The Birth of Bioethics

A primer on medical ethics likens the current state of medicine to the airplane whose pilot announces that he has both good and bad news: “The bad news is that we don’t know where we’re going. The good news is that we’re getting there fast.”1 We should all be grateful, then, that one of the charter members of the bioethics movement, Albert Jonsen, has taken time to write its history in his newly published The Birth of Bioethics.2

Jonsen begins his story with the articulation of informed consent by the Nuremberg Tribunal in 1947. He wisely recognizes, however, that the Nuremberg Code did not turn out to be a turning point in research ethics for another 20 years. It was Vietnam and the attendant social disruption of the Johnson and Nixon years, not Nuremberg, that ignited the patients’ rights movement. The process was anything but orderly. A series of exposés and media events (most notoriously the disclosure of the Tuskegee syphilis study) cast doubt on the trustworthiness of the medical profession. Legitimate researchers were caught in the crossfire. Even such a prominent pediatric leader as Saul Krugman found himself under attack by the likes of the young Geraldo Rivera in 1972 for alleged experimental abuses. A decade later neonatology found itself besieged during the wake of the Reagan administration’s infamous Baby Doe rules requiring that intensive care nurseries post a “hot line” phone number to report suspected untreated children.

Jonsen’s task is to show how all this led to a new discipline and discourse that became known as bioethics. His analysis centers on the theologians and philosophers who brought the movement to fruition. Here his approach contrasts with that of other leading history of bioethics, David Rothman’s Strangers at the Bedside, which focuses more on bioethics as one aspect of a broad social movement.3

How far the basic principles of liberalism will continue to sustain bioethics in a pluralistic society remains to be seen. The genius of bioethics, as with classical liberalism, lies in its recognition of the value of dialogue and compromise. Its challenge is to articulate a minimalist ethic without reducing clinical ethics to the level of the contractual. Popular discourse in medical ethics tends to focus on the bizarre dilemmas of the intensive care unit rather than the more basic commitments underlying ordinary medical practice.4 Yet it is the latter that are most challenged by managed care. Bioethics succeeded by giving voice to the patient over the physician. What remains to be seen is whether it will sustain the patient against the corporation.

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Why Do Child Cyclists in the United States Remain Unhelmeted?

The magnitude of bicycle-related head trauma and the protective value of helmets have been known for more than a decade, yet they are worn by all-too-few American children. The exact percentage is not known. In one survey conducted in 1991, the parents of 399 children under 15 years old reported that 26% owned or had use of a helmet, and that 15% wore the helmet “most or all of the time” while riding.1 In another survey conducted in 1994, the usage rate among children 5 to 14 years old was said to be 25%.2 Both studies depended on the reports of parents contacted through random-digit telephone dialing. Based on our own surveys indicating that parents substantially overreport helmet usage, we suspect that the actual rates are much lower. Other than in affluent neighborhoods, in most communities in the nation it is rare to see child cyclists wearing helmets. A successful national campaign, defined as inducing 70% of American schoolchildren to wear bicycle helmets, would result in
more lives saved, more injuries prevented, and more long-term disability reduced than any other single injury control intervention available. That is because bicycle-related head injuries remain a relatively frequent and severe trauma problem for which an inexpensive (less than $20), and effective (85% reduction in risk of injury) intervention is readily available. Yet no such effort is currently on the planning board.

HOW DO INTERVENTION CAMPAIGNS GET LAUNCHED?

What impels public health officials to launch intervention campaigns against some diseases or types of trauma and not against others? In 1993 4 children died as result of eating hamburger tainted with 
\textit{E coli} 0157:H. As a result of these well-publicized deaths, lawsuits were successfully pursued, congressional hearings were held, and the Department of Agriculture proposed major changes in the handling and inspection of meat. Another swift response came in 1997 after 48 children were killed by air bags. The National Highway Transportation Safety Administration ordered engineering modifications and conducted a massive public education campaign. Yet, every day in the United States, an average of 1 child dies, and 50 sustain brain injuries from bicycle-related trauma. The response of the public health community is a collective yawn.

THE SEATTLE CAMPAIGN

In 1987 we initiated a helmet promotion campaign in our community. Our motivation was personal. As pediatricians working in a regional trauma center, we are intimately involved with head-injured children and their families. The knowledge that most of the deaths and disabling brain injuries that we witnessed could have been prevented provided us with more than enough energy to get started.

In contrast to some of the other childhood trauma issues with which we deal, such as pedestrian and firearm injuries, we viewed the helmet campaign as relatively easy. The intervention was simple, and noncontroversial. The campaign elements were straightforward. A range of organizations interested in children’s health and welfare, cycling, and brain injuries were mobilized to work in a collaborative fashion. Because most of the expenses were covered by in-kind contributions, the costs were modest. We were successful. Helmet usage in Seattle-area children rose from <1% in 1986 to 60% in 1995 and bicycle-related head injury admissions to local hospitals among children aged 5 to 14 declined by two thirds. Many similar campaigns, some involving legislation, have been reported from other communities.

