Shaping the Millennium:
Applications to Leadership Systems

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Key Words: Public health protection, child safety, child injury prevention, childhood injury,injury prevention, safety, history.

The opinions are mine alone and do not necessarily represent anyone else, nor any group or organization.

See related detailed commentaries on the history of injury prevention leadership, some at Archivist Attic in ICEHS Newsletters, at icehs_section@connect.apha.org (at archives and at communications) and Section Members have web access to APHA ICEHS Section library archives.

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Part 1 Home and Children Injury Prevention

Abstract

Using history, leadership systems and personal reflections, the author assesses more than 190 articles, primarily published in Public Health Reports, The American Journal of Public Health and other supportive sources for gaps, on child and home injury prevention in ancient times, in the Middle Ages, during the nineteenth century … to the creation of the American Public Health Association's Injury Control and Emergency Health Services Section in 1972. The resulting" bookshelf" on the impacts of historical injury prevention personalities, on events and values, overlaid by several modern leadership systems conceptual frameworks, may better interface contextually on the continued progress of modern injury epidemiological and prevention systems. The understanding of interacting injury control historical and current leadership systemscan promote newer evidence- based science and art crafts and skills. More applied historiographical research, in service training and professional education curricula can guide continued professional and organizational growth in injury prevention, especially during losses of institutional memory and economic downsizing of resources.

"Science is built with facts, as a house is built with stones. But a collection of facts is nomore a science than a heap of stones a house."

Henri Poincare. La Science et l'hypothese Flammarion, Paris, 1902). Introduction. In Mark Buchaanan. Nexus. Small Worlds and Groundbreaking Scienceof Networks. W W Norton &Company, NY, NY. 2002.11

"Verily, the works of those gone by have been circumstances and examples to men ofmodern day, that folks may view what admonishing chances befell other folks, and therefore take warning. "Arabian Nights

"The only new thing in the world is the history you don't know."

Harry Truman"There is no dichotomy between government and

politics." W. Wilson

Omnia mutantur, nos et mutamur in illis. (All things are changed, and we change withthem). various, after Ovid

"One death is a public concern; millions are just statistics" Stalin, not.

Introduction/ Background

As a fifty-year, seasoned veteran injury prevention researcher, practitioner and educator
/Advocate, I often passionately still seek the unattainable" magic" bullet to improve our nationaland international legacy to prevent injury risk, risk status and

poor outcomes.

The US history of the injury control movement offers significant guidance in leadership of potential transfer value to worldwide [1] educators, practitioners and researchers for current injury

epidemiological, primary prevention, acute care and rehabilitation practices. However, there is little awareness and application of diverse earlier and gradient successes and failures, and of newer models in leadership systems. From the initial idea of a program to today's [1]economic national downsizing cycles of organizations, institutional memory must be assessed. Today, such memory, if resonated at all, is only the one-year-old web review that has no view of the pages that preceded it, to help guide long range efficient and effective decisions on public service during national and international economic downturns. [2] Injury Prevention, with relatively less resources as a newer public health discipline, has been especially susceptible to such 'ups and downs".

Although, certainly, William Haddon, JR's sentinel injury etiologic and preventive framework is usually taught,[3] (see Part 7 An Epilogue and Summary: One Leadership Archetype), little in-service training in injury control history and leadership systems is being conducted in the United States. [4] [5] [6] [7] [8] (Figure 1: An Historical Timeline).

Figure 1: A Selected Historical Timeline of Injury Prevention [9]

1913 US Congress charters National Safety Council.

1924 Cadillac offers first car with safety windshield glass equipment as a standard

1932 Maryland is first US State to introduce mandatory car inspections.

1937 Godfrey publishes one of the first U.S. statements on the need for public health involvement in "accident" prevention, in AJPH.

1943 APHA Committee on Administrative Practice appoints a subcommittee on "accident" prevention.

1945 APHA Subcommittee on "Accident" Prevention develops program guidelines for accident prevention.

1950 American Academy of Pediatrics forms Committee on "Accident" Prevention. and Poison Control.

1955 McFarland publishes Epidemiological Principles Applicable to the Study and Prevention of Child Accidents in AJPH.

1956 First annual Stapp conference on the biomechanics of crashes.

1957 APHA policy statement urges health agencies to assume an active role in all "accident" prevention programs; INDY 500 physicians racing enthusiasts establish American Association for Automotive Medicine (Association for the Advancement of Automotive Medicine); Snell Memorial Foundation's testing, development, research and educational leadership in helmet standards.

1959 Insurance Institute for Highway Safety founded.

1960 APHA publishes public policy statement recommending that "accident" prevention be recognized as a major public health problem.

1961 APHA publishes Accident prevention: The Role of Physicians and Public Health Workers.

1961 Journal of Trauma begins.

1963 Haddon publishes "injury matrix" concept paper.

1964 Injury Prevention training offered in 11 schools of Public Health. hu

1965 Ralph Nader published Unsafe at Any Speed.

1966 National Highway Safety Bureau (later National Highway Traffic Safety Administration, NHTSA) established to set car safety standards in 1968.

1966 National Research Council report: Accidental Death and Disability: The Neglected Disease of Modern Society is published.

1968 The Federal Gun Control Act passed by Congress

1968 American Trauma Association Established

1968 Lap belts in all seated occupants are installed by the four major manufacturers of US automobiles.

1969 Accident Analysis and Prevention and, also, the Journal of Safety Research begin publication.

1968: APHA, ICEHS Section "began" as SPIG (special programs not large enough for Sections)

1970 The Federal Poison Prevention Packaging Act passed.

1970 National Institutes on Alcohol Abuse and Alcoholism established.

1970 National Institute for Occupational Safety and Health established.

1972 The Federal Flammable Clothing Act passed.

1972 Consumer Product Safety Commission established.

1972 American Public Health Association establishes

Injury Control and Emergency Health Services section

1973 EMS Act passes US Congress.

1974 General Motors produces first air bags.

1974 Congress mandates 55 mph national maximum speed limit.

1974 National Association of Governor’s Highway Traffic Safety Representatives established.

1976 National EMS/ PCC law passed with limited funding.

1973 National Center on Child Abuse and Neglect established.

1977 Prevention Institute founded as the national center for developing and advancing the practice of primary prevention.

1978 US State of Tennessee first worldwide to mandate child passenger safety law.

1978 US RID (Remove Intoxicated Drivers) established.

1979 Federal Division of Maternal and Child Health (DMCH) of the U.S. Department of Health and Human Services established (designated as a Bureau later).

1979 Promoting Health/Preventing Disease: Objectives for the Nation published.

1979 Center for Disease Control (CDC) establishes a violence epidemiology branch to track

incidence of interpersonal violence.

1980 First population-based and emergency room-based injury surveillance system implemented in two states.

1980 Mothers Against Drunk Driving (MADD) established.

1981 First National Conference on Injury Control, sponsored by the Johns Hopkins University and CDC.

1982 CDC publishes Injury Control Implementation Plan for State and Local Governments

1983 MCHB publishes Developing Childhood Injury Prevention Programs: Administrative Guide for Maternal and Child Health (Title V) Programs.

1984 Congress establishes the Emergency Medical Services for Children program.

New York State enacts first US seat belt law.

1985 Every state has passed legislation requiring the use of child safety seats.

1985 Injury in America: A Continuing Public Health Problem published by the Committee on Trauma Research.

1985 Surgeon General's workshop on "Violence and Public Health."

1986 CDC awards five academic centers $2 million to address research on injuries.

1986 MCHB awards demonstration funding to address violence prevention.

1986 Minimum Drinking Age passed by Congress.

1987 Launch of the National Safe Kids Campaign.

1987 First Injury in America Conference, (as partnership with CDC and NHTSA).

1988 Injury Control, a follow-up to Injury in America published.

1988 CDC established the National Center for Injury Prevention and Control.

1988 Surgeon General's workshop on drunk driving.

1988 The Future of Public Health released by the Institute of Medicine.

1989 Injury Prevention: Meeting the Challenge published as a supplement to the American Journal of Preventive Medicine.

1989 Release of Cost of Injury, a report to Congress.

1990 Healthy People 2000 - National Health Promotion and Disease Prevention Objectives report published.

1990 E-coding mandated by six states.

1991 WHO Helmet initiative begins.

1992 California Wellness Foundation begins a 5-year Violence Prevention Initiative.

1993 State and Territorial Injury Prevention Directors Association (STIPDA) is formed during Second World Congress on Injury Prevention and Control. Now http://www.safestates.org/?

1993 President Clinton declares violence to be a public health emergency.

1995 Injury Prevention begins publication.

1997 E-coding mandated in 17 states.

1997 Institute of Medicine National Committee on Injury Prevention and Control holds public meetings in Washington DC.

2001 Funding of National Poison Control Center Enhancement Act

2004 Release of Firearms and Violence –A Critical Review, NRC

2013 Release of Priorities for Research to Reduce the Threat of Firearm-Related Violence, NAS

I primarily focus on a nascent intensive analysis and application of a reconstructed interpretation of the history of U.S. child-home primary injury prevention research and practice. The historiography is to promote several newer analytical empirical, less normative, leadership systems for the present and future history of creative thinking for injury prevention actions. The historical time period, from ancient times to the mid 1970's, precedes a major shift in conceptual frameworks from" accidents" to the effective science (epidemiology) of injury causes and to the start of the sophisticated art (of management and leadership) in injury control. The science and art of injury prevention has greatly matured. However, the art disciplines still lack systems alternatives to just isolated and unlinked components (surveillance, planning, organizing, initiation, coalitions, funding, etc.), VS. a broader overall creative interacting leadership structures and collaborative systems for social change. Moreover, personalities impact history.

One might respond to the above historical premises, as did the French philosopher Valery[10] who affirmed that there are no lessons from history of personalities, events and ideas. For times always change... and even today's patterns of injury and violence, are indeed unique, after the World Trade Center disaster? One might challenge the premises on maturing our injury prevention leadership systems. Certainly, many individual and collegiate studies, reports and real child injury control progress and outcomes recently have transpired, especially since the creation and successes of the federal CPSC, the NHTSA, DHHS-DMCH, and CDC's National Center for Injury Prevention and Control and its Injury Control Research Centers (ICRCs).[11 12 13 14 15]

Christoffel and Gallagher,[16] Fisher,[17 18]Waller,[19 20 21 22 23], Runyan, [24 25] Hemenway,[26 27] Felcher [28], Thygerson,[29] and Sleet* have offered the most extensive descriptive, analytical, and dynamic / fluid historical assessments of injury prevention and control leadership. Leon Robertson[30] and Jess Kraus[31] also include professional career memoirs on traffic injury research and epidemiology.

Christoffel and Gallagher, in their first edition textbook update the descriptive historical timeline (prepared primarily, by Fisher, Archivist, American Public Health Association's Injury Control and Emergency Health Services Section).

Fisher analyzed trends in the history of environmental health injury prevention. He derived a dynamical program managerial conceptual framework. Waller, mentors and reflects from his fifty years of experiences, primary in home and traffic emergency and trauma medicine research methodology. He reviews contributions of national leaders in the political dynamics of injury control since 1940 and focused on the rise and fall of the Public Health Service's Division of Accident Prevention and describes how new leadership was short lived in the 1960's and early 1970's. He cautions about tendencies for insular national in-house research and narrow professional agendas.

**Sleet DA, Baldwin G, Marr A, Spivak H, Patterson S, Morrison C, Holmes W, Peeples A, Degutis L. The History of Injury and Violence as Public Health Problems and Emergence of the National Center for Injury Prevention and Control at CDC.* Journal of Safety Research *43(4):233-248, 2012.*

Baker, also a pioneer in injury control research and teaching, describes the roles of key military, aeronautical and medical-safety pioneers from WWI through post WWII, whose work, over many decades, led to traffic, home and public injury prevention.

Runyan's "paradigm" offers policy focuses for injury control and revisits Haddon's conceptualizations, while Hemenway longitudinally and extensively describes sixty success stories in injury prevention of heroes in injury prevention and in his earlier book had tracked, extensively, the similar successful histories of the public health approach to motor vehicles, tobacco, and alcohol, with applications to firearms policy.

Felcher reviews the historical failures of the federal Consumer Product Safety Commission in protecting the Americans, especially their children, from risks in the marketplace.

The Thygersons mentor on national competency standards for unintentional injury prevention so as to enlarge the pool of skilled professionals.

Rivara cites the history and accomplishments of injury research and control and reviews the need for scientific evidenced based interventions. [32].[33]

CDC offers concise histories of injury prevention in several books, in MMWR

[34]. [35], and prepared a 2012 National *Action Plan for Child Injury Prevention*, developed in partnership with more than 60 stakeholders. The goals of the *National Action Plan* are to raise awareness about the problem of child injuries and the effects on our nation, offer solutions by uniting stakeholders around a common set of goals and strategies, and mobilize action to reduce child injury and death. The *National Action Plan* can be found at www.cdc.gov/safechild/NAP and *Preventing Multiple Forms of Violence: A Strategic Vision for Connecting the Dots*. at http://www.cdc.gov/violenceprevention/overview/strategicvision.html , http://journals.lww.com/jphmp/toc/2018/01001. CDC examines child firearms injuries (Fowler KA, Dahlberg LL, Haileyesus T, et al. Childhood Firearm Injuries in the United States. Pediatrics. 2017;140(1):e20163486) .CDC continually cites my injury prevention archives. [36]

In January 2013, the Johns Hopkins University convened more than 20 of the world's leading experts in gun violence and policy to summarize relevant research and recommend policies that are both constitutional and have broad public support. [37]

Safe States pioneered at http://www.safestates.org/? www.safekids.org and https://csn.org/ also guide practitioners and http://www.savirweb.org/About_Us researchers. The Prevention Institute https://www.preventioninstitute.org is a major advocate.

However, one cannot explain the present by just the present, everything has a history. No publication has built on recent efforts to further: (1) create a listing of 200-and more- references, primarily on child-home injury prevention, a "bookshelf" on the fluid and dynamic interacting structural and organizational systems and on personalities, gradient events and ideas, longitudinally over the last century, (1900- 1976), nor (2) attempt to begin an overlay of that history on current conceptual interacting frameworks of modern leadership, especially with a focus on leadership power leverages available at any level of one's career.

Methods

I, initially, manually searched the stacks of a medical library for the word" accident" and" injury", in the annual indices, 1900 – 1976, of the two primary public health journals, viz. the

American Journal of Public Health and *Public Health Reports*. I then reviewed and assessed main developing thesis and evidence in those journal articles primarily on child and home injury prevention. To fill some gaps in historical continuity, I supplemented these articles with professional reports and journal articles from or of the same period (I chose my time periods somewhat artificially and with less *in vivo* fluid blending of efforts across those periods). I then reviewed my collection of old and examined newer leadership systems literature and updated my professional skills with history and leadership courses (see acknowledgments).

