

## Bike helmets—Can we improve on a good thing?

In Canada, roughly 50 children die each year from bike accidents, with 75% due to head injuries.<sup>1</sup> In 1996, British Columbia became the first province to implement legislation requiring children and adults to wear helmets when riding a bike. Helmets are known to reduce the chance of serious head injury by 70% or more.<sup>2</sup>

A survey by MacPherson in 2002 examined 9700 bicycle-related hospital admissions across Canada. Results showed that in provinces with helmet regulations, childhood head injuries fell by 45%. In those provinces with no regulations in place, there was a 27% decrease in head injuries.<sup>3</sup> These results are supported by a 2008 Cochrane review of North American studies.<sup>4</sup> Most importantly, helmet legislation is associated with fewer deaths due to bike-related head injuries. Wesson and colleagues showed a 52% reduction in childhood deaths (one life saved every 8 weeks) in Ontario after the province implemented helmet legislation.<sup>5</sup>

The economics seem to make good sense, too. It is estimated that every dollar spent on bike helmets saves \$30 in indirect medical costs.<sup>6,7</sup>

As happened with the introduction of seatbelts, the number of people wearing helmets prior to legislation was small, but increased once compliance was made mandatory. Between 1995 and 1999 (dates pre- and post-helmet legislation) the proportion of riders using bike helmets rose from between 15% and 30%.<sup>8</sup> By 1999 roughly 75% of riders were wearing helmets.<sup>8</sup>

Despite the clear benefits of wearing a bike helmet, a significant gap remains between the proportion of cyclists wearing helmets (75%), and the percentage of drivers using seatbelts (92%).<sup>9</sup> There are also reasons to worry that without ongoing programs

to encourage and enforce helmet use, the number of people wearing them will decline.<sup>10</sup>

Clearly there is room for improvement and other options are available to encourage helmet use. Royal and colleagues summarized the results of 13 trials that examined helmet campaigns ranging from school-based programs to community-wide efforts, including the provision of free helmets. All such efforts were associated with increased usage.<sup>11</sup>

Across Canada, enforcement of bike helmet laws varies. Most jurisdictions have taken an educational approach and others maintain the option of administering fines ranging from \$21 to \$100 for infractions. In some areas, fines are waived when a properly fitted helmet is purchased.<sup>12</sup> Disturbingly, some provinces and territories (Saskatchewan, Manitoba, Quebec, Newfoundland, Yukon, Northwest Territories, and Nunavut) have no bike helmet legislation.<sup>13</sup>

Doctors can continue to advocate for helmet use and educate their patients on the benefits of wearing a properly fitted helmet. The BCMA web site has more information for patients under the Health and Wellness section ([www.bcma.org/patient-advocacy/health-and-wellness](http://www.bcma.org/patient-advocacy/health-and-wellness)).

As a public health measure, particularly for children, bike helmet use should remain a priority issue—and one well worth the cost.

—Lloyd Opper, MD  
 Chair, Council on Health Promotion

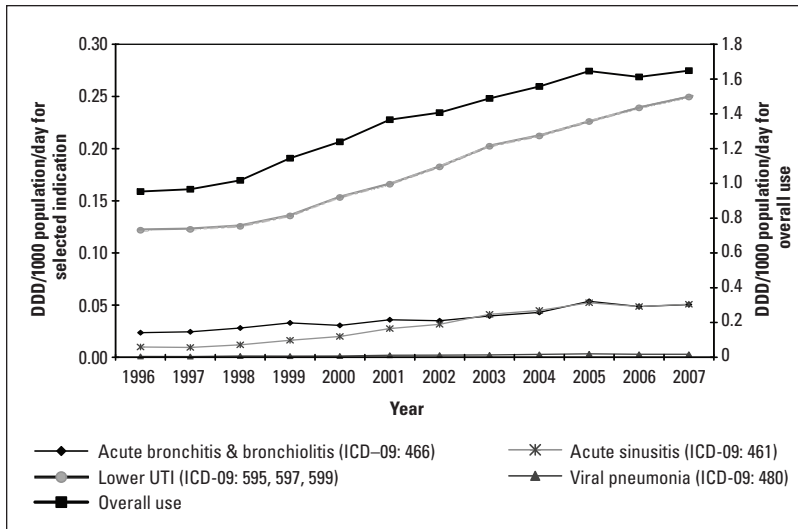
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**Figure 3.** BC consumption of fluoroquinolones for selected indications, 1996–2007.

fluoroquinolones are used for urinary tract infections ( **Figure 2** and **Figure 3** ).

Although we have shown that overall antimicrobial use has decreased, it is apparent that there is a substantial increase in use of broad spectrum agents, particularly the macrolides and newer fluoroquinolones (levofloxacin and moxifloxacin). As such, we need to focus our efforts to reduce inappropriate use of these agents, in particular through:

- Public education about how certain infections do not require antibiotics.
- Reinforcement of basic infection control practices in the community, such as hand washing.
- Reinforcement among physicians and pharmacists that many classes of infection do not require antibiotics to resolve and that first line

(e.g., simple beta-lactam) antibiotics are an appropriate first step in managing many community-acquired infections.

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in-law are expecting their first baby in early December—this first Christmas as a grandparent is a long-awaited milestone. So I am both thankful and grateful for all that I have. And I hope all of you find the

opportunity to reflect and realize all that you have to be thankful for. From my family to yours, I wish you all a happy and safe holiday season.

—Bill Mackie, MD  
BCMA President

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an EMR through the PITO program receive assistance through the Implementation and Transition Support Program and one-on-one support from a local relationship manager and a local physician champion to capitalize on their experience to help make their EMR implementation successful.

Most of all, as Drs Wong and Simkus found, physicians can increase the probability for a successful EMR transition by including all of the stakeholders—MOAs, office managers, receptionists, even patients. Threats from change can be quickly turned into opportunities with a collaborative approach from the start.

—Jeremy Smith  
PITO Program Director

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injured workers throughout British Columbia receive consistent service from WorkSafeBC.

If you have any questions or concerns regarding opioid/narcotic prescriptions for your injured worker patient, please call your local WorkSafeBC office and speak to a medical advisor.

—Peter Rothfels, BEd, MD, ASAM  
WorkSafeBC Director of  
Clinical Services  
Chief Medical Officer