



Risks on the roads

In a recent article about global trends in injury,¹ Sally Murray describes prevention efforts for traffic-related injuries, but 2 independent trends in the developed world may reverse some of the improvements that have already been made: the aging of the population and the increase in the use of sport utility vehicles (SUVs).^{2,3} Despite improvements to newer passenger vehicles to reduce the effect of collisions with larger vehicles, including SUVs, concern persists regarding the greater risk of injury to the drivers and occupants of passenger vehicles and to pedestrians during collisions between vehicles of differing size and mass^{4,5} (these factors being the chief determinants in severity of injuries).

In the United States, 40% of new vehicles purchased are classified as light trucks or vans, many of which are SUVs. The preference for an SUV is shaped not only by individual choice but also by environmental influences, including economic and social factors.⁶ SUVs, some of which are marketed and purchased for their perceived safety image, are suggested to offer robust protection for child occupants. However, a recent study showed that despite greater vehicle weight, aggressive vehicle design and size of SUVs, the safety benefits for child occupants are similar to those offered by small vehicles.⁷ Given that motor vehicle crashes remain the leading cause of death and acquired disability in children,⁸ these data are troubling at best. SUVs also have the highest death rate for their own occupants of any broad class of vehicles,

mainly because of high rollover rates.

Traffic safety literature indicates that SUVs and trucks inflict substantial external safety costs when involved in a collision, causing damage to other vehicles, road infrastructure, roadside objects and vulnerable road users.^{3,6,7,9} In particular, the risk of injury is an important deterrent to walking and cycling. In the United Kingdom, cycling accounted for nearly 25% of all road traffic in 1951, but by 1994 this figure had fallen to just 1%.¹⁰ The number of miles walked also declined, on average, by 17% between 1975/76 and 1994.¹⁰ In a recent study that explored why children don't walk to school more often, 40% of parents reported traffic danger as one of several factors.¹¹ If traffic danger continues to discourage people of all ages from walking and cycling, the disease burden related to inactivity will increase.

Ediriweera Desapriya

Department of Pediatrics
Centre for Community Child Health
Research
Vancouver, BC

Ian Pike

Director

Pamela Joshi

Research Assistant
BC Injury Research and Prevention
Unit
Vancouver, BC

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Sally Murray's article on rates of global injury and violence¹ highlights the role of traffic-related injury and death. In discussions of traffic injuries, there is a tendency to use SUVs as scapegoats for increased risk to other road users and pedestrians because of incompatibilities between SUVs and other vehicles in terms of height, weight and frame geometry. This heightened risk is well known and is of even greater magnitude for full-sized trucks and vans.^{2,3}

However, a rapid evolution is under way in the design of SUVs, from obsolete body-on-frame construction to unibody designs, resulting in benefits to occupants in handling and ride quality. It is likely that these new designs also decrease the risk to other road users, although perhaps unintentionally.

Until the recent arrival of the Honda Ridgeline, no light trucks have used unibody technology. All other vehicles in the light-truck category retain conventional body-on-frame designs, which align stiff longitudinal steel members with the head and upper torso of car occupants. This design, in combination with non-independent rear suspension, a recent trend to increasing frame height and the attraction that light trucks hold for aggressive young male drivers, renders these vehicles lethal.

Currently, collision data are assembled by lumping data for disparate frame designs into categories that describe external appearance better than internal construction. Much research remains to be done before the effect of frame construction can be quantified.⁴

Wider recognition of the relative risks posed by specific vehicles and frame types to other vehicles, cyclists

and pedestrians is sorely needed. The external costs in terms of population morbidity and mortality are too great for collision incompatibility issues to continue to go unregulated.

Ted Mitchell
Hamilton, Ont.

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Why the surprise?

Mark Baerlocher¹ expresses surprise that, according to results in the 2004 National Physician Survey, geriatricians constituted the second most satisfied group of doctors.

Geriatricians' high level of satisfaction with their current professional life is not surprising and has in fact been reported before. For example, a US study found that physicians in geriatric medicine were more than twice as likely as family physicians to be very satisfied with their careers.² In Britain, geriatrics is the largest medical specialty, and its practitioners are reportedly the happiest.³

What should be surprising is that Baerlocher (and presumably many others) are gobsmacked by this finding. I suspect that this attitude is a manifestation of ageism.⁴ A unique feature of this form of prejudice is that the members of the "in" group (younger folk) will, if they survive, eventually join the "out" group (older people). With the aging of Canadian society, nearly all

physicians should be embracing the principles of good geriatric care, and a good (and hopefully growing) proportion of them will have to make the care of older patients the focus of their professional practice. Negative stereotyping of older individuals creates barriers to the achievement of both goals.

David B. Hogan
University of Calgary
Calgary, Alta.

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The perverted irony of Health Canada's Special Access Programme

The *Oxford English Dictionary* defines the word "irony" as "a state of affairs that appears perversely contrary to what one expects." A recent description of the use of Health Canada's Special Access Programme (SAP) to obtain breast implants¹ is by all means "perversely contrary" to what we expect from the SAP — or is it?

The SAP is designed for patients with serious or life-threatening conditions and who require "emergency" and/or "compassionate" access to drugs not authorized for use in Canada, when conventional therapies have "failed, are unsuitable, or are unavailable."²

According to the news story,¹ 67% of SAP requests annually are for breast implant devices, and over the past 5 years, the SAP has approved over 21 000 requests for silicone implants. The cosmetic surgeons interviewed explained that "small breasts" and "slight rippling of the skin through saline implants" are the medical conditions for which implants are sought through the SAP.

In April 2005, we applied to the SAP for "emergency" access to 2 experimental drugs on behalf of 6 patients with advanced AIDS who could no longer derive a clinical benefit from the anti-HIV drugs available in Canada. SAP denied our application and all appeals.

Hence, we question the *raison d'être* of the SAP and its mode of operation. One of our patients died during this 10-month battle, but no one has ever died from "small breasts" or "slight rippling of the skin." Without disparaging the difficulties experienced by women who need breast implants, we cannot contain our moral outrage at the ineffectiveness of the SAP in dealing with this truly life-threatening matter.

Timothy K.S. Christie
Health Care Ethicist
Julio S.G. Montaner
Director
BC Centre for Excellence in HIV/AIDS
Vancouver, BC

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Changes at CMAJ

I have been shocked by recent events at the *CMAJ*, including the firing of John Hoey and Anne Marie Todkill as editor-in-chief and senior deputy editor. In a situation like this one, what are the rights of long-time CMA members, like me, whose fees have helped to support the association and its flagship journal over the decades? What are the rights of readers, who have relied on *CMAJ* for high-quality intellectual honesty and the bravery to question the increasing corruption of academic medicine by outside interests? What about those whose intellectual creativity has helped to make *CMAJ* an important international force in medical and health science?

When free speech is suppressed,