I have chosen various modern contextual leadership frameworks and overlays to fulfill my objectives:

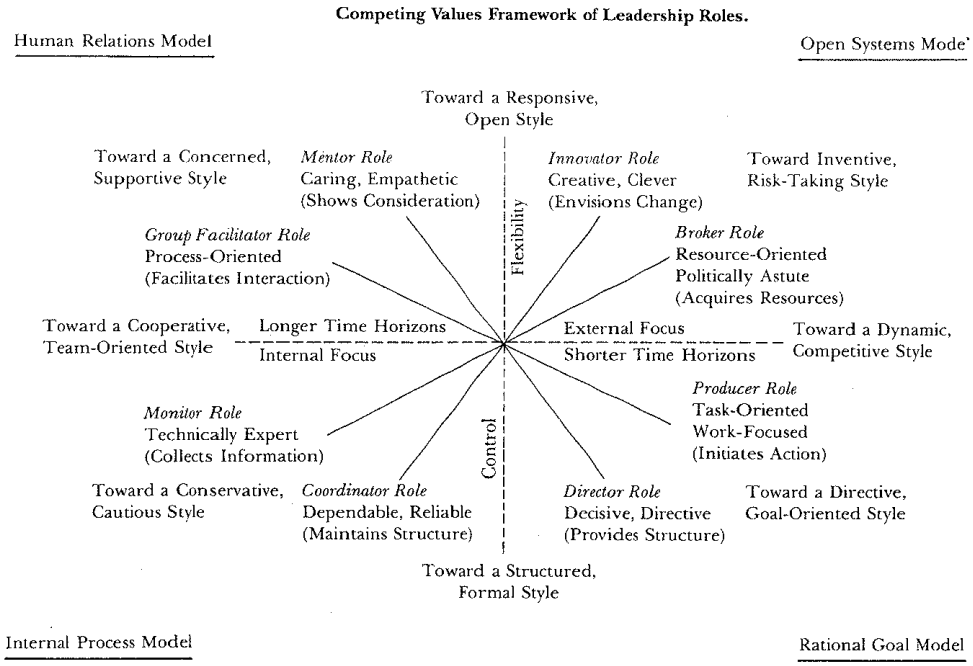
The Institute of Medicine's *Committee for the Study of The Future of Public Health*, conceptualizes" public health practice": assessment, policy options and assurances. Assessment refers to needs of the community, investigating the health effects / hazards, and analyzing the determinants of health and safety needs. Policy development represents advocacy, building constituents, setting priorities, developing plans and policies to address priorities; assurances focus on managing, implementing and evaluating.[38]

The second conceptual framework, as quadrants of a circle, the Competing Values Framework: an interacting system of eight archetype leadership roles is superimposed on the Future's "public health practices." These eight leadership models, integrate as a structural system, on contrasting, competing, though complimentary values. The eight model components: The ***internal process model*** (*monitor*: reducing information overload, analyzing information with critical thinking, writing effectively*; coordinator*: planning, organizing and controlling). The **rational goal model**, (*director*: taking initiative, goal setting, delegation; *producer:* personal productivity, motivating, time and stress management). The **open systems model** (*innovator*: living with change, creative and managing change; *broker*: building and maintaining (e.g., leveraging) a power base, negotiating, presenting ideas orally). The **human relations model** (*facilitator*: team builder, participate decision making, conflict manager; *mentor*: understanding yourself and others, interpersonal communication, developing subordinates).[39] The Competing Values Framework of Power and Influence are toward the use of trust and faith, resource acquisition and allocation, assertiveness and conflict, goal clarification, structures and authority, information, and group values.(Competing Values Framework of Leadership Roles for Power and Influence).[40] Any of these conflicting, and yet complimentary values, of 'the pieces of the full system, 'pie of leadership ', when not balanced for excessive or under used leadership profiles, may result in dysfunctional leadership in injury prevention, or in any discipline. Leveraging may influence the leadership for unfavorable or favorable leadership values; for one example: moving away from just over- friction competition toward prizes for competitive -collaborative innovations (for injury control by multi- governmental, industry and non-profits organizations).

The Krebs Cycle of Creativity further generates the sequence of reactions by which organizations generate leadership energy relationships from science, art, design and engineering. https://slice.mit.edu/2016/03/25/pubpub-and-jods-meet-antidisciplinary-design-and-science/

Milburn M A and Conrad SD in The Politics of Denial (The MIT Press. Cambridge, MA. 1996. 292 pages.) historically studies the emotional driving force of rage, vociferous polar oppositions, and radicalism in current political dialogues and decisions, affecting leadership for public policy and for injury and violence prevention, as well. Defying facts is a badge of courage in the post-truth twist era (https://www.wsj.com/articles/truth-isnt-the-problemwe-are-1521124562).

Figure 2a: Competing Values Framework of Leadership Roles
Figure 2b Competing Values Framework of Power and Influence



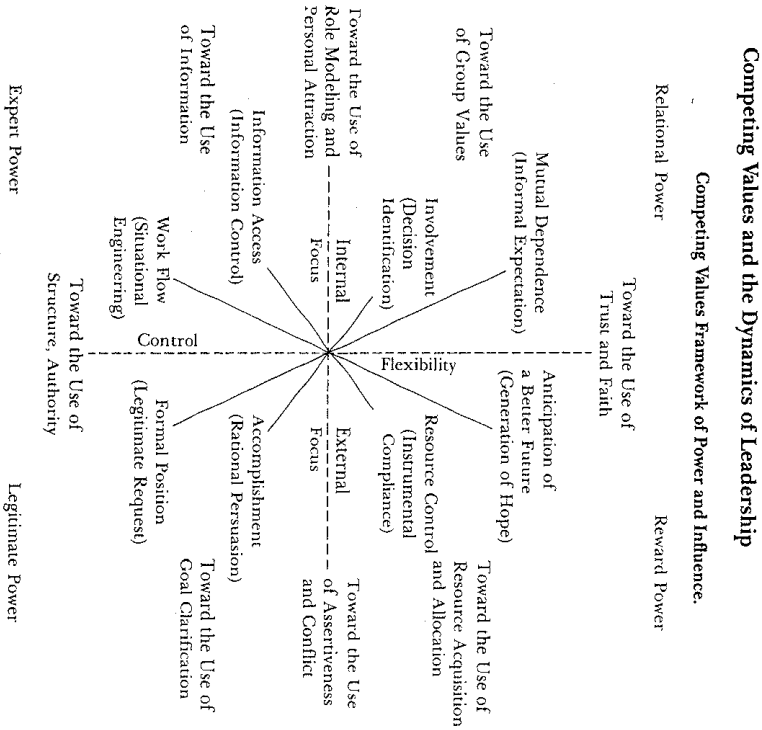
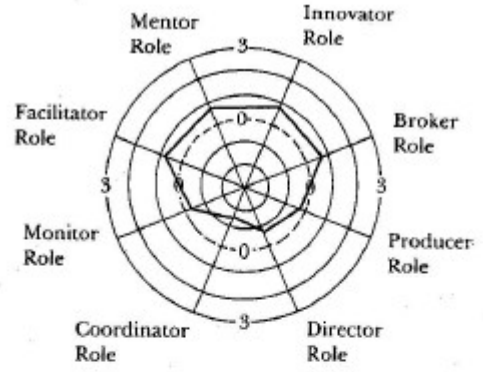
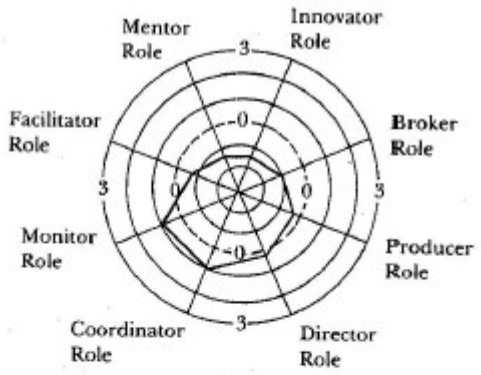


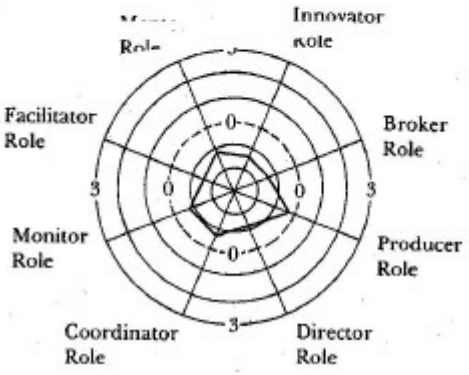
Figure 2c: Profiles of Perceived Ineffectiveness



1. Chaotic Adaptives



2. Abrasive Coordinators



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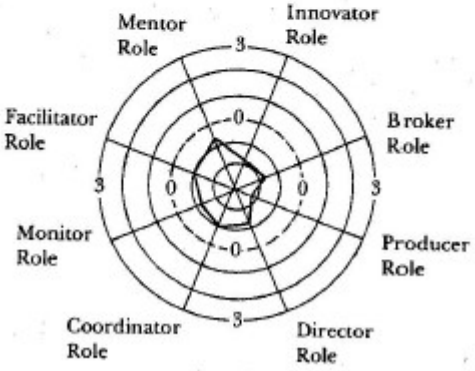
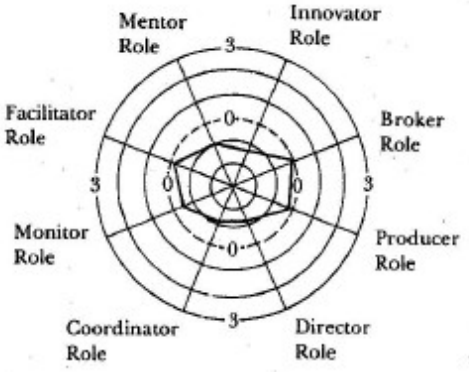
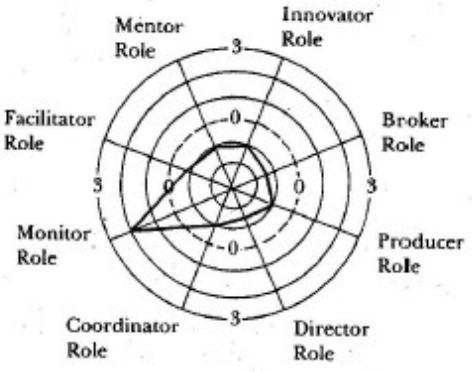


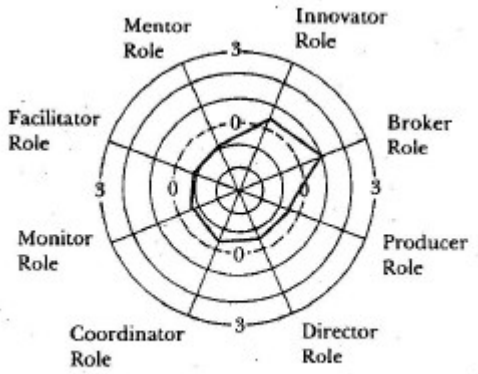
4. Extreme Unproductives



5. Technical Incompetents

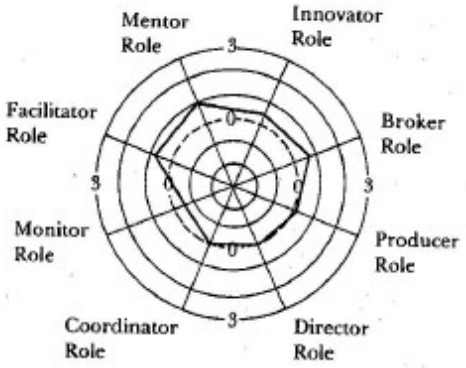


6. Obsessive Monitors

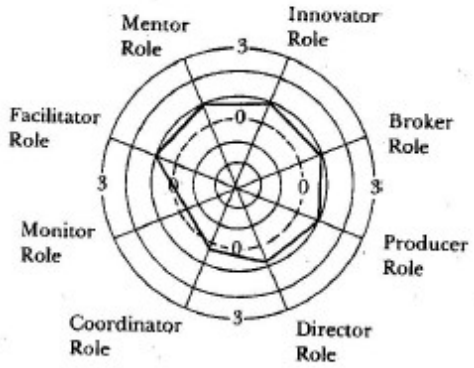


7. Disorganized Externals

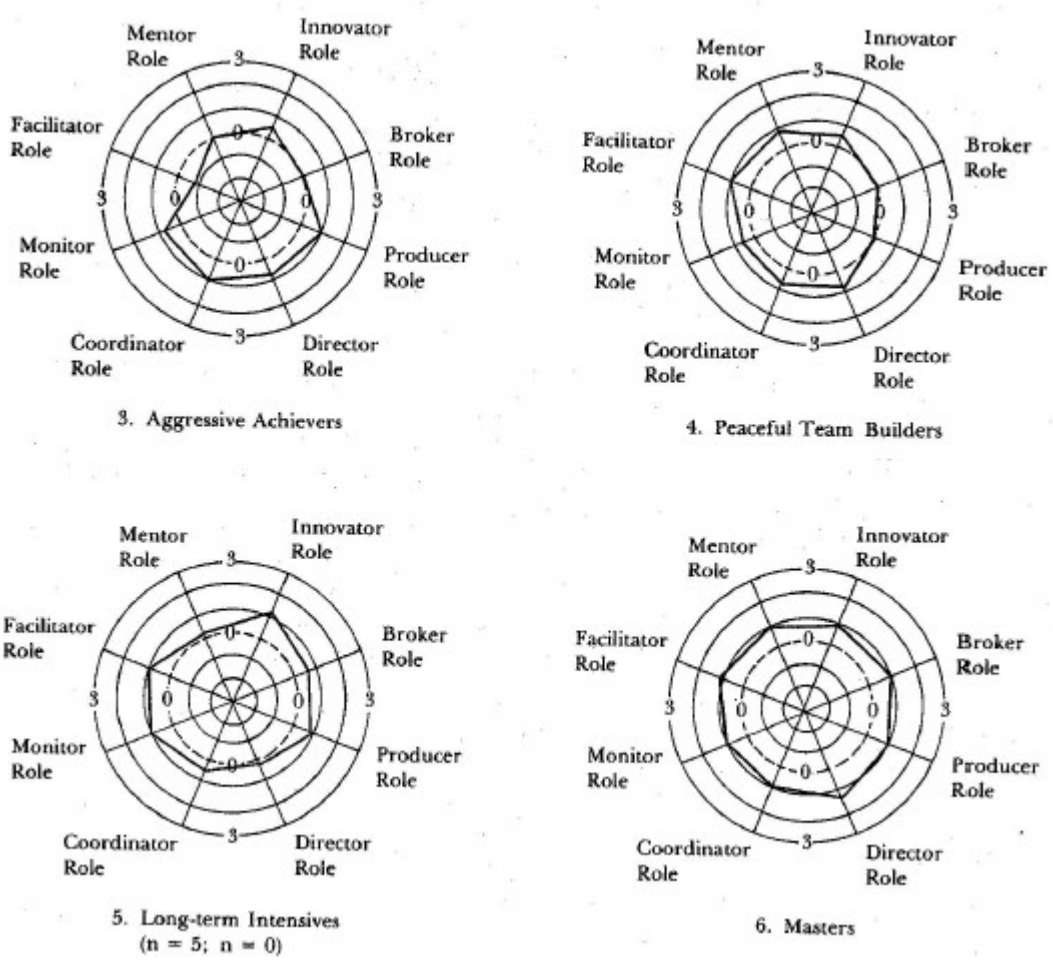
Figure 2d: Profiles of Perceived Effectiveness



1. Open Adaptives
(n = 8; n = 6)



2. Conceptual Producers



Quinn RE. *Beyond Rational Management*. San Francisco: Jossey-Bass/ Wiley, 1988. Reprinted by Permission of John Wiley & Sons, Inc. NY, NY. For Figure 2a-b, page 86; Figure 2c, pp. 96-97; Figure 2d, pp. 102-103.

A third framing of leadership systems interactions refines the just current injury programming leadership components (planning, partnerships or evaluation, etc.) and linear cause - effect chains. It identifies patterns of interrelationships not just snapshots. This framing also increases a personal process of change, especially in underlying beliefs. Focusing on systems thinking, it also aims at personal mastery, mental models for leverage, building shared vision, and team learning.[41]

A fourth leadership framework, also integrated into this paper, is even more dynamic and fluid: Historical, political, sociological, and epidemiological leadership system skills are all overridden by constants, such as temperament. Leaders' temperament trumps their intellect: Characteristics of superior leaders are honesty, integrity, credibility, competence, forward looking shared vision / Innovator, persistence, public service dedication, compassion, enthusiasm, obligation for continued learning and for what is true, right or just and systems focused. [42] [43] The leader or his/her close associate uses not only his own but also others' leadership gifts and preferences for leverages.

The Ancient Safety World. Much Not Using Preventive Practices: Weak Ethical Leadership. Guidance for Today's Global Violence and Injury?

