

WMA STATEMENT ON TRAFFIC INJURY

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PREAMBLE

1. Serious injuries and mortality in road collisions are a public health problem with consequences similar to those of major diseases such as cancer and cardiovascular disease. Worldwide, about 1.2 million persons are killed each year on the roads and an additional 20~50 million are injured. By 2020, road traffic injuries are expected to be the third largest contributor to the global burden of disease and injury.
2. In addition to the immeasurable personal and social price paid by the victims of road crashes and their relatives, traffic injury has a significant economic impact. The direct and economic cost of injury and disability resulting from traffic injuries, including emergency and rehabilitative health care, costs of disability, disability adjusted life years (DALYs) and other costs, amount to 1% of the GDP in poorer countries and 1.5~2% in wealthier countries. Much of this burden is borne by the health sector.
3. Road injuries continue to increase in many countries, particularly low and middle-income nations that currently account for 85% for all road traffic deaths, and are the second leading cause of death among youth worldwide.
4. Most traffic injuries could be prevented by better countermeasures. Combating traffic injury is the shared responsibility of many bodies, groups and individuals, including governments, NGOs, industry, international, national and community groups, public health professionals, engineers and law enforcement personnel.
5. Speed is widely recognized as the most important determinant of road safety, affecting the likelihood that a crash will occur and the severity of resulting injuries if a crash does occur. An average increase in speed of 1 km/h is associated with a 3% higher risk of a crash involving injury and a 5% higher risk of serious or fatal injury.
6. However, efforts to decrease road crashes and injury also require a "systems approach" that recognizes and addresses the many factors that combine to increase the risk of traffic accidents and resulting injury, including human, vehicle and road design variables.
7. Human, vehicular and environmental factors interact before, during and after a collision. Intervention at each of these stages will help reduce crashes and injury. Effective intervention requires public education as well as professional involvement in the fields of engineering, law enforcement and medical care.

8. Pre-collision intervention is aimed at preventing crashes and reducing risk factors. Examples include: preventing drivers from driving when fatigued (especially drivers of heavy vehicles), distracted (including prohibiting the use of hand-held cellular phones) or under the influence of drugs or alcohol, and measures such as night curfews or graduated licensing for young drivers. Pre-collision intervention also includes setting vehicle design standards that ensure that vehicles are roadworthy and cannot be driven at excessive speeds. Other interventions include setting and enforcing appropriate speed limits, installing speed cameras, and optimizing road design and layout to prevent crashes.
9. A second level of intervention is aimed at preventing or reducing injury during the crash. Such interventions include: enforcing the use of seat belts and child restraints, requiring helmets for cyclists, manufacturing vehicles equipped with safety devices and crash-protective design, lowering and enforcing speed limits and removing heavy, rigid objects such as concrete or metal dividers, light posts and abutments from the sides of roads.
10. Post-crash intervention is aimed at maximizing life saving and injury reducing treatment and includes improved pre-hospital and emergency trauma care and rehabilitation.

RECOMMENDATIONS

1. The WMA adopts the findings and key recommendations of the WHO Report on road traffic injury prevention (2004) and calls for their implementation by its member National Medical Associations and their governments and relevant bodies.
2. Physicians must view traffic injury as a public health problem and recognize their responsibility in fighting this global problem.
3. National Medical Associations and their member physicians should work to persuade governments and policy makers of the importance of this issue and should assist in adapting empirical and scientific information into workable policies.
4. National Medical Associations and physicians should be key players in public education, and should include road safety in health promotion activities.
5. Physicians should be involved in the collection and analysis of data regarding road crashes and concomitant injuries, including injury surveillance systems.
6. Physicians should work towards changing the public attitude toward road travel, including pressing for improved public transportation, bicycle paths and proper sidewalks to encourage less car use and the adoption of healthier options such as walking and cycling.
7. Physicians should be active in addressing the human factor and medical reasons for road crashes, including, but not limited to, the use of prescription drugs or medical conditions that may impair driving ability, and explore ways to prevent and reduce the severity of injuries.

8. Physicians should lobby for the implementation and enforcement of the measures listed above, which have been shown to decrease the risk and severity of vehicle crashes, and the evaluation of their impact.
9. National Medical Associations and their member physicians should encourage research and development of improved training systems and medical care at all stages, including effective communication and transport systems to locate and evacuate the victims, emergency medical care systems to provide life-saving first aid services, and expert trauma and rehabilitative care, and should lobby for increased resources to help provide these services.

RESCINDED