestrian advocates spent much 'bandwidth' in the last quarter discussing the role of traffic law. One thread focused on the differences between how countries define 'walking across a street'. European participants were surprised to learn that in many parts of the US, a person may cross major streets only at intersections. (Whether pedestrians should be allowed to cross mid-block has also been discussed in the medical literature.[1]) Robert Bump (robbump@tu.albany.ny.us) pointed out that, theorectically, a mid-block crossing should be less likely to result in a conflict with a motor vehicle. He noted that at intersections, pedestrians are potentially endangered by motorists turning left and right, in addition to cross traffic. North American pedestrians face an additional danger from right-turn-on-red laws. In contrast, a mid-block crossing has just one potential conflict from each direction of traffic.

Bump also compared the restrictions on movements of pedestrians with restrictions on movements of motor vehicles. Motorists do the equivalent of mid-block crossings when they enter or exit driveways. Bump questioned the fairness of allowing these maneuvers by cars while outlawing their equivalent by pedestrians.

Support for the notion that mid-block crossing could be safer comes from statistics showing pedestrians are 90% less likely to be injured in streets with a raised center median. Indeed, every step toward two separate traffic streams makes it safer for pedestrians. (Because turning vehicles endanger bicyclists and motorcyclists, the latter would also benefit.) A raised median is safer than a painted median—a painted median is safer than a continous two way left turn lane—a two way left turn lane is safer than a painted line. But, too often, traffic engineers compromise pedestrian safety to maximize traffic flow, and are reluctant to devote more road space to separation.

Controversy emerged over whether motorists only expect to see pedestrians at intersections and whether mid-block crossings would, therefore, more likely result in collisions. This question is a variation on a long running (and unresolved) controversy about pedestrian safety—do painted crosswalks create a false sense of security? More generally, the question being debated was whether safer pedestrian environments lead to more risk taking by pedestrian? (*Editor's note:* a future issue will include an Opinion/Dissent on 'risk homoeostasis'). Or do they lead to more cautious behavior by motorists?

Legally, motorists must yield to pedestrians in crosswalks. The 'false sense of security' argument shifts that burden to the pedestrian. Observation of actual behavior shows that, at least with children, motorists already leave most of the responsibility for avoiding collisions to the pedestrian, even if the pedestrian is a child![2] Drivers fail to anticipate possible conflicts by slowing or increasing the distance between themselves and children waiting to cross the road. However effective such a shift in responsibility would be with agile adults, removing painted crosswalks would be at the expense of children and the disabled.

In another thread the politics of pedestrian safety were aired on PEDNET. In the US, a Senate hearing on transportation safety took place without pedestrians (or bicyclists) being mentioned. This official slighting of one sixth of the fatalities angered PEDNET participants.

Much of the Senate discussion centered on 'road rage'. Advocates for more roads used the opportunity to lobby for their cause, saying that unexpected travel delays cause this anger. The American Trucking Association and American Automobile Association argue that money should not be set aside for safety improvements, and that all road projects are safety projects. This view was countered by Representative Earl Blumenauer (Democrat, Oregon), who compared easing road rage by building more roads with dealing with spousal abuse by giving a wife beater more room to swing. PEDNET participants were surprised (and disappointed) to learn that the National Highway Traffic Safety Administration's administrator testified in favor of the 'bigger road' school of safety. Unfortunately, in the eyes of many, bigger, faster, wider roads are safer. In reality, such roads are the nemesis of all pedestrians, regardless of age, but especially for children.

PETER JACOBSEN
PO Box 712433,
Los Angeles,
CA 90071-7433, USA

1 Teanby DN, Gorman DF, Boot DA. Pedestrian accidents on Merseyside: the case for criminalization of jaywalking. *Injury* 1993; **24:** 10–2.
2 Howarth I. Interactions between drivers and pedestrians: some new approaches to pedestrian safety. In: Evans L, Schwing RC, eds. *Human behaviour and traffic safety.* New York: Plenum Press, 1985: 171–8.

BOOK REVIEW

Management of Injuries in Children. By John Glasgow and H Kerr Graham. (Pp 423; £34.95 paperback.) BMJ Publishing Group, 1997. ISBN 0-7279-0925-8.

Unusually for a book entitled *Management of Injuries in Children*, this book does pay considerable attention to the epidemiology and prevention of injury. It cites both the launch of the International Society for Child and Adolescent Injury Prevention and the Journal *Injury Prevention* in its preface. Written by two specialists from Belfast and Melbourne, it is aimed at 'all those who come into contact with injured children', particularly accident and emergency and paediatric health care workers.

I have approached this review from the perspective of someone working in injury prevention research from a social science background. The book provides much useful information on different types of injury, such as open and closed fractures, on the Glasgow coma score and its adaptation to a children's coma score, on burn depth and body surface area covered. What particularly impressed me about this publication is the quality of the illustrations. Photographs have been chosen with care to illustrate different injury types, for example typical cigarette burns on babies' legs or a baby's foot immersed in scalding water. These immediately provide a very vivid illustration of the problem of injury. Diagrams are similarly clear and complement the text well: examples include how a child can receive multiple injuries by rushing out in front of traffic or directions on the suturing of facial lacerations.

There are 15 chapters in the book which deal with the identification and immediate management of head injuries, bruising and abrasions, burns and scalds, lacerations, fracture, bone injuries, and injuries to the spine and pelvis. As well as the chapters on epidemiology and prevention, there are also chapters on physical abuse and writing medical records on injured children. Thus, it is broadly based and includes a useful section on the importance of communication with parents and families. The text is clearly written and well set out and good use is made of summary boxes to extract the key features from the text.

Although welcoming the inclusion of two chapters on the epidemiology of injury and the prevention of injury, my main criticism of the book relates to these sections. For a book published in 1997, the data quoted is somewhat out of date. On page 4 for example, 1990 road traffic accident statistics are provided, whereas far more recent figures are available from the Department of Transport. In other cases, figures are quoted, but we are not told the dates or sources of information: an example is provided of this from one of the authors' paediatric teaching hospitals of the new attendances at the accident and emergency department but we are not informed when this study took place. There are also inconsistencies in numbers quoted: page 7, a figure of 1200 accidental deaths is given for children in the UK (no age is defined) whereas on page 347 a figure of 900 deaths is quoted (for ?0–14 years). Both are considerably higher than the actual figures today.

Another concern is that the information on prevention is also somewhat dated. More recent publications on reviews of the literature in this field are not cited, nor are some of the key texts (for example Wilson '*Saving Children*') or original publications on preventive interventions (for example the Statewide Childhood Injury Prevention Programme or the Falköping Programme). An important area where accident and emergency specialists can contribute significantly to prevention is in the collection of good data on the nature and circumstance of injury. Surveillance is mentioned briefly but its importance is not stressed. A good bibliography is provided, but it is a pity that references are not given in the text.

In summary, this is a useful, clear, wide ranging text on the management of injuries in children, but I have some concerns about the