Contrary to common myth, the concept that accidents were Acts of God, unlike diseases, never was officially recognized by Western religions.[44] However, for most of the ancient world, slaves, women and children were considered property and the most heathen practices included sacrifices of children to the gods. In contrast, the Hebrews considered life sacred; they did not sacrifice children but maintained religious obligations that included assuring almost an impossibility of carrying out of any capital homicidal injunction against even the most dysfunctional child [45]. The Roman historian Tacitus[46] ridicules the Jews as backward because it was a deadly sin for them to kill an unwanted child. Moreover, the Hebrew Bible would not permit homes to be built without fences on the roof where many social activities took place and also required them not to place a stumbling block[47], intentionally or non-intentionally, in the path of a" blind man". However," thou shall not kill" referred to murder -not self-defense - and one was obligated to kill a night intruder of his home. [48] (Also see ICEHS Section, Archivist Attic. Oct 2010. Violence in the Bible).

Biblical and Talmudical contextual stories on suicides. Include: Samuel! 32:2-4, Samuel II, 17:23, Babylonian Talmud Avodah Zarah. Page 8A, Bab. Talmud Gittin P 57B, Leviticus 19:14, and Genesis 1:27

The Greek philosopher, Thucydides,[49]recognized that for its essence a society requires leaders with justice:" Justice will come to Athens when those who are not injured are as indignant as those who are injured." Hippocrates noted in 425 B.C. less injury potential from blunt objects striking the head than from sharp ones; reflecting current safety engineering and environmental design strategies. So, what, when, by whom, and why did that ancient wisdom on child injury prevention, get almost lost?

The 18th Century. Peter Frank's Seminal Mis-Assessing Practice: Poor Mentoring Leadership. Results in Long Standing Negative Consequences for a Societal Role in InjuryPrevention

James Madison forged the American visions and current futures on weak, non- progressive US Presidents leading toward tyranny, while Thomas Jefferson viewed the leadership value of conflict in power and influence as the main preferences for essential Progressive politics, and polarities. [50]. However, the Federalist Papers' and our Constitution 's earliest relationships (e.g. the general welfare clause) for home and child safety are beyond the IVP scope- but not on historical polarization of leadership competencies (https://www.wsj.com/articles/the-founding-liberal-and-the-founding-conservative-1507905412 and https://www.wsj.com/articles/review-adams-and-jefferson-two-friends-divided-1508528403)- discussed in this paper; lest to say much of the action on public health injury and violence prevention took place in Europe.

Johann Peter Frank [51], the father of modern hygiene, in 1788, first identified injury as a public health problem, but one caused by fate and carelessness. While the late 18th Century's Age of Enlightenment of worldly studies, or even the later 19th Century Scientific Revolution formulated modern theory of disease causes, the modern theory of causes and prevention of injury did not fully evolve until the early 1970's.

Frank's four (mis)-beliefs, on injury still recycle into the dominant mental imaging and leadership of government and industry:" Accidents" (sic) are from human mini - action, result from fate, can only be prevented by changing human behavior.

Figure 3: 19th Century Woodcut

From *The Book of Accidents, Designed for Young Children.* New Haven: Babcock, 1830.

On the Frontier. Little Injury Prevention Practices: Much Housewife Leadership. My Home is My Castle.

In the America's new free pioneer frontier, the protection of children and family from" home accidents" was the role of the woman, the ' home manager '. There, adult risk taking prevailed and" accidental" injury or death on the farm or homestead was considered part of that new freedom of the frontier. One's home and farm were private castles but laced with risk. Women in homes became" safety system managers" in emergency follow -up treatment and much later in primary prevention. And yet, childhood "accidents" (not necessarily the injury) were preventable when ' being careful ' was taught and practiced.[52] (Figure 3: 19th Century Woodcut) [53]

The Industrial Revolution. The "Gilded Age". Disregard for Injury Prevention Practices:New Documentation / Innovation Leadership

The extensive publicity in the industrial revolution on increases on injury death, led to reforms in European and American Conservative working conditions, especially for young stray children wandering streets, and their working in sweat house and in overcrowded, flammable and unsafe factories. [54] Public embarrassing of those who allow children to be hurt has become a productive injury prevention leveraging option in each age.[55] The US "Gilded Age" (1865-1896) landscaped economic and public health disparities. In 1877, America's first 'public goods" base regulations from the Supreme Court decision, based on English law regulating common goods, began the economic reform of the railroads with the creation of the Interstate Commerce Commission (ICC). [56].

The 20th Century American "Progressive Era" Reform Movement. More Assessments andAdvocacy Practices: Innovative Leadership, but mostly for Industrial Safety

By 1900, Workman's Compensation Insurance sparked systematic research to find the causes of [57]accidents; however, the prime cause of accidents focus remained just on worker's fault based upon religious lessons of blaming the victim, the accepted military preference to follow orders or get injured and the temperance moment stand on the use of alcohol. [58] [59]

"Progressive Era's "(1896-1920) energetic reforms of President Theodore Roosevelt (circa 1901) ('Forget the Constitution give me men that fight for reform') galvanized the Presidency. threatening more negative publicity, leaned up and broke-up corporate trusts, further regulated the railroads, interstate commerce, labor, the food and drug industries, and defended the health, wellbeing and safety (in part from his stressing in his earlier books and in family memoirs about the 'natural Darwinian historical Anglo-Saxon destiny of America' but less later in his actual practice.[60]) for the American underprivileged and worker. He acted to reduce youth football injury deaths (https://www.wsj.com/articles/what-football-needs-is-another-teddy-roosevelt-1507931402) .

In 1903, the American Medical Association became actively concerned about burns and other mishaps then frequently resulting from uncontrolled common use of fireworks and about the same time period, the poison [61]control movement began after children's exposures to lye at home. [62](See also: June 2008 Newsletter, Archivist Attic). Actions on The New York State CommissionReport of the 1911 Triangle Shirt ("sweathouse") Factory fire in the NYC Lower Eastside, led byRobert Wagner and Al Smith in the State Legislature, reformed child and adult worker safety.
Franklin D. Roosevelt, a budding New York State senator from Duchess County, kept the debate going on the bills so that key NYC legislators could arrive to vote [63] [64] Roosevelt, as NYS Governor (1929-33), would test out his "try something" experimental concepts of Federal "New Deal" welfare programs while Eleanor would have learned the art of effective activism, going from door to door. [65](also, see: May 2007 Newsletter, Archivist' Attic)

Progressive President Woodrow Wilson (1913-1921) brokered several major thrusts for injury control: The establishment of the Federal Trade Commission (1915), prohibition of child labor and limiting railroad workers to an eight-hour day (1916).

The flu epidemic of 1918.and the Great Depression, as with COVID-19, caused great disruptions in the then public health priorities; certainly," accidents" were not such a priority -as a careless

cause. (See www.ajph archives on influenza and reports on the Great Depression.in increasedblack suicides, lower auto “accidents”, etc.

National Prevention Week was established to commemorate the Great Chicago Fire, of 1871 which killed more than 250 people, left 100,000 homeless, destroyed more than 17,400 structures and burned more than 2,000 acres. The fire began on October 8 but continued and did most of its damage on October 9, 1871. In 1920, President Woodrow Wilson issued the first National Fire Prevention Day proclamation, and since 1922, Fire Prevention Week has been observed on the Sunday through Saturday period in which October 9 falls. According to the National Archives and Records Administration's Library Information Center, Fire Prevention Week is the longest running public health and safety observance on record. The President of the United States has signed a proclamation proclaiming a national observance during that week every year since 1925. (More details on Fire Prevention Week can be found at the NFPA website).

This leverage for America’s safety movement took place for the National Industrial Safety Council, (1914), as it expanded into the National Safety Council’s Public Safety Division (1920) and then published an annual statistics report (1921) now known as *Accident Facts* [66]. (See also: August 2007, Nov 2007, Jan-Feb 2009 Newsletters, my Archivist Attic, for more history of injury morbidity and mortality reporting and for newer injury control historical book reviews). The United States Secretary of Commerce Hoover in 1924 called for a conference on street and highway safety (in time periods of conservative political and social environments) that resulted in broader questions on accidents in the home and public places.[67] [68] Excessive child fatalities from the use of children in unsafe coal mining industries resulted in intensification of safety campaigns (1929) from editorials on the Nation's accident problem. (See: Newsletters Jan 2008, March 2008)[69,70] [71]

The reform movement of the early 20th century moved the public health - type practice of assessing the nature, extent and causes of injuries into policy options for injury prevention and control. However, the home-castle - unlike the closed systems workplace – with many complex environments, the dweller’s inability to select safest products[72] and his/her over familiarity in repeating non-safe practices, increased child and other home injury. Based probably on the police system need to find a guilty party, society in the Great Depression blamed the victim or his /her family for not being “careful”.

Interregnum, The Great Depression of the 1930’s. Rational Documentation and AdvocacyPractices: Human Relations Leadership for “Accident” Prevention

The Great Depression continued conservative philosophical or programmatic progress on injury prevention; however, in 1935, innovative national data collection started on the class of child and home injury. Non-fatal home accidents were first included in the Nation Health Survey by frequency of disability of one week or more by means and nature of the injury, age, sex, employment, extent of impairment, and persons disabled for the twelve months immediately preceding the day of interview. [73]. By 1936, about 36,500 Americans died in auto accidents and 36,000 in home accidents, a newly recognized growing threat to the public health. (A New York State study showed that by 1940- 1948, home injury deaths in upstate New York had greatly accelerated than those of motor vehicles.[74]) In a plea for state cooperation to reduce motor

vehicle related injury to occupants, President Franklin D. Roosevelt, sent in 1936 a letter to the Governors of the forty-eight states. [75] In 1937, leaders of the National Safety Council and the State and Provincial Health Authorities of North America conferred on:" What shall we do about accidents?"[76]

A follow-up thrust for later planning and development for injury prevention started at the October 23, 1936, Annual APHA Meetings, Vital Statistics Section, in New Orleans. New York State Health Department Commissioner, Edward Godfey, subsequently APHA President, stated his thesis statement that health departments study of "accidents" required an epidemiological approach:

> "Few, if any health officers or health departments are displaying any interest in prevention of injury and death from accidents. They are content that statistics shall be tabulated and published, leaving prevention entirely to other agencies or the will of God. … It is the field of home and public accidents however, that I believe the health department has the greatest responsibility and opportunity."[77]

Godfrey, while offering an agrarian thesis of a rational documenting system for preventing accidental deaths (he offered evidence that injury deaths were beginning to exceed deaths from the major communicable diseases, and the 1938 APHA Resolutions requested Congressional funding support for accident prevention [78] [79]), would fail to neither develop a program plan nor organize a structure, nor suggest any evaluation approaches. He, instead, proposed collecting of data and vague informational remedies of being safe and careful. He, like Shattuck in Boston or Chadwick in England on rational and on emotive public health leadership for changing poor housing conditions, was unable to directly leverage real change.

And Godfrey's pleas would be on deaf ears as The War had converged on other foci, not unlike today, for the country and the world.

WWII: One Priority Setting Practice: But Post War, Needs Other Leadership Models

In contrast to pre-war years, World War II, a midwife of much industrial progress for the United States, debatable brought America out of the Depression, but also moved injury prevention leadership forward. A new mental image emerged: on self-responsibility, in the home[80] and factory for safety from" accidents", that killed more Americans than any war. And in 1942, President Roosevelt, speaking at the Pennsylvania Hotel, NYC, publicly declared at the National Safety Council's Home and Farm Safety Conference that accidents drained the war effort. His administration's focused New Deal political agenda had to be to win a war, just like today's national war priority.[81] The American Red Cross, tried unsuccessfully to also structure a home safety thrust, from the mid 1930's through 1940, but it withdrew due to the Council's presence [82] National promotion of State to County to City safety conferences stimulated awareness of" accidents" and" being safe".[83] In 1943 the APHA Subcommittee on Accident Prevention surveyed state and local health departments, the first of many generations to follow by APHA, and found few dedicated state accident prevention programs.[84]

One Focus After WWII: National Assurances and Direction for Injury Prevention Practices and Leadership

Godfrey's, vision led in 1946 to the accident prevention section in APHA's appraisal schedule for states and local health departments. In 1947 that APHA Subcommittee began home safety programming suggestions for each professional health department discipline.[85]

By 1947, as a consequence of these efforts, the Public Health Service hired its first full time staff person to work with state health departments on home accident prevention, the first-generation federal accident prevention program. But again, the theme was the public should not be careless: Nurses, sanitarians and other tried to limit home risks, mostly by public information.

The Harvard School on the Human and Environmental Factors. Monolithic Policy OptionPractice and Leadership Direction: But A Leadership Learning Organization

At the Boston, Mass Annual APHA Statistics Section, on November 12, 1948, Dr. I. J. Brightman reported on the first state home accident prevention program - in New York State.[86] Brightman assessed the state's home accidental deaths, first separately tabulated in 1932. He showed no reduction in home accidental death rates - unlike motor vehicle, industrial and public place accidents- related to prevention programs.[87] While little program outcomes were reported, he fulfilled, a goal of using collected data rather than just reporting them.[88] At the same APHA shared learning session, Dr. John Gordon from Harvard University, observed that accidental and violence deaths rates remained identical (88/100,00) from 1900 and in 1946 and not just human (here, accident prone[89]) in cause but also involved environmental and agent factors (which he ill-defined as various household products). [90] This debate continues on gun safety, today, as it did with automobile safety.

Other Harvard University learning organization leaders included: Drs. Ross Mc Farland, who studied airplane pilot fatigue and accidents; James Goddard, McFarland's student who at the New York State Department of Health developed a seminal medical condition driver licensing program and later led the federal Public Health Service's second re-creation of national Public Health Service, Accident Prevention Program,[91] and also the Food and Drug Administration. William Haddon, Jr., graduated Harvard Medical School and joined the New York State Department of Health's Epidemiology Residency Program in 1957 until 1961, and then in 1965 he became Assistant Director, Division of Chronic Diseases. Goddard, his mentor, encouraged Haddon to go to Albany, NY to join the Department of Health and take over Goddard's work under Governor Harriman's administration. Robert Haggerty pioneered in the child accident and poisoning prevention control center movements, and later directed Rochester, NY poison control center. (See also: ICEHS Newsletter June 2006)

Any student of injury control can recite and hopefully apply Haddon's sentinel matrix of injury control strategies that prevents, limits and minimizes the effects of kinetic (chemical, mechanical, electrical, thermal) 'energy gone wrong', the causative agent of injury or any other condition.

Table 1: Here's a condensed application for leadership energy leveraging. The Haddon Matrix Applied: Examples of Haddon's Matrix for Injury Control Applied to Leadership Leveraging (ICEHS Newsletter May 2004):

1. Prevent formation of energy.

Stop manufacturing, sales or use of highly injurious products (certain guns, drugs of abuse, sharp or leaded toys); non-pasteurized milk; leaded paint; lead gasoline; leaded or other toxins in food and drinking water

For leadership leveraging:

Seek archives and historical institutional memories; when feasible, frameworks forecasting including "smoke-out" the full system's real values and problems, plans, translations, leadership and potential programming/risks; develop shared visions and cooperative efforts to devise and weigh more than ONE leveraging decision, alternative futures, or policy option by using all essential and desirable criteria for future forecasting scenarios by essential leadership crafts and competencies. Then only initiate programs and mandates which have resources, (technical, managerial, interpersonal and political " leadership "energy supply") or for which evidence of low cost/ high benefit is documented. Some criteria: weigh not only morbidity reduction but job losses, taxes, cost containment; reassess what can go wrong with any decision; trouble shoot. Live balanced life. [92]

2. Reduce amount, modify the release of energy.

Household cleaners, medicines in lower nontoxic concentrations; lower scalding hot water heater temperatures; low lead solder for plumbing; enteric coated medicines; flame retardant children's nightwear and tents; additives to roasting /cooking bags; properly installed and used car safety seats, seat belts and airbags; short cord electrical appliances; always clean children's hands. Phase in effective piloted programs but only related to funding expectations.

3. Separate the energy from the host or environment.

Sewage from water & food supplies; install street electrical conduits above or below ground; drink hot beverages away from children; require two exits in mobile homes or trailers; store household poisons out of reach of young children, safety packaging. Require triplicate prescriptions scripts and a 30-day supply of certain controlled prescription drugs; use child safety gates on stairs/steps; require child resistant packaging on household hazardous substances; Prescribe less toxic or abusive products for same purpose; make crib slats too narrow to strangle child; stabilize unbalanced tipping refuse bins; Cease Fire-Chicago.

Streamline, separate like leadership skills and crafts quadrant modes and leverage styles: Humanistic, Innovative, Director/Coordinate, Internal Controls Groups, become more efficient and effective by enthusiastically by knowing the "True North", dedication, and leveraging your leadership competencies - regardless of location or your job position; use veteran prior historical memory, expertise for assessing, developing policy options and problem solving. As feasible, involve the needs (reduced production loss days; boosted profits, visibility) of the injury control supportive business and industrial community as prevention and health care management creative partners. Hold landmark conferences acknowledging that public and private safety practices go hand in hand. Show effective marketing of public health and safety and watch.

4. Minimize, repair or rehabilitate the damage.

Proper EMS ED and rehab services; out placement training; career and stress management; job information interviews; better press, communications and legislative relationships; lateral transfers of skills and competencies; taking vacations, new assignments, and professional courses in leadership, avocations or volunteer work. These countermeasures are a mix of interventions; and so, must our leveraging of complimentary but competing values, power and influence leadership. And as above, it is not always clear where best to categorize any one approach; but instead, it is better to lead and act with the best available data for saving 'lives and limbs'.

More on Federal Assurances Practices and Leadership Production

Kent and Pershing from the U. S. Public Health Service, Home Accident Prevention Unit, Division of Sanitation of the Bureau of State Services, (begun in 1946), provided checklists to local health department nurses and inspectors to alert housewives to the principal hazards in their home. By 1949, five staff were assigned to a home accident prevention unit. By 1961,[93] the Bureau of State Services of the Public Health Service established a Division of Accident Prevention with a staff of 153 by 1966, had reviewed" past endeavors in home accident prevention, to reconsider present problems in the light of history, and to contemplate the future.[94] [95] [96]

Kent and Pershing sorted out and prioritized the major home injuries by the extent of the problem, for example by easily solvable, less severe and more publicly and politically visible problems. They reported different methods for determining and using baseline nonfatal home accident data, studying sudden infant death syndrome, mechanical suffocation, child accident repeaters, and conducting nursing visits to homes to check for safety risks, in consensus partnerships with homebuilders, manufacturers and the medical communities, in lieu of the social reform of the earlier century.

Nurses from Travelers' and then Metropolitan Life Assurance Company, under the leadership of Armstrong and Cole, its medical directors, collected data for development and planning of child and home injury preventive programming. [97]

Shift Toward Building Partnerships for Communications and Empowerment Practices. Partnerships among Government, Industry, and Professional Organizations: Some Documentation of Community Needs and Commitment

Partnerships of APHA, American Academy of Pediatrics (AAP), and Met Life in 1942 resulted in an effective political subcommittee on accident prevention of the APHA Committee of Administrative Practices.[98] The subcommittee under its pediatric leadership of Armstrong and Cole facilitated and brokered support with the Federal Security Agency, Children's Bureau, for home and child injury prevention, and trained physicians in accident prevention. In [99]1948, the AAP had spearheaded a national child safety educational project jointly funded by the US Public Health Service and Met Life. [100] [101] [102] Pediatrician George Wheatley, a Vice President of Metro Life, not only advocated child injury prevention, but he skillfully negotiated, among adversary visions and groups. He exchanged board memberships on the National Safety Council, a marriage of ' Romeo and Juliet' that preceded by decades Congress's similar leadership archetype of the enactment of law for federal DOT funds to learn what is known about injury and later partially fund CDC's injury programming.[103] Pediatricians' leadership in injury prevention is

seminal; the initial optional focus on children is more politically acceptable in developing, planning and initiating injury prevention programs. [104]

In 1944, the AAP had split off from the APHA Committee with an AAP, Accident and Poison Committee. The early history of the childhood poison prevention movement [105]which began in 1910 with an interest in poison control centers following childhood home ingestions of common lye products [106], mirrored earlier focuses of educating families and physicians on "accident proneness". [107] [108] However, the improved hazardous labeling law for toxic substances (1950's), thePublic Health Service's National Clearing House of toxic products, the limiting of concentration and contents of an aspirin container (1960's), and the use of child safety packaging (1970's) demonstrated the successes of focusing on preventing and limiting the flow of chemical energy, and guided other thrusts for making other household products safe. Almost 50 years later, national Congressional and National Academy of Sciences reports of successful preventive and poison control center programs, (including this author's own research and related "cost containment political interests"– not just injury prevention "rational or logical injury values" guided passage and funding of the state regional poison control center law), helped fund the stabilization and upgrading of poison control centers. Funds, however, were cut. [109] [110] [111] [112] (See also: My March[113] and Sept 2004, ICEHS Section Newsletter commentary). Industrial delaying politics on safety labeling of toxic household products illustrated a common history toward consumer product safety and more recently on gun violence prevention. [114]

Dr. Barry King, Director, Medical Services, Office of Aviation Safety, Civil Aeronautics Administration suggested, in 1949, another form of partnership: Various scientific disciplines brought to bear upon a specific problem of accident proneness as a clinical entity, physical impairment as a contributing factor in accidents, and stress levels leading to injury. [115] [116] His idea that researchers, practitioners, and other teams share a vision to accomplish greater injury prevention and control process may seem of more recent vintage[117].

And in the same journal, the State's accident prevention role was reviewed by Dr. Beelman, Kansas State Board of Health Executive Officer. He reviewed reports from state health officers; only New York State reported a (part-time) program. [118] Dr. Beelman recommended using more health educators on accident prevention, changing the environment as done with Kansas's highways, and identifying" accident prone" persons.

In 1950, the Lynn, MA, Project expanded the Kansas State Fatal Accident Record with health department home nursing staffs surveying accidents. [119] In 1953, the Tennessee Health Department described statewide accident fatalities, 1946-1950, but offered no specific preventive guidance.[120]

The 1950's National Kellogg Foundation's Community Demonstrations. Planning and Directing One Managerial Goal, Changing Safety Behaviors: A Generation of "Weak Whim" Innovative Leadership in Demonstrations Processes

Supplementing the federal government's thrust, the Kellogg Foundation, Battle Creek, Michigan, funded community demonstration projects were managed, implemented and, at times, evaluated, but based primarily on "whims" on ideas for child "accident" prevention. (Today's national or local injury control practitioner, researcher, legislator or academician should be familiar with their successes, failures and consequences of "whims" or" rhetoric" – for example in myth that guns protect in public places, etc.):

In 1949, Kalamazoo City- County Health Department, Michigan, under the Kellogg Foundation primarily conducted an injury fatality home accident prevention program with health department staffs.[121] The Harvard School of Public Health and the Cambridge (MA.) Health Department were one of the first to promote the collection of not only injury mortality but also the more commonly taking place, morbidity data from community hospitals. However, the researchers found (and so have repeatedly each generation of researcher) that hospital records excluded much epidemiological data, and that follow-up interviews and site studies were further needed to enlarge these data across Cambridge [122]. Kentucky's, Missouri's and other state funded projects cited "accident proneness" causes; however, Dr. Ross McFarland's, broad epidemiological viewpoint advocated not only human but environmental causative factors.[123] [124] [125] [126]

With Kellogg projects' managerial and leadership weaknesses in proper designs and assessments of diverse etiologies of sub-categories of injury, these projects did support the role of the local and state health department in reducing accidents. By 1955, Dr. Edward Schlesinger's 18 item questionnaire data found that 33 states, 3 provincial and 296 local health departments were conducting accident prevention, up from nine states and 25 health departments in 1950. [127]

Other major technical leadership weaknesses of these projects: In most cases morbidity data was nonexistent. Targeted populations were not identified before developing or offering any intervention. The programmers never provided, today's public health practice of developing and weighing policy and program options for impacts, cost - savings and potential success before starting the program. (Or, today, do we first frame, develop, improve and weigh more than one 'real world' policy option for injury prevention and safety before beginning a new firearms surveillance system or federal gun safety legislation? And do we first assess if our systems outcome -both good and bad- will be greater than our effort? [128] [129] Do we still, in violence prevention, for example, develop educational and other interventions with insufficiently proven effective conceptual databases, although these [130]efforts can prophetically move the field forward?[131])

Illustrative of weaknesses in Kellogg's Birmingham, Alabama and the San Jose Projects: Repeated elsewhere since then, the San Jose project directors did not think about what could go wrong before the project was started. [132] (See my June, July and December 2003 Commentaries in ICEHS Newsletters on California's Story) As today, both the effects of both study population migration and staff departures on project made results of the intervention unclear [133] [134]. Ingenuity may be more important than large scale studies; a special accident morbidity survey is not always necessary. [135]

1960's Harbingers of Evidenced -Based Practices and Leadership in the States

Non-control research studies of Washtenaw County, Michigan (1952) and Richland County, Ohio (1954) tested certain accident prevention measurers recorded on a safety calendar and from a home hazard check list monitored by public health nurses. [136] [137] The Contra Costa County (California) Health Department project volunteers taught safety in study but not in control neighborhoods [138] which led to reported improvements in safety behavior. The 1955 APHA Annual Meeting, reported related activities in North Carolina, New Jersey and New York.[139] [140] By 1956, the Public Health Service's Special Services had been assigned expanded responsibility for the second-national generation "accident" prevention program. Robert Haggerty, Director, Boston Poison Control Center and Associate Professor of Pediatrics, Harvard University, in

1959, codified that progress in child and home safety. (Figure 4: From the US Department of Health and Welfare: The Human Factors Injury School)[141]

William Haddon JR., advisor for federally funded Rockland County (NY) controlled research project, showed a negative research outcome and the City of Philadelphia controlled public education demonstration project reported some statistical associated reductions in injury.[142] [143]

Figure 4. Dynamics of home accidents

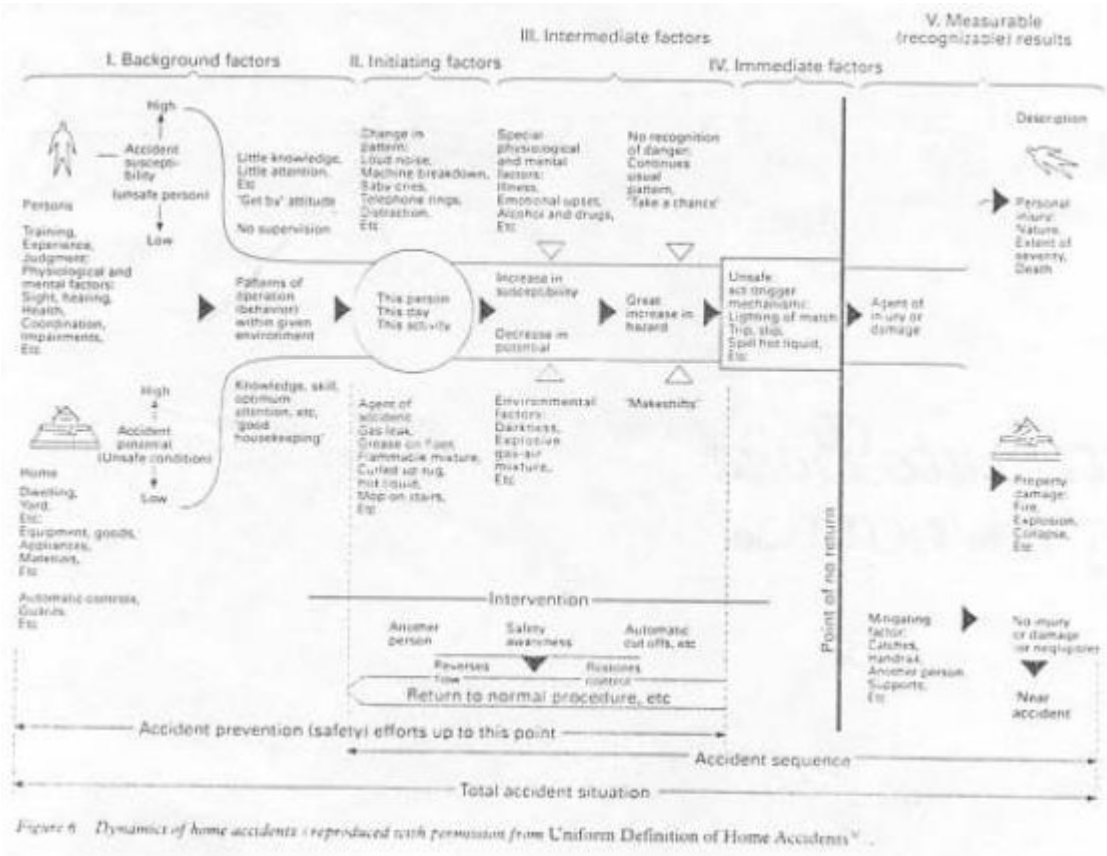


Figure 4 Dynamics of home accidents : reproduced with permission from Uniform Definition of Home Accidents[V]

1960's Also Assessing and Assuring: Leaderships on Documentation and Codifying

Consolidating and codifying the decades of accident prevention, from 1930's through the 1960's [144] for new and old researchers and practitioners, the Public Health Service and the American Public Health Association published *Accident Prevention: Guide for Physicians and Public Health Workers* on child, school, elderly, home and highway and program management. In 1974, the leadership of the American Public Health Association's new Injury Control and Emergency Health Services Section published its "Bookshelf" of the proceeding twenty years of archives to promote greater training of new professionals in injury control. [145] For the most part, both the 1960's and 1970's reviews were monolithic when (as some work, even today) the only focus was on the human causes and human prevention of the" accident".

Injury Prevention Meeting the Challenge,[146] brokered in the 1980's by practitioners who had also facilitated the funding of regional child injury prevention demonstration projects [147], with this author's initial advocacy to federal DHHS leaders for a" blue (cover colored) book" for

practitioners vs. the "red book"[148] on injury control research. At my suggestion, the "blue book's", first and subsequent chapters' highlights brief descriptive histories of injury control. Recent vintage studies[149] have included my historical timelines; however, few assess prior efforts in injury control leadership systems history. [150] [151] (See also: ICEHS Newsletters, Nov 2004, Jan 2005)

Sea Change: 1960's William Haddon, JR's Building and Integrating System Wide Practices for Leadership: Not Yet Completed Assurance for Scientific Practices that Injuries are Prevented nor Controlled: Bridges for Change, Brokered and Leveraged Leadership, Not Yet Completed

William Haddon, JR's legacy in injury control is included in my and other historical works (see introduction section); Here, I will attempt to show his leadership attributes: Haddon recognized the weaknesses in prior poor scientific design and conduct of injury control research. **[152] [153]** He galvanized and adapted ideas from Dr. Hugh De Haven, a Cornell Laboratories (NY) physiologist, who studied the survivorship in falls of airplane pilots from various heights; and James J. Gibson, who studied the effects of environment, showed energy as injury's common thread and critiqued the use of the word," accident". Haddon, the change agent, expanded with his associates the mental imaging from the theory of disease causation and of pre- injury event, event and post- event to an overall system of energy exchange and the strategies for prevention and control.**[154] [155] [156]**

Meanwhile, Albert Iskrant, Chief, Developmental Research Section, federal Division of Accident Prevention described, at the 89th Annual APHA Annual Meeting in Detroit, fruitful hypotheses rather than their testing as probably where the real contributions of science were made. [157]

Haddon and his political partner Senator Patrick Moynihan[158](See My Commentary in Spring 2003, ICEHS Section Newsletter), a colleague as New York Secretary of State, were disturbed by the expensive lack of science from the Division of Accident Prevention Division, and the too cooperative approaches with the highway safety industry. Haddon, the first head of the National Highway Safety Bureau, 1966 - 1969, outwitted critics by his public service which synergized tens of promulgated standards within a few months of moving from New York. As a self-stated" bridge"[159] between different points of view, but always with framed visions and decisions for evidence-based research and practice, ('prove it to me ') he was a public service adversary of the traffic industry's limited concern for consumer safety. After 1969, his dialogues with the insurance industry led again to his self-renewal with a funded Institute for Highway Safety, an early quasi- research foundation, where he helping the professional growth of his staff by sending them to Australia to assess its safety laws. [160]

The Federal Division of Accident Prevention, traffic safety leadership, focused on non-evidence-based research with public informational themes, was" politically" transferred to the newly established National Highway Safety Bureau, under Haddon's leadership.

The appendage of the old Division of Accident Prevention moved to Cincinnati, Ohio with focus on community environmental management. This open wedge led to its human factor laboratory soon dissolving [161] [162] [163] [164] [165] [166] [167]Haddon's successful leadership of educating, executive, congressional and legislative staff on injury prevention remains another lesson of historical watersheds.

The climate of the safety of consumers Vs. consumer beware, from safer products had begun (even in the Division of Accident Prevention which later was shifted to the FDA) and so had that wave of President Johnson, the U. S. Congress and public interest in preventing consumer product related injury. Johnson established the Consumer Product Safety Study Commission whose staff's compassion and dedication, (in" historical retrospect") applied the" Competing Values Framework" of innovative leadership in monitoring and analyzing scientific data linked to leveraging positive shared vision and visibility with their Congressional and certain industrial partners for leadership. And, all that now was timely with a wave of consumerism. The Study Commission, and later its created federal Consumer Product Safety Commission (CPSC) (PL 92-573), publicized its collected injury data in the media and at Congressional and other hearings. Those study and agency leaders successfully applied arts that embarrassed certain industries for their lack of product safety design and for blaming of all injury on consumer misuse. Conversely, the product safety movement worked closely and negotiated with statesmen from industries that believed and practiced prevention of substantial and unreasonable risks and injury (That dichotomy is valid today when such partnerships can help move litigation to enforce the older Progressive reform values of" social contracts" or perhaps for legislation or regulation to prevent violent injury related to guns, et al). No longer would reduction of injury be just from conducting community informational or educational programming to the public, untested for effectiveness and /or known duration of outcome. [168] [169] [170]Or, are these ineffective efforts still done today in lieu of targeting advocacy and unclear definition of the relationship between our science and our action [171] including shared visions with legislative staffs?

Technical Discussion

My manual topical literature database searches excluded home hygiene (that included falls, fires, scalds, sanitation, etc.) that were missed as they gave no clue of the injury content. [172] Nevertheless, my focused on denoted 'accident' topics in journal archives, with some other 'fill-in-the-blanks', admittedly somewhat artificially when denoted by periods of decades with just unchangingly fixed in those historical perspectives; monolithic leadership archetypes and overlays on the past by later histories; offers a new historical leadership prospective for our field. In the age of websites, subsequent historians can easily go to www.ajph.org for such extended searches, as I have more recently published with permissions from AJPH in my ongoing" Archivist Attic" commentaries archived at ICEHS Section <icehs_section@connect.apha.org> newsletters, histories of injury prevention leadership. Social- political leadership histories should not be restricted to just from 'polished 'professional journal sources.

Tracking the shifting definitions of the public health movement superimposed by the roots and overlays of societal values will continue to affect the histories of injury prevention and other sciences and arts. [173]

Reflections on My First Fifty Years in Injury Control: The Learning Continues:

Bildungsroman

1964, was exciting adventure, on going, to enter the "accident" prevention field at the City of Philadelphia Department of Health, (See ICEHS Newsletters November 2002 and September 2003, my additional commentary of" The Philly Story") as one of less than a dozen remaining at the state or local level. I received federal DHEW in-service injury prevention training while in

Philadelphia and later when I moved to the New York State Health Department in 1968. In 1972, I attended the U.S. Congressional Hearings on Product Safety of U.S. Senators Moss and Magnison, as guest of the National Product Safety Commission's Study Director, William White; I had admired and spoke with at a DHHS injury training course.

The working "accident prevention" leadership paradigms and archetypes had now shifted. And, as I look back (See ICEHS Newsletter, Sept. 2003: MSS on the NYS History of Injury Prevention with my anecdotes and commentary and Part 2, below), I had, (here, I use a retrospective case study, which is a historiological failure from ex post facto assumptions.), imaged how I wanted to manage my career and superimposed a version of public health practices and the four leadership models of the "Competing Values Framework":

*Mentoring (**human relations model)** from the Product Safety Study Commission's passion and mastery, helped me leverage and transfer injury prevention theory into practical innovations (**open systems model –broker: leveraging**) for limiting or reducing the releases of dangerous levels of energy in consumer products. I then directed, by imitation, (**rational goal model**) my own earliest product safety practices. Monitoring and collecting injury data and assuring their use (**internal process model**) would guide my brokering (**human relations model**) of new state and federal leadership of laws, regulations or voluntary industrial actions. These together limited the physical energy of pins in blow-gun pea shooter toys trapped in children's trachea[174]. Other impacts were on: the thermally exploding oven roasting bags,*

*burns of flammable children's nightwear, toxic chemicals exposures to toddlers, deaths and injury from mechanical energy of home glass door fixtures, thermal fireworks injury, mobile home fires without two exits, exploding fondue pots, flammable camping tents, toxic school paste, laundry detergent related rashes, allegedly mutagenic art spray adhesives, etc. As the Study Commission, did I, too, leveraged and orchestrated newspaper, radio and television interviews that cited people's stories of harmful contacts, on the exotic hidden danger trends in household products (note again: the **open systems model** and a few basic principles of effective news reporting) (Figure 5: Montage of sample of my newspaper clipping interviews) with public responses from a team of leaders of consumer organizations, industry and local and national governmental agencies*

My next development, from the Commission's findings, was not to conduct the" whim" or unproven public educational and informational activities, cited above, but instead to improve the then historical state of the art of public health practices to assess, develop options, direct, evaluate and assure effective outcomes. These trends of successful injury case studies showed prevented or marshaled energy in consumer products. I then broader my "outcomes" work with, the only available, small federal CPSC, insurance or foundation funded community demonstration contracts and grants (1970's - 1990's) on injury prevention from toys,

playgrounds, poisonings, non child automobile restraint devices, etc.(See Table 2a-c (below): New York State Historical Gradients in Injury Control Broker (Leveraging) Power/ Influence, Leadership in: a. Poison Prevention, b. Burn Prevention and Control and c. Traffic Safety: See ICEHS Section Newsletter www.icehs.org, Sept. 2004 and www.icehs.org) These published studies focused on the use of "early warnings" of newer substantial injury risks, developing and using new state and national reporting and surveillance system data. I used the CPSC's National Electronic Injury Surveillance System, which I had helped set up in New York State, and data on risk and injury reports from fire, other hospital emergency departments and consumers. From such data, follow-up effective advocacy of governmental, consumer and industrial communities and regional interventions funded by corporations and the federal government, could be measured, if not by changes in injury, alone, then also by 'proxies' of injury prevented, especially when research funds were almost null to fully prove outcomes. [175] [176] [177] [178] [179] [180] *My career leadership and management limiting value/factor for continued success and not Zerrrissenheit (being torn apart) was to remove myself, as manageable, from low self-esteem, inexperienced and untrained supervisors, who found difficulty with my competing use of a vertical, logical, (**internal process and rational goal models**) but with also with a strong horizontal innovative, thinking process, (**open systems and human relations models) -** career management.*

One Gradient Time Line of Historical Safety Legislation Landmarks (to 1980's) in New York State

Table 2a: Historical Leveraging of Poison Prevention and Control Leadership in NYS

1956 Mixed proficiency from four and 17 smaller Upstate poison control centers (PCC); $5,000 NYS Legislative appropriation to DOH to coordinate; NYC PCC contracted (began in 1955) for its expertise; beginnings of governmental supports. Rochester Center established in 1956; then LIPCC.

1970 DOH requests PCC data and operational tabulations on cases which were used in National Study Commission on Product Safety on drain cleaner poisoning risks and in NYS to show overlapping services and limited proficiencies of smaller centers

1979 Federal Title V, MCH funds ($15,000) to centers, later only to NYC PCC; Bill for Federal appropriations to regional poison control centers not funded so PCC Directors go to DOH Commissioner for support. No funding but an Ad Hoc Advisory Committee established of regional centers who submit annual reports to DOH

1980 Monroe County Regional Poison Prevention Project illustrates, after five-year intervention, significant changes in risks and poisoning ingestions; Used by Congress in late 1990's; DOH PCC Advisory Committee established. State Legislature bill to fund Pittsburgh PCC to support NYS PCC's not supported by DOH.

1983 DOH data on poisonings and PCC submitted to Legislature leads to a NYS bill justified by cost containment of PCC's. After some there years, NYS legislative minority party gives up bill. Bill picked up and passed by majority party, signed by Governor with appropriation enhancing hospital reimbursements from Medicaid funds to DOH designated regional poison control centers. Standards developed by PCC Advisory Panel to DOH, lead to NYSD and national regs. (see: Fisher L. Community – base poison prevention. Injury Prevention. Aug 2004; Voices from the Past. Amer J of Public Health, June 2004 and The Committee on Poison Prevention and Control.

Forging a Poison Prevention and Control System. Institute of Medicine (IOM) of National Academies of Science. National Academy Press Washington, DC: 2004; 73-100 and 189-238.) By 1990's, from six, just two NYS regional centers: NYC and Syracuse.

Table 2b: Historical Burn and Fire Prevention Leveraging in NYS

1967 Penal Code: 270.000) Polytechnic limits on fireworks

1968 State Attorney General (AG) requests Department of Health (DOH) background information on clothing burns in NYS. Newspaper clippings of incidents and other data submitted.

1969 AG creates a state intergovernmental agencies task force, leveraging toward potential new state requirements

1970 Federal DHEW-PHS contracts with DOH to study CO levels in mobile homes; findings led in 1973 to Executive Law on fire resistance, multi exits, and smoke detector requirements; Fire departments successfully lobby State Legislature for Burns Care Institute in DOH as firefighters are being injured results in Public Heath Law C 806 1970 for coordinating burn care; AG's Office request DOH begins statewide fire injury surveillance system from fire departments and for State Labor Department to analyze flammability of sampled fabrics: New General Business Law established on children's nightwear flammability standards

1972 National Commission on Fire Safety requests DOH, only State Department nationwide to testify in Chicago; National interest grows nationally on burns prevention and control

1974 DOH establishes a hospital ED surveillance system sample; hot beverage scalds predominated followed by meetings with beverage industry for assistance; Federal Consumer Product Safety Commission awards contract ($88,000) for investigations of consumer product related injuries. DOH had helped set up the precursor to NEISS.

1978 NYS leverages and obtains state and federal flame retardant standards for tents following DOH investigations of childhood burn injuries and deaths followed by written press and television coverage showing ignited tents burning in minutes.

1979 The NYS Executive Office, Consumer Protection Board, establishes an interagency coordinative panel and initiates programs on the proper selection and use of smoke detectors, alerts on retrofitting for risks of aluminum house wiring fires.

My story:

My Uncle had a surgery practice in the Ozarks and a beautiful Frank Loyd Wright home with a tree in the kitchen growing thru the roof. His patients mostly paid in corn; but he could afford and loved his new bells and whistles big car that kept stalling. On one a late afternoon drive with him, I said a few times; "Aren't we going too fast"

A few minutes later after my respectful question the fourth time, he was pulled over by siren state trooper's car.

After I saw my uncle in the rear-view mirror seemingly with overall large facial expressions with the police man, for about 20 minutes, I could not help laughing to fmyself.as I had suggested to my uncle four times that we were going too fast.

The trooper left and my uncle returned to his car, and we chatted." And then I asked, slowly, what happened what penalty ticket did you get?

"Oh no, Les. I delivered his 9 pound son yesterday morning. And we were reminiscing, how his wife was doing,. and celebrating!

Table 2c: Historical Leveraging for Motor Vehicle Injury Prevention in NYS

1942	De Haven's 'Protective shell' for airplane pilots later conceptualized to motor vehicle occupants
1956	NYS Governor Jonathan Bingham establishes Governor's Traffic safety Committee, interagency coordinative body
1959	D.P. Moynihan, Secretary to NYS Governor, lectures at Syracuse University and West Point, NY on auto safety as not a accident, law enforcement, but a public health issue.

1960 Moynihan inserts into President Kennedy's speech that motor vehicle injuries are one of the greatest national public health problems.

1965 NYS Legislator Senator's bill (S228) for safety designed car, passed:


Safe Car Offered

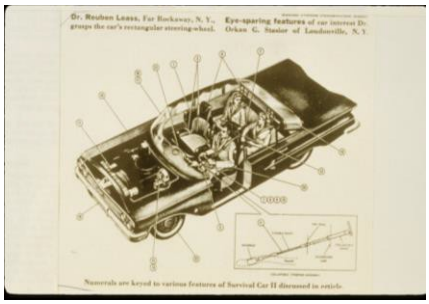
Rocky Unveils Ideas For New Safety Car

STATE OF NEW YORK

SENATE — ASSEMBLY

AN ACT

'Survival Car' Incorporates Safety Features


Dr. Reuben Leass, Far Rockaway, N. Y., groups the car's rectangular steering-wheel.

Eye-sparing features of car interest Dr. Orkan G. Stasior of Londonville, N. Y.

Numerals are keyed to various features of Survival Car II discussed in article.

1966 National Traffic and Motor Vehicle Safety Act, (PL 86-563) links national, state polity and fiscal resources with funding to Governors' offices

1968 National Highway Safety Act (PL 89-564)

1980 NYS Senate passes child auto restraints; however, Assembly does not

1981 Consumer and medical advocacy leads to child auto restraint law

1982 National Highway Traffic Safety Administration leverages states to pass child auto restraint laws by funding supports; NYS Health Commissioner requests from Executive Director, Governor's Traffic Safety Committee seed funding for three low income health clinics and similar sites; some 30 eventually funded

1984 NYS Occupant Restraint Law requires all drivers, front seat passengers and children under age 10 to use car safety restraints; John States, MD, Chair, Injury Prevention, NYS Medical Society had led a statewide coalition of various groups.

Today, such 'all or none' job leveraging may be more difficult: However, I, later learned how to cope with others' foreign- to- me competing values by learning from different 'tinted lenses' of the world and tried to learn how to apply positively those passions; however, I sometimes felt emerged as Socrates in Plato's ***Apology*** *(Defense)! (see also: Sophocles'" Antigone "or Xenophon's "Education of Cyrus") Ten years after I retired, a deputy commissioner apologized for her negative IVP leadership. Coaches and mentors minimized that negative leadership energy.*

Each person has positive gifts to share and apply to others. We all should learn to manage our careers and life by continually learning and applying other's true leadership crafts mentioned in this paper: Of living a balanced life, including volunteer work, etc. (See also: Meyer-Brigg Preferences and 360 Degree Performance Reviews) [181]

Unique personal philosophies, attributes and characteristics of the learning organization's leaders make the difference. However, it's not about problem solving – making what one does not want, go away, it's about creating -into reality, what you do. It's not about alliance building but collaborating across boundaries, all for positive social change and for what is right. [182]

APHA. ICEHS Section Newsletter. Archivist's Attic March 2006. Page 12:

How to Be A Strong Leader in the History of Injury Control

Based on How to be a Weak Leader. Steve Goodier. From Life Support, 02-24-06 (Copyright Permission for ICEHS Newsletter to reproduce "How to be a Weak Leader" granted by SteveGoodier http://lifesupportsystem.com on 3/9/06. The injury control historical leadership comments are from the ICEHS section archivist) 1. Weak leaders are blind to the current situation. They solve the wrong problems in the wrong way.

Good leaders understand what is happening. They size up the situation, put themselves in the right position to respond, prepare, and then act at the proper time.

The 1960's auto industry refused to accept any responsibility for safety; then Secretary of State Moynihan wrote into President JFK's speech that preventing automobile injury was a national public health priority. Ergo the 'NHTSA' and its first head, William Haddon Jr. (See also: Waller J. Public health then and now: Reflections on half century of injury control. Am. J. Public Health. April 1994;84:664-70 and Baker SP. Injury Science comes of age. JAMA.1989;226:2284-5.) 2. Weak leaders discourage others. They find fault and blame. They criticize when things don't go right.

Good leaders encourage. They give credit when things go well and take responsibility when they don't go well.

Alabama football coach "Bear" Bryant was once asked how he learned to inspired players. He responded, "Well, I'm just an old plow hand from Arkansas, but I've learned a few things about getting people to do what you want them to do. When things go wrong, I did it. When things go semi-good, we did it. And when things go well, you did it. That's all it takes to hold a team together and win football games.

He like Haddon adopted diverse disciplines (e.g. engineering and medicine) to injury control starting as a medical residency intern with the NYSDOH (1957-61) Haddon would always ask :"where's the evidence that what you are doing works?" (see Moynihan DP. Keynote address: Motor vehicle injuries. In symposium on motor vehicle injuries. Bulletin of the NY Academy of Medicine. 1988;64:610-616 or my in memorial ICEHS Newsletter , June 2003) 3. Weak leaders know it all. They already have the answers.

Good leaders keep learning. A cross-discipline study of leadership indicated that effective leaders in all fields are always learning. They constantly improve their skills. The best leaders, even in IC, were and are perpetual learners, they use: Senge PM. The Fifth Discipline: The Art and Practice of the Learning Organization. New York: Currency Doubleday;1994. Unlike weak leaders, they know that a spurt here and a spurt there does not make one an expert! 4. Weak leaders never rock the boat. They won't make courageous decisions for fear of failing. They

prefer to keep things as they are, even if the system is not working all that well. Weak leaders will almost always follow the well-worn path.

13

Good leaders, however, will often go where there is no path and leave a trail. They are sure of their direction and they act boldly.

Wheatley (G. Child accident reduction: the challenge to the pediatrician. Pediatrics. 1948;2:367368.) Armstrong (DB), and Cole, (WG.) Can child accidents be prevented in your community. Am J Public Health. 1949;39:585-592), at Met Life 1950's would rock the pediatric communities boat : they partnered with the National Safety Council and the Public Health Service to get all working together for child injury prevention. (Also see: Brown T and Fisher L. Voices from the past: Donald Budd Armstrong and W. Graton Cole, Early Injury Control Advocates. Am J Public Health, 2004; 94:941.See also: Micik S. The pediatrician as an advocate. Pediatric Clinics of North America; 1985:343-249) 5. Weak leaders keep others in their place. They remind them who is boss.

Good leaders know that authority is more earned than granted.

A young Army officer found that he did not have the correct change for a soft drink vending machine. Noticing a subordinate nearby, he said, "Private, do you have change for a dollar?"

Cheerfully, the man said, "I think so - let me look."

"That is no way to address your superior, soldier!" scolded the officer. "Now, let's try it again. Private, do you have change for a dollar?"

The soldier snapped to attention, saluted and said, "NO, SIR!"'

David Boyd a founder of US EMS systems would always say at meetings-"You got to have Moxy " (Shah MN. In Public Health Ten and Now: The Formation of the Emergency Medical System. Amer J Pub Health 2006;96 414-423) 6. Weak leaders do all the work themselves. They delegate poorly. They micro-manage and control.

Good leaders identify the gifts, strengths and limitations of those they lead. They assign, train, encourage and then get out of the way.

Robert Haggerty (Home accidents in childhood. NEJM. 1959;260:1322-1331) and others at Harvard University worked closely with diverse students many of whom became leaders in poison prevention and injury control 7. Weak leaders sabotage the successes of others. When those below them succeed, they feel threatened.

Good leaders, on the other hand, help their subordinates find success. They give a hand up. They realize that when one is lifted to another's shoulders, both stand taller.

Tiboni E. (A profile of a local health department's accident control program. Am J. Public Health.1967;57:665-676) was the staff training bedrock for much of injury prevention in local, state and federal agencies. (He was for me, too) and Berman (AB. Ed. Political approaches to injury control. Seattle, Washington. University of Washington Press;1992) 8. Weak leaders ask others do what they are not willing to do themselves, and try to get others to go places they have not been.

Good leaders always lead by example and examples.

(Westby J. A bookshelf on injury control and emergency health services. Am J Public Health. 1974;64:394-401. See also any of the many National Academy of Sciences Reports on Injury). 9. Weak leaders motivate by force. They cajole, intimidate, threaten and issue ultimatums.

Good leaders know that motivation by force destroys morale. They understand that people respond best to positive incentive. They know that people who believe in themselves will do more work and better work.

10. Finally, weak leaders do not listen to those they lead. Their minds are already made up and they charge recklessly ahead.

Good leaders listen and learn. U.S. Secretary of State Dean Rusk once said, "One of the best ways to persuade others is with your ears --by listening to them." Good salespeople know this. Good motivators know this. Good leaders know this.

Secretary of State Kissinger's staff knew that the drafts he wanted to review were not the first, second nor third. Want to become even a better historical leader in injury control, et al. Be principled: Start with: Covey SR. Principle-Centered Leadership. New York: Simon and Schuster; 1991 or any of the leadership and IC archival works I've cited in our Newsletters and

at Members Only. May we all be back shadowed as good leaders in the future archives of injury control! Copyrighted 2006 Leslie Fisher (Views are mine alone) Les Fisher M.P.H. Safety / Management Consultant (Archivist , American Public Health Association, ICEHS Section (see my injury PXHX commentaries www.icehs.org) 97 Union Avenue South, Delmar NY, 12054 ,USA; 518-439-0326

It was the early 1970's crest of national public safety concern that led to full establishment of the new thrust of emergency health services and post injury care - but, at first, ems care for children was only for small adults. In 1972, the APHA's the Injury Control and Emergency Health Services Section, also rode on this political / social wave. Unfortunately, few health agencies initially jumped into the arena of injury and risk from consumer products. Except for New York State Health Department, the action was elsewhere in injury prevention and consumer product safety (The federal consumer product safety act excluded firearms (See Part 3, below) food and drugs and other federally regulated products).[183] In that decade, many health departments did see a more tangible "secondary agent", the value of secondary prevention of using ambulances and emergency health services. (See Fall 2003 ICEHS Newsletter and Part 2-4 (Below).[184]

Recommendation

What should be the institutional responses to meet the above schemes on the above scholarship and adventure stories?

I hope that others will assess in their studies, curricula, and policy and other publications, the history of injury prevention practices, its past and potential leadership systems and personalities, events and ideas to guide current research and programmatic priorities. The establishment of a nationally funded archives and applied injury prevention leadership system institute, perhaps in a US School of Public Health, could offer practitioner- in - residents' in service training, (See Part 6 (below) and ICEHS e-Newsletter, Archivist Attic, for a Nascent Syllabus, Spring 2003 and forthcoming entries on discussion questions, and after dinner speech) consultation and information on current unintentional and intentional injury prevention leadership systems, seems a worthy consideration. Leaders need to identify, develop, improve and motivate their personal leadership systems for improving injury health status.

How can our history and leadership systems further guide our" conflicting values" framing into the modern period, post Haddon, during severe economic downturns? First, leadership practices, should not to be confused with management: Leadership identifies patterns that control events, of where actions and change can produce improvement, and of gaps between theory, reality and vision. I will conclude by sketching, incompletely, how leadership, and its holder's temperament today, as yesterday, can affect the success of evidence – based interventions, management of interventions and programs, and oral communications, using diverse leadership arts disciplines.

However, as mentioned before, it's not about problem solving - making what one does not want to go away. It's about creating –into- reality, what you do. It's not about alliance building but collaborating across boundaries. All for positive social change and for what is right.[185]

Summary, Conclusions and Lessons

ICEHS Section Newsletter Sept 2002 assessed primary and secondary archival publications, one historical leadership reconstruction for child injury prevention. The “rivers and streams” on fatalism, human responsibility alone and epidemiology have (not shown) branched out and many ideas still flow, while others remain in the” garbage can of history”. (Table 3 and see also: September 2003 Newsletter).

Table 3: A Brief “Rivers and Streams” History on the Paradigms of “Accident”/InjuryPrevention with a Focus on Children at Home – Assessment, Policy Development, Assurances (Ancients – mid 1970’s)

prospective	causes	remedy	time-period	references
DETERMINATION/FATE				
pagans	chaos of gods	sacrifices of infants	Gilgamis, Greco-Roman	Titus /other writers
Hebrews Lev 19.14,20 Deut 22.8 Exod 21:12-13	free will	ethical G-D	biblical- updates	
Freedom home is castle	careful	prevent accidents mom supervises;	frontier/agrian	McIntire 1980 Kelsey 1994 Tarr 1996
Fate	human behavior people interact	prev. acc by human behavior	1800's- current	Waller 1971
Economics : ongoing children working in coal mines	blame victim 1922-1929,	muckraker/reform	Indust. rev.-1920's	AJPH Jackson 1995 sweat houses,
Accident prone prev. accidents Research on human factors	psychological	psychologists /gov		Weinerman 1947 King,1949,66,67

ASSESSING THE NEEDS,INVESTIGATING HEALTH EFFECTS,ANALYSIS OF FACTORS

Epidemiology (I) Normative - like disease	epidemiology	1930's	Godfrey, 1937
Epidemiology (II)	prev. acc.-host, envr , partial agent		Gordon, 1949

BUILDING COALITIONS

Partnerships	prev. acc.	indus/gov/med	Wheatley, 1948, 1954 Armstrong.1949

FEDERAL, STATE AND LOCAL GOVERNMENTAL ORGANIZATIONS

Structure in agencies	prev .acc .	gov't	AJPH 1945, Brightman 1952
child/home safety			Kent,1957

COMMUNITY PRIORITIES, PLANS AND POLICIES

Community demos 1950's grants whims	grass routes	HD- locals,states, feds	Kellogg Foundation

SYSTEMS PRACTICE APPROACHES

Poison prevention/control product ids/concentrations/labels	Chicago PHS Clearinghouse		Press 1954
Energy is cause:	injury	NYS	Haddon (from bridge medicine ; control strategies Vs Acc. DeHaven) 1960s:sking 62
Data driven			Haddon, Klein ,1964
Caveat Emptor-product safety reform passive not active alone		Congress: Study	1970,1972

For more details on the titled paradigm, Public Health Practices e.g. assessments to assurances (major heading rows of the table) see *Committee for the Study of the Future of Public Health*, Division of Health Care Services, Institute of Medicine, Washington, DC, National Academy Press, 1985. For more details on the columns in the table for about half of the cited references, also see Fisher, L. Childhood injuries – Causes, preventive theories, and case studies: An overview on the role of the sanitarian and other health professionals. *Journal of Environmental Health*, 1988; 2:123-6.

I am not the prophet from Albany! Nor, do I (nor anyone else) have a monopoly on the truth:

Historians know that there are few clear lessons from history; context is everything and what was done in any era is not likely in our era. : The early 1800's and pioneer's , the late 1800 major capitalism thrust of the Gilded Age, the early decades of the 1900's Progressivism that

focused on governmental experts not politicians ,the technical and social impacts of World Wars, the 1950's thrust on youth psycho-social discontents and alienations, the 1960's Cold War and Rachel Carlson's advocacy for protecting our environment from radiation and poisons , the 1970's *caveat emptor 's* consumer protection movements, etc. However, the US traditionally is a conservative nation. With blimps of liberal thrusts. (www: MovieHistory.Us (Session 1 SUNY-ALB History Department Course, that I audited in Delmar, NY; Special Archivist Attic: Polarized Polity and the Challenge of Change - More Than Just Pictured On a 5T$ Bill, James Madison's Serendipitous Arts Are Needed Today. Les Fisher, Section Archivist, icehs_section@connect.apha.org, List serve e-mails, Nov 10, 2016.

In IVP and PH historical watersheds of impacts, we successfully focused first, as a first gradient, on childhood injuries. Moreover, progress took place when suburbia was infected.

And psychological, human factors as the cause with just public informational (active) interventions later became evidence-based epidemiological, engineering/legislation/and polity educational (passive) remedies for priority on child seat belts, CRDs, home poison prevention, flammable sleepwear, fireworks, and similar preventive cost/savings (not just prevention of injury) policies and laws; many partnered by industrial leadership.

And, while one must not reflect retroactively on an earlier period without attempting to "live through" the context of that earlier time, that being said:

Moreover, one must not reflect retroactively on an earlier period without attempting to "live through" that earlier time. That being said:

Today, we critically need, like Brightman build, more bridges to intersect ideas from Godfrey's, philosophical leadership paradigms and archetypes on effective injury prevention systems.

In the USA, should federally funding and regulations decrease, crisis leadership from states and localities will rely on less available national and total funds to achieve outcomes in reducing newer emerging or older injury risks to children or seniors from unintentional injury, violence and suicide.[186] [187] [188]

Support for injury prevention and control expanded research, historically only an ***internal* process model**, mostly for evidence- based research and managerial program control, may, too, become more limited during a down sized government.

Today, media communications can be improved (post Anthrax, 911, Ebola and weekly diverse values on economics or politics) for injury prevention by using single source scientific experts who provides full disclosure and who know ahead of time what will go wrong with any communication.[189] Spokespersons would avoid speculations and offer remedial strategies - for 'perception of reality is reality' (**human relations model**), ala Wheatley or Haddon; communicators would adjust to fast changes (**open systems model,** especially leveraging (regardless of job level, for self managing careers), to do what is right and to expect, at times, that good will not be rewarded!**)**.

During this current and potential future 'thunders of history', when national political values do not support gun violence nor other injury prevention reforms, can our willpower for leadership actions effectively enhance Haddon's interventional strategies by broader new advocacy, lobbying on cost containment findings and leveraging newer societal values - during economic downturns (e.g. see archivist attic" newsletters: June 2006, Feb, Nov, Dec. 2007)? Will, or can,

these competing value models, emphasizing system changes, shared vision, consensus building, creative problem solving, political adaptation and conflict resolution, be integrated more into 'modern', (not just managerial control), leadership for injury control? Will the focus be less on the **internal process model,** highlighting excessive documentation and defining responsibility or only on the **rational goal model,** only rational and not values, analyzing?

The leaders' temperament trumps their intellect: Personality characteristics of superior leaders are honesty, integrity, credibility, competence, forward looking shared vision / innovator, persistence, public service dedication, compassion and action for others' leadership gifts, enthusiasm, obligation for life-learning and for what is right or just, and systems approaches-especially in times of change – of not just technical / rational / analytical but also emotional, political, inspirational, mindsets and psychodynamics leveraging or reframing on power and influence. [190] [191] [192] [193] Superb injury control researchers and practitioners are not exceptions to these historical leadership dynamics and suitable interventions. Even the dictator, Stalin, who lacked integrity and justice, recognized that history towers over the present like a mountain.

Repeating failures in leadership history of interacting personalities, ideas and events are not a necessary consequence. Historical forces create the circumstances in which leaders emerge, but the characteristics of the particular moral and just leader in turn have their impacts on history.[194] [195] [196] [197]

Stay tuned for a complete historical review on the last thirty- six years and the next thirty-six of injury prevention and control leadership – history in the making – still somewhat early to fully assess! [198] [199] [200] [201] [202] [203] [204] [205]That dialectic and action on effective injury control research models, then, will hopefully use historical evidence-based conceptual frames, frameworks, paradigms and archetypes from the practical arts of leadership. New tools from the systems arts of competing values, principle-decision frameworks on collaborative synergistic and interdependent leadership, not only from the epidemiological sciences, are essential. [206] [207] [208][209] [210] As the ancient biblical prophet: Justice, justice you shall pursue - Deuteronomy. "God is not in the accident; He is (with us and our leadership actions) in the "ambulance" - Harold Kushner

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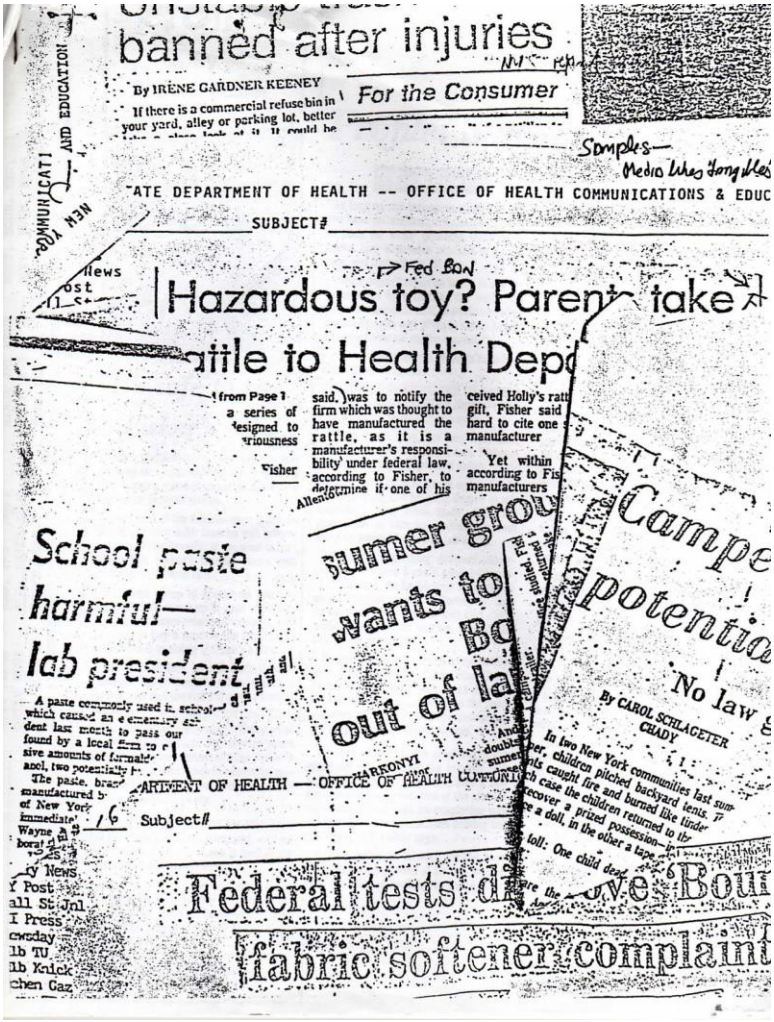
Finally, let's link more to the" Fourth Estate" and historical innovative collaborations for the IVP system. See also Figure 5-6 below, and in text and endnotes cites in Parts 2-4 (below)

When and where has our historical use of the media, "The Fourth Estate" made any significant difference in evidenced based leadership systems for public health injury control? For over 50 years I have published professional journal articles, presented at national lectures and panels, appeared on many television and radio program commentaries and been interviewed in the written press-on injury prevention needs and potential impacts. For the last decade, I have routinely expressed opinions in our local written press, The Times Union, read by our Albany Capital's politicians and their staffs .My serial piece on Jan 12, 2006, published at www.timesunion.com: "Illegal guns are getting serious consideration" offered kudos for the December 23, 2005, Times Union editorial, 'Action in Albany' (on new state law for illegal guns and shooting and killing police officers) and to its 2004 special series on gun violence; to the state Legislature and governor on the new gun trafficking law. (Full text at: http://timesunion.com/ss.asp?s=438862&c=OPINION&b=. For samples of similar historical

interviews and opinion pieces see: www.icehs.org Members' Only, my NYS Historical MSS , Part II and III , respectively, intended especially for dialogues by students of injury control, medicine and public health on IC leaderships' and the mass medias' roles. For a related full graduate course description on historical injury control systems see my IC Policy Archive MS, also at ICEHS Members' Only.) But, do my or others' public mass media contacts, make any evidence-base difference in saving lives and limbs? If so, where should we rank and weigh such ' advocacy' in our injury control applied art systems' resources and priorities? Darn if I know- for sure it depends on some parameters, to be tested. Historically, mass media (shotgun) programs, usually for feeling good whim informational blitzes, were a main (and still are?) component for injury control arts systems (see: Fisher L and Brown TM. . Donald Budd Armstrong and W. Graham Cole: Early Injury Control Advocates. Am J Public Health, Jun 2004; 94: 941). Few case control studies of those earlier, very expensive, national, state and local diverse media efforts illustrated any real outcomes for injury control (for related archives see: Robertson LS. Injuries, Causes, Control Strategies and Public Policy Lexington Books. DC Health and Company. Lexington MA. 1983. ISBN: 0-669-046647. Library of Congress Catalogue Number: 81-47553; 100-102 and The Final Report of the National Commission on Product Safety. Presented to the President and Congress, June 1970. Library of Congress Catalogue Card Number 76-606753) I yield to many modern updates on professional opinions and evidence-based research studies linking the media and injury control arts to successful outcomes. e g. www.aphabookstore.org: Injury Prevention for Children and Adolescent: Research, Practice and Advocacy, edited by our own section 's leader Karen Liller). I do know that the 'Fourth Estate', the press, historically, has been a very strong partner for overall favorable changes in public health and injury control systems. From my own history-based judgments and career experiences, the press does moves injury control, but under certain leadership arts systems' principles. What principles seem to work? Public media efforts in injury control should, I believe to be effective arts, focus with ongoing persistence on specific concrete, tangible, targeted and timely political advocacy manageable gaps or successes. (some run on, huh!) Main objectives should be to reinforce (not just to sensitize one shot) significant specific ongoing public injury control debates of state legislative, Governor's Office and media leaders. Of course, all that combined with one educational advocacy or lobbying seems always better, but not always practical. One strategy that I tend to apply is: "BROS" (belonging, opportunity, recognition and safety) i.e. creating Kudo images of public, mass media editorial and governmental and industrial leaders' coalitions to support our field's work and needs. Hey, students help prove my hypothesis! Does any of all this make any difference? In my career, it has, as we successfully moved forward the need and succeeded in obtaining new injury control laws, regs, technologies, federal funding resources for new impacts in the safety of tens of consumer products and for funding and institutionalizing regional poison control centers, etc. - I/ we did save lives and limbs. (See: Fisher L. Letter to Ed: Community based interventions: less than perfect Injury Prevention. 2004,10:255-256.). Who knows what some limited promising injury control leadership art testing, today, may lead to historical proven leadership, tomorrow? The Talmud mentions that the process is, many times, the only outcome: Leadership must not necessarily complete the final tasks, but move them forward. Our injury control science should be historically evidenced based; and as feasible, so should our IC arts - including those with the "Fourth Estate". The above opinions are mine alone. Leslie Fisher copyrighted 2006 ~Les

(Reprinted from APHA, ICEHS Newsletter Archivist Attic. Jan 2006. Page11ff)

Figure 5. Newspaper clipping montage



Part 2
Injury Prevention in New York State (1800- 1960's)

Sporadically, for decades, New York State groups have assessed the nature and extent of child morbidity and the determinants of child safety needs; advocated and built constituencies with federal, state and local health agencies, insurance, academic, pediatric, medical, industry, media, and consumer groups; and carried out, managed and evaluated public health practices to enhance public health protection for children's safety. This essay consolidates and reviews published journal articles, legislation and reports on effective[2] primary prevention largely, but not entirely, as applied to child safety in New York State from the late 1930's thru mid 1990's and a later focus on gun violence prevention. Themes on theory and practice of technical, interpersonal, managerial leadership activities for child safety serve as an historical institutional memory and compendium to help public health practitioners' review and reconsider old and new plans and initiatives for new leadership options, as well as for more classically assessments, policy development, and assurances on public health practices for prevention of childhood trauma. The experiences of child safety leaders and their impacts on ideas and events in child safety, with repeating or diverse leadership styles, will help efficiently guide current prevention and public health leadership on newer emerging public health issues, adolescent and young adult drug abuse, violence and injury, especially during" downswings" of public resources. The essay is dispersed with the author's own anecdotes and vignettes of his greater then forty- five years of experiences in the injury prevention arena.

"Verily, the works of those gone by us have been circumstances and examples to men of modern day, that folks may view what admonishing chances befell other folks, and therefore take warning. - Arabian Nights

Introduction and Methods

In my prior commentaries for APHA ICEHS Section Newsletters, Archivist Attics, and elsewhere in the journals on injury control; I had cited several states' (Pennsylvania, (see below), California, (ICEHS Newsletters e.g. June 2003, Jan 2004) MA., (Newsletter, Aug-Sept 2013), etc.) leadership history. New York State has had paramount import to the field of injury control.

For near a century, childhood and related family safety has been a sporadic public health concern of New York institutions - state and local agencies, insurance academic, medical groups and the state legislature - as published in professional public health journals and articles (1, 2). During those decades, these articles and summary reports, involving the New York state health, consumer and industrial groups and agencies; The US Public Health Service; American Public Health Association; American Academy of Pediatrics; Medical Society of the State of New York and the National Safety Council; emphasized that childhood morbidity was a leading preventable cause of suffering and deaths. Today, trauma is described as a leading cause of years of life lost, and epidemiological causes and control, in many instances, are well documented in the literature. However, there as been little consideration of those earlier research and practice for possible use

by current child safety and public health workers or even in health care financing of incentives for prevention. This essay, primarily using published journal articles, laws and newspaper accounts from, or concerning, New York State groups, describes these contributions and "benchmarks"- from both opportunist and dedicated primary preventive programs. Part 1-4 with footnotes and endnotes will serve other public health practitioners who wish to delve more deeply into this broad area, historically reviewed for the first time in New York State.

Several terms are best to be defined in this paper. First: Child safety encompasses epidemiology, primary prevention, acute care, trauma rehabilitation, and biomechanics. This paper deals primarily with enhancing primary prevention. For discussion purposes," primary prevention" is weakly defined as the potential (theoretical or actual) freedom from danger of unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of such essentials such as heat or oxygen. Secondly, the term" public health practice", cited in the 1988 Institute of Medicine Report, The Future of Public Health,(Washington, D.C: National Academy Press) involves the process of assessment (determining the safety needs, in-depth field arid data investigations of causes, and the analysis of determinants of risk and morbidity), policy development (advocacy, networking, priority setting, planning and policy options for priorities), arid assurance (including management, implementation, evaluation and feedback toward reassessment of practices). Thirdly, while this essay encompasses child safety, "accident" or injury prevention history, it essentially deals with broader interpersonal, conceptual and policy leadership concerns on overall public health protection. Finally, the body of this Part 2, because of space limitations, generally excludes intentional trauma related to newer public health concerns of child violence and injury. However, Part 4 highlights lessons for reducing teenage and young adult drug abuse, violent injury - examples of many newly emerged child safety issues.

This essay will attempt to respond to three important state and national questions on child safety practices:

1. During the decades, what concepts were envisioned and reported on child safety in New York State and how did those concepts affect other practitioners in nearby states and nationwide?
2. To what degree did the developed practices or strategies succeed or fail, and why?
3. What are the lessons of that earlier work for today's researchers, educators, and practitioners to improve policy management, and historical memory for primary prevention of child safety? Can the experience of the past help guide the future, especially for better fiscal support of public health child safety preventive and protection programs during possible down sizing from health care reform?

This paper, usually divided into summaries of a specific decade's trends in personalities, events and ideas and followed by annotated discussion, may help public health leaders review possible rediscoveries on technical, interpersonal and conceptual managerial and policy challenges for improving the practice of child safety in the twenty-first century. (My memoirs, related vignettes and quips, many footnotes and my speaking-writing are not meant solely as journal scholarship; its voice/style/point of view/story and purpose are to aid the practitioner on the art not only the science of injury and gun violence prevention and control. Copies of my newspaper and TV safety series interviews, national speeches, etc. are archived at U of Colorado, SPH, at Denver

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Normative Frameworks and Harbingers of Injury Prevention: Pre and Late 1930's – circa1955

New York State Department of Health founded in the late 1800's focus of those earlier decades addressed sanitation to communicable diseases, not unlike other health agencies nationwide.

The period 1936-1955 philosophical descriptive and normative ideas and on theoretical organizational bureaucratic settings, first cites safety programs needs in the State Health Department. The New York State Department of Health commissioner, Edward Godfrey, Jr. (1936-1947) offered a philosophical advocacy for preventing accidents.3 Later, staff from Cornell Medical College explored the causes of injury. The Metropolitan Life Insurance Company collected and analyzed data on child and family "accident prevention". Finally, the state's work interacted with other states. Using the best available technology, the sole institutional safety strategy of these institutions was to inform the public about their own ethical responsibility to reduce its own generalized and poorly defined" accidents", often without any attempts to determine if the informational strategy affected the outcome. While the "blame the victim" practice (probably adopted, in part, from police reports that classically attempted to find the culprit) was weak in rationale, a shift by 1950 from New York's practitioners such as De Haven, and Brightman, and Armstrong, helped move from simplistically naive (and still improperly used today) public health practices of just distributing press releases, public service announcements and pamphlets about being safe and careful, to re-engineer environmental and agent dangers and then evaluate outcomes. Public health practice was almost entirely focused on advocacy for the improvement of the "human condition" of childhood accidents.

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On October 23, 1936, NYSE Commissioner of Health, (1936-47), Edward Godfrey, Jr., M. D., future President, American Public Health Association, 1939-1940), reviewed the needs for public health action for prevention of accidents, in the common descriptive (vs. quantitative research and analyses) journal articles common through the1970's, at the Sixty-Fifth Annual Meeting of the American Public Health Association, Vital Statistics Section:

> "... few, if any, health officers or health departments are displaying any interest in prevention of injury and death from accidents. They are content that statistics shall be tabulated and published, leaving prevention entirely to the will of God or other agencies... there has never been a paper on the subject of accidents before any other section of the American Public Health Association, other than the Vital Statistics Section".

He then offered an epidemiological solution to the" accident" epidemic—an epidemic that in his day had increased more than typhoid fever and diphtheria—to use the tools of public health to alleviate accident hazards:

> "… accidents, by plotting them on" spot" maps, discovering common hazards, influence can be brought to bear for the removal of these hazards just as influence of the health

> department removed the hazards of polluted water supplies – (and) reducing the hazard of raw milk" (3).

Godfrey's statement, I would greatly speculate, was a partial attack on the American agrarian myth that farming, (and earlier in the country's coal mines and sweatshops-[4]) with young working children in risky conditions, as natural and essential for society to prosper. His framework would remain as a pioneering innovative cornerstone for child and home safety, as reported at a first (1953) conference on home accident prevention. However, Godfey's vision of epidemiological fact-finding and advocacy for more governmental health action would, for two decades, only be translated into broad public information campaigns, the then current state of the art (4).

The change in emphasis was as serendipitous as this story, told during the first Public Health Service seminar on accident prevention that I ever attend, circa 1964, in NYC. ((I can remember thinking how I too would like to be a presenter someday)). Topics included showing how gasoline fumes could be ignited by a gas pilot light, carbon monoxide poisoning, drown proofing, and this quip was reported: Seems that an entrepreneur of a plane manufacturing company was going into bankruptcy within 24 hours, unless he could prevent his planes from crashing and injuring occupants. He was truly down and out and went to a bar to unwind. He told his woes to a gentleman next to him: "It's terrible, every time we do a mock up of the plane; the wing breaks just where the wing and the fuselage come together. I am at wits ends. We have tried everything." His new acquaintance offered a novel solution: "Punch holes where the wing and the fuselage come together." The business man, the next day, is accosted by his chief engineer: "You got to do something; our bank is closing us down". The owner responded: "Do anything... punch holes where the wing and the fuselage come together...anything." The engineer and owner are gratified, as the mock up worked. And the company is saved! The engineer asks his boss where he learned about punching holes in the fuselage. The boss thinks and remembers the night before at the bar... he returns to the bar and waits for the guy to come in at 10 P.M., according to the bartender. He thanks the chap for saving his company and asks him how he knew about punching holes in the fuselage - wing. The man says: "I am not an engineer, and I am only a janitor; but I do know that toilet paper never rips on the holes."

While the field of injury control has had those who contributed their janitorial instincts and impulses to prevent and reduce "accidents" and then publish descriptive norms of what should be - without too much empirical research nor evaluation - a new age of research would move injury prevention forward and names like De Haven, Moore, Stapp, Anderson and Litchford would be its leaders. Like many leaders their visions, ceaseless energy, concern for what is right would be ignored and perhaps even abused.

Another phase that change to a more etiological study and prevention of "accidents" took place from work at the Cornell Medical College and experiences during World War I of airplane accidents, believed to be survived only by fate alone.

In 1942, Hugh De Haven, aeronautical engineer at Cornell Medical College, established an interdisciplinary crash injury research program (After World War II, Cornell Aeronautical

Laboratory became Calspan Field Services, Inc.) to study injury thresholds in human body-mechanical energy exchanges that validated crash packaging concepts of safety belts and safely-designed cars in the 1960's. De Haven recognized the importance of bioengineering for safety. He wondered why not all the airplane crash victims, he saw during WWI, were not injured and published that injury was not a function of fate or force alone, but of structural separations to reduce the force of impacts (5). His work on energy absorbing crash compartments in front of the pilot ('crumble zones') and the use of broad, energy absorbing safety belts, would require several decades before it was applied to child and adult passenger safety belts and other restraints in automobiles.[5] Four related obits follow:

1. Also at Cornell, a leader in aircraft and automobile safety, John Moore, left a legacy of safety across North America. (www.timesunion.com: (Times Union, Albany New York) Obit. Feb 4, 2003, B7):

".In the US Army Air Command Medical Corp, during WWII, as a physiologist, he made seminal contributions in research on crashes to enable, with others, redesign of air fighter planes from the instrument panels and fuselage to better assist pilots' functions, to installing harness seat belts to increase pilot survival and to the installing of auto seat belts. He continued his research as Chief of Crash Injury Research for the Directorate of Flight Safety Research, US Air Force and he directed, from 1951-1953, the Cornell Medical College Crash Injury Project, which collected data on what happened top humans in crashes. His work led to redesign of instrument panels, eliminating protruding objects, adding padding to dashboards, safety door locks, anti- lock brakes, creation and installation of safety glass. Many current researchers and practitioners 'rest on his shoulders'. He later directed research and development for NYS Motor Vehicle Department (and his funded principal investigator listing is published in a study of the role of the public health service in accident prevention)."

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2. US Air Force Colonel John Paul Stapp, M.D., Phd. (1910-1999), would be his own guinea pig: he tested De Haven's concepts on injury impact with his deceleration and stopping on test sleds. The impetus of 1955, 1956, and 1957 Stapp Safety Meetings "served to stimulate the public interest, congressional hearings, and several research projects at universities throughout the country dealing with various aspects of automotive safety. Such universities as Harvard, Cornell in New York State, University of California, Wayne State, University of Minnesota, and University of Michigan have made outstanding contributions in this field." [6]

"Many of the safety features discussed and recommended were passed along to traffic experts and automotive engineers. Some of the recommendations included moving dashboards forward, with energy absorbing padding; fitting doors with safety locks so they would not fly open in a crash; removing rear window shelves; fastening seats more securely to car body; improving bumper design; and, of course, proving the effectiveness of seat belts."

(http://www.stapp.org/stapp.shtml accessed Aug 24, 2011)

3 Samuel Alderson's, a pioneer safety engineer, (honored after his death by the APHA ICEHS Section with a life achievement award) dummy manikins would limit the need for animal or human test subjects, (Obituary section of the Los Angeles Times - 2-18-05); that obit is followed by another (NYT 3-9-08), George Litchford, an air safety pioneer who had a vital role in development of the air collision warning system used on every airline:

"Samuel W. Alderson, a multifaceted inventor who created crash test dummies such as those used in automobile safety tests, has died. He was 90.

Alderson died Friday at his home in Marina del Rey of complications associated with myelofibrosis, said his son Jeremy.

The mechanically inclined Alderson, who grew up puttering in his father's custom sheet-metal shop, built the first automobile test dummy at his Alderson Research Labs in 1960. But the idea caught on, he said, only when Ralph Nader's consumer protection book, "Unsafe at Any Speed" was published five years later.

Reacting to consumer outrage engendered by Nader's book, the National Highway Traffic Safety Administration began buying Alderson's dummies to test seat belts, air bags and other devices designed to minimize deaths and injuries in car crashes. Various dummies, including the Vince and Larry models popular in television advertising, were standardized over the years as Alderson and his colleagues improved the technology.

In 1973, Alderson left his original company and formed a competitor, Humanoid Systems. The two firms dominated the crash test dummy market until they merged in 1990 to become First Technology Safety Systems.

Alderson was the last surviving founder, his son said, of the Stapp Car Crash Conference, an early organization that fostered automobile safety research.

When Alderson created Alderson Research Labs in 1952, nobody was thinking about testing the survivability of car crashes. His customers were the military and the National Aeronautics and Space Administration (NASA).

He first landed a contract to make anthropomorphic dummies for use in testing jet ejection seats and parachutes, and later for the Apollo nose cone's planned water landing.

"The manlike test dummies duplicate not only the shape, size and weight of future astronauts," a Times story said in 1964," but their motions as well, and their skulls, necks, stomachs and chests contain a variety of instruments to record landing forces."

The drop tests, the article continued, were "designed to ensure that the spacecraft and its systems provide maximum safety for the return of Apollo explorers."

In the 1950s, Alderson also was under contract to develop "phantoms," or dummies that could measure radiation doses, originally during nuclear testing. Based on that experience, he formed another company that he managed until shortly before his death, Radiology Support Devices, to supply the healthcare industry.

Born in Cleveland, Alderson moved to Southern California with his family as a toddler. Because of limited money during the Depression, he studied intermittently at Reed College, Caltech, Columbia and UC Berkeley.

During World War II, he helped develop an optical coating to enhance vision in submarine periscopes at dawn and dusk, helped devise electronic equipment to aid planes in dropping depth charges on German submarines, and worked on missile guidance systems.

Married four times, Alderson is survived by two sons from his marriage to Betty Weir, William of St. Augustine, Fla., and Jeremy of Hector, N.Y.; and four grandchildren.

Neil Clark

RCA, LLC

By Matthew L. Wald

Published: March 10, 2008 New York Times"

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4. "George B. Litchford Sr., a prolific aviation inventor who had a vital role in the development of the collision warning system now used on every airliner in the United States, died on Feb. 28 in Albany. He was 89 and had lived most of his life in Northport, N.Y.

His death was confirmed by his son, George B. Litchford Jr.

Mr. Litchford began working in navigation and surveillance technologies for airplanes in 1941 at Sperry Gyroscope Research Labs and was still at it 50 years later. One of his insights was that hardware already on planes that help controllers on the ground keep track of them could also be used in an anticollision system.

The equipment is called a transponder. A rotating radar system operated by the Federal Aviation Administration sends out electronic queries that planes answer with their transponders, robot radios that give the plane's identity and altitude. By taking note of the precise timing of the signal, the system can determine the plane's location as well.

Mr. Litchford worked for years on elements of the system that eventually became the Traffic Alert and Collision Avoidance System. Congress required that the system be installed on all passenger planes after an Aeromexico DC-9 collided with a private plane near Los Angeles in August 1986, killing 82 people.

"He was an industry leader in developing one of the most significant aviation safety systems ever designed," said John Cox, a safety consultant and former safety official at the Air Line Pilots Association.

Mr. Litchford also patented a method for a receiver on the ground to eavesdrop on airplanes answering the F.A.A. radar. A company that licensed that method, Passur (then called MegaData), used it to track the last moments of T.W.A. 800, the Boeing 747 that exploded off the Long Island coast en route to Paris from New York in 1996.

The company now operates the system in 90 locations worldwide, covering 150 airports. Airlines use the data to track their arrivals, and airports use it to identify flights that violate noise regulations by flying at times or in places that are forbidden.

Mr. Litchford also worked for the Navy on a landing system for aircraft carriers and on equipment to help civilian planes land in low visibility Besides his son, of Albany, he is survived by a daughter, Jane Ellis Litchford, of Salem, Mass.; and a brother, Donn, of Portland, Ore."

5. Lafayette Whitmore "Pete" Knapp, JR, age 90, died October 24, 2015. (source: John Lundell from: http://www.legacy.com/obituaries/press-citizen/obituary.aspx?n=lafayette-w-knapp-pete&pid=176219707&fhid=13554:

Memorial services will be 1:00 P.M., Thursday, October 29, 2015, at the Congregational United Church of Christ, Iowa City with visitation at Gay & Ciha Funeral and Cremation Service from 4-6:00 pm. Wednesday, October 28, 2015. L.W. "Pete" Knapp was born in Erin, NY, July 19, 1925, son of L.W. "Fay" and Jennie (Prince) Knapp. The family relocated to the Ithaca, NY region where Pete attended a one room school through 8th grade, taught by his mother, and graduated from Dryden High School in 1943. He later attended Cornell University graduating with an MS in Agricultural Engineering in 1951. His Masters thesis was a groundbreaking study on farm tractor rollover safety. Upon graduation Pete joined the Cornell University College of Agriculture as a district extension engineer for New York State beginning a lifetime career in farm safety and public health. While at Cornell he designed numerous farm structures for farmers in his district, wrote over 900 articles on farm safety and hosted a weekly radio program. He promoted the placement of the power take-off shield on tractors among other tractor safety features. In 1959 Pete joined the faculty of the University of Iowa, College of Medicine in the Department of Preventive Medicine and Environmental Health. As the director of the Accident Prevention Section of the Institute of Agricultural Medicine, he was instrumental in convincing the farm equipment industry to incorporate tractor rollover frames as a standard feature on tractors and protective housing around chains and gears on farm equipment. Both features protect farm equipment operators from life threatening injuries due to contact with moving parts of their equipment. Pete authored the grant received from Kellogg Foundation to construct the Accident Prevention Laboratory located on the Oakdale Campus of the University of Iowa which today carries on the ground-breaking work of preventing accidents in the home, the agricultural environment and with farm machinery. Upon retirement as Professor Emeritus in 1988 from the University of Iowa, he and his wife Jackie became involved in helping to establish a coffee cooperative, a fruit farm and the Rotary Club of Marcala, Honduras. They also established a foundation providing scholarships to encourage young girls of Marcala to stay in school through the 6th grade. In between his work and traveling his hobbies were designing and constructing homes and buildings and often remodeling them over his lifetime. Among Pete's numerous memberships in organizations, he was most passionate about belonging to the Congregational United Church of Christ of Iowa City, (past moderator) Acacia Fraternity (Past National President), Rotary Club of Iowa City AM Club and Coralville North Corridor Rotary Club, American Society of Agricultural Engineers
(ASAE) and International Association of Agricultural Medicine and Rural Health (IAAMRH). Pete served as a consultant to the International Labor Organization (ILO) headquartered in Geneva, Switzerland, an agency of the United Nations, and traveled throughout the world at their behest promoting agricultural safety. Pete is survived by his daughter Deborah (Dean Shannon) Knapp of Cornelius, NC, son Christopher (Vernette) Knapp, grandsons Thomas and Andrew Knapp, all of Iowa City, his sister Sandra (Don) Swenson and niece Mara Swenson of Mt Vernon, Iowa, brother in law Francis Frost and niece Brenda Frost Payne of Ithaca, NY. He was preceded in death by his wife of 65 years, his parents and a nephew, Brian Frost.

In Memoriam - Dr. Julian Waller, MD, MPH

By Charlotte Baker, President , Injury Control & Emergency Health Services (ICEHS) Section ..Discussion APHA LEAD 8/25/2022

Julian Waller, MD, MPH died last week at the age of 90. Julian was one of the early leaders in injury control, and did a great deal of work on traffic safety issues, with a particular focus on alcohol-impaired driving. He was also a mentor to many people in the field.

Dr. Waller was a graduate of Columbia University and earned his MD at Boston University and an MPH at Harvard University.

He served as a public health physician before taking on a faculty position at the University of Vermont, where he remained for much of his career, and chaired the Department of Epidemiology and Environmental Health.

He was a consultant on injury control for the World Health Organization and a member of the Board of directors of the Consumers Union of the United States. He also served as a consultant to the U.S. DOT and was a member of the National Highway Safety Advisory Committee to Secretary of Transportation. He was an active member of APHA, the American College of Preventive Medicine, American College of Epidemiology, Association for Advancement of Automotive Medicine, and the Human Factors and Ergonomics Society

The following article highlights some of his perspective on injury prevention: . Waller JA. Reflections on a half century of injury control. Am J Public Health. 1994 Apr;84(4):664-70. doi: 10.2105/ajph.84.4.664. PMID: 8154576; PMCID: PMC1614769.

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'Indeed, the history of leadership for aeronautical, farm, motor vehicle and related injury prevention and control cites major successful outcomes.[7]

William Haddon, Jr. (See Part 1 and below in Part 2) would adapt De Haven ‘s and other’s concepts to show injury control was by the control of the release of energy. Personalities of these leaders made history of injury control possible within changing settings. Another key transition in public health practice, from just using public information to reduce injury, took place from empirical data collected during national surveys of public health practices in state agencies and of insurance policy holders.

In 1943, the American Public Health Association Committee on Administrative Practice appointed a Subcommittee on Accident Prevention, chaired by Donald Armstrong, from the Metropolitan Life Insurance Company, New York City. The study revealed six states and two local health departments had some program activity in accident prevention. However, only New York State maintained a full- time program. Subsequently, in 1945, suggested guidelines for accident prevention in health departments were published in the American Journal of Public Health. In 1950, the subcommittee under I. Jay Brightman, Assistant Commissioner, New York State Department of Health, conducted another generation of modern studies, findings and recommendations for local health departments’ safety activities. That subcommittee found the number of health departments reporting activities in home safety had risen to nine states and 25 local health departments. In 1955, Dr. Edward Schlesinger, later with the New York State Department of Health, helped develop and conduct a related national survey on effective and appropriate measures for accident prevention with an 18-item questionnaire. Findings in 1955 showed 33 states, 3 provincial and 296 local health departments conducting accident prevention work. These findings lead to the Committee’s publication, “Suggested Home Accident Prevention Activities for Health Departments” (6, 7).

The Subcommittee also sponsored home accident prevention sessions at the Annual APHA Meetings at which NYS presenters were well represented among the national leadership

During the late 1940’s other articles by New York State medical leaders had motivated pediatricians to form coalitions to promote campaigns for reducing childhood injuries. In 1947, the Public Health Service inaugurated its national home accident prevention programs with the assignment of a full-time person; in the 1960’sthis would become a fully operating Division of Accident Prevention with grant and program supports to New York and other states.

Starting in 1940, the Metropolitan Life Insurance Company, under Dr. George Wheatley, (previously Principal Pediatrician in Charge of School Health, New York City Health Department, Donald Armstrong, and Graham Cole, (Fisher L and Brown TM. Donald Budd Armstrong and W. Graham Cole: Early Injury Control Advocates. Am J Public Health, Jun 2004; 94: 941), favorably influenced child safety practices by collecting empirical data. They57 analyzed their company's reports of home accidents from home-nursing care services and emphasized that accidents had become a leading cause of morbidity among children. They recommended that public health nurses conduct child-safety home visits to identify and reduce unsafe parental behaviors.

By 1942, New York State Department of Health public health nurses were conducting child safety reviews during home visits. Another outcome of the approaches advocated by Metropolitan (Traveler's Insurance began first) Insurance Company, forged support with the American Public Health Association, Committee on Administrative Practices, for programs of the National Academy of Pediatrics, the US Children's Bureau and the National Safety Council to train physicians in their communal and public health organizational responsibilities for reducing accidents.

I was born in May 1942 in a small NE Pennsylvania town, Pottsville, (see www.icehs.org Newsletters, Archivist's