COMMENTARIES

Opinions expressed in these commentaries are those of the authors and not necessarily those of the American Academy of Pediatrics or its Committees.

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.” 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.

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 in 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 under-treated 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.

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. 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.

JEFFREY P. BAKER, MD
Duke University Medical Center
Children’s Primary Care Division
Durham, NC 27704

REFERENCES
1. Smith HL, Churchill LR. Professional Ethics and Primary Care Medicine: Beyond Dilemmas and Decorum. Durham, NC: Duke University Press; 1986
2. Jonsen AR. The Birth of Bioethics. New York, NY: Oxford University Press; 1998
3. Rothman DJ. Strangers at the Bedside: A History of How Law and Bioethics Transformed Medical Decision Making. New York, NY: Basic Books; 1991
4. Hauerwas S. Suffering Presence: Theological Reflections on Medicine, the Mentally Handicapped, and the Church. Notre Dame, IN: University of Notre Dame Press; 1986

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.

In another survey conducted in 1994, the usage rate among children 5 to 14 years old was said to be 25%. 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 school-children to wear bicycle helmets, would result in

Received for publication Feb 12, 1999; accepted Feb 12, 1999.
Address correspondence to Jeffrey P. Baker, MD, Duke University Medical Center, Children’s Primary Care Division, 4020 N Roxboro Rd, Durham, NC 27704.
PEDIATRICS (ISSN 0031 4005). Copyright © 1999 by the American Academy of Pediatrics.

Received for publication Mar 15, 1999; accepted Mar 15, 1999.
Reprint requests to (A.B.B.) Box 359774, 325 9th Ave, Seattle, WA 98104.
E-mail: oscarb@u.washington.edu
PEDIATRICS (ISSN 0031 4005). Copyright © 1999 by the American Academy of Pediatrics.
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.

**IMPEDIMENTS**

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. 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.

Abraham B. Bergman, MD
Frederick P. Rivara, MD, MPH
Department of Pediatrics
University of Washington

and the Harborview Injury Prevention and Research Center

Seattle, WA 98104

REFERENCES

1. Rogers GB. Bicycle helmet use patterns among children. Pediatrics. 1996;97:166–173
2. Sacks JJ, Kresnow J, Houston B, Russell J. Bicycle helmet use among American children—1994. In: Injury Prevention. 1996;2:258–262
3. Thompson DC, Rivara FP, Thompson RS. Effectiveness of bicycle safety helmets in preventing head injuries. A case-control study. JAMA. 1996;276:1968–1973
4. Bergman AB, Rivara FP, Richards DD, Rogers LW. The Seattle Children’s Bicycle Helmet Campaign. Am J Dis Child. 1196;144:727–731
5. Rivara FP, Thompson DC, Thompson RS, et al. The Seattle Children’s Bicycle Helmet Campaign: changes in helmet use and head injury admissions. Pediatrics. 1994;93:567–569
6. Farley C, Haddad S, Brown B. The effects of a 4-year program promoting bicycle helmet use among children in Quebec. Am J Public Health. 1996;86:46–51
7. Morris BA, Trimble NE. Promotion of bicycle helmet among school children: a randomized clinical trial. Can J Public Health. 1991;82:92–94
8. Farley C, Haddad S, Fortney JL. Increasing bicycle helmet use in a community measuring response to a wide-scale, 2-year effort. Can Fam Physician. 1994;40:1126–1131
9. Ni H, Sacks JJ, Curtis L, Cieslak PR, Hedberg K. Evaluation of a statewide bicycle helmet law via multiple measures of helmet use. Arch Pediatr Adolesc Med. 1997;151:59–65
10. Morris BA, Trimble NE, Fendley SJ. Increasing bicycle helmet use in a community measuring response to a wide-scale, 2-year effort. Can Fam Physician. 1994;40:1126–1131
11. Abularrage JJ, DeLuca AJ, Abularrage CJ. Effect of education and legislation on bicycle helmet use in a multicultural population. Arch Pediatr Adolesc Med. 1997;151:41–44
12. Centers for Disease Control and Prevention. National Immunization Survey. MMWR Morb Mortal Wkly Rep. 1998;47:108–116

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. 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 hospital for children 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 hospital for children with suspected pyelonephritis.