EFFORTS TO ORGANIZE A NATIONAL CAMPAIGN

Given this experience, since 1988 we have proposed to all who will listen a similar effort at the national level. Several national organizations did embark on helmet promotion efforts. A total of 275,000 low-cost Troxel helmets were distributed between 1990 and 1994 in an American Academy of Pediatrics program funded by Sandoz Pharmaceuticals (personal communication from Richard Timms, MD, President of Troxel Corporation, March 1999). Over the past decade, the National Safe Kids Campaign designated bicycle helmet usage as one of their top priorities. Lately Safe Kids have emphasized promoting state legislation. Currently 15 states and more than 30 local communities mandate helmet use for children. The effect has been variable, but is generally associated with a 20% increase in usage rate. The National Center for Injury Prevention and Control provides grants to state departments of health to promote helmet usage. The Brain Injury Association produces literature and urges local chapters to promote helmet usage. None of these efforts, however, are coordinated.

In November 1995 the National Center for Injury Prevention and Control contracted with us to bring together organizations interested in helmet promotion to explore the feasibility of a coordinated national campaign. The effort we envisioned would bring together at a national level the same type of coalition that made the Seattle campaign successful. National media would be used to convey the seriousness of bicycle-related head trauma to parents (through use of victims), and prominent sports figures would be recruited to promote the wearing of helmets by children.

The meeting was instructive and discouraging. Instructive because all the attendees supported the concept. Discouraging because each organization felt that they were already putting forth maximum effort, and were not inclined to devote more resources to helmet promotion. Although no opposition to working in a collaborative fashion emerged, there was scant enthusiasm for doing so.

IMPEDEMENTS

If no opposition exists, what impedes the launching of a coordinated national campaign? We speculate that some of the following factors are responsible:

The “Full Plate Syndrome”

All the potential players feel that they are already taxed to meet current obligations, and do not look for “extra” things to do. No federal agency has been willing to develop a truly coordinated national campaign.

Lack of Global Perspective

There are no wise elders (or even youngsters) who look at feasible interventions for unmet child health needs. Theoretically the American Academy of Pediatrics, the Institute of Medicine, or the Maternal and Child Health Bureau could play this role, but do not. Instead, they are more apt to respond to strong advocates for particular interventions. For example, the massive efforts to detect and treat children with elevated blood levels of lead in the last decade took place because of the efforts of a relatively small number of physicians, scientists, and officials from the Environmental Protection Administration.
Provincialism
Organizations generally are not interested in sharing credit with others. For example, as a result of a $5 million legal settlement with the US Consumer Product Safety Commission, McDonald’s has been planning a bicycle helmet promotion campaign. Neither McDonald’s nor the Consumer Product Safety Commission have shown interest in linking their effort with any others. In 1998 the Prudential Insurance Company announced a helmet promotion campaign at a well-attended press conference in the US Capitol Building. The campaign has distributed approximately 15,000 helmets (R. Timms, ibid), but there has been no collaboration with other actors in the field and thus has had limited national impact.

Lack of Constituency
For action to take place, the public and policy makers must individualize an issue in human terms. In the Seattle campaign, our most persuasive motivational tools were media stories of brain-injured children. The media are especially attracted to the plight of prominent victims. None have stepped forward in the bicycle trauma realm. Victim advocacy groups have the potential power to spur action by government agencies, but have so far not done so.

In marked contrast is the vaccine constituency. Pediatricians have traditionally spent most of their “prevention energy” on immunizing American children against an ever-increasing number of infectious agents. Scorecards on percentages of “fully immunized” children are maintained for each state; lapses stimulate vigorous corrective action.12 The large number of physicians and other public health officials interested in immunizations, along with the economic interests of the vaccine manufacturers ensure that the issue will remain at the top of the prevention agenda.

Lack of Economic Stakes
It always helps when some deep pockets exist to fund good deeds. High stakes are present for auto manufacturers with child restraints; for pharmaceutical manufacturers with vaccines; and for the abatement industry with lead screening. In contrast the companies who produce helmets are relatively low on the capitalistic ladder. The manufacturers and mass retailers of bicycles have remained aloof from helmet promotion efforts, fearful that their popular product may be deemed “unsafe.”

CONCLUSION
There are no causes of death in children that are “worse” than others; the lives of all children are equally precious. Prevention goals should not only be set by the quantity of media attention or the strength of a constituency group. Are not the dangers to children who ride bicycles without helmets, equal or greater than the dangers to unimmunized children? We, of course, do not recommend a lessening of efforts to promote universal immunization or other effective public health measures. We do recommend, however, looking at all the potential agents that can harm children; determining which are the most grievous in terms of mortality, morbidity, and disability, and for which interventions are available, and forge preventive programs accordingly. Using those criteria, prevention of bicycle-related head trauma ranks high. A coordinated national campaign to promote helmet usage is long past due.

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Pyelonephritis at Home—Why Not?
ABBREVIATION. UTI, urinary tract infection.

In this issue of Pediatrics, Dr Hoberman and his colleagues have provided us with the data to justify outpatient management of the young child with suspected pyelonephritis.1 Children between the ages of 1 and 24 months who presented to emergency departments with fever and suspected urinary tract infection (UTI) were randomized to receive oral antibiotics at home or intravenous antibiotics in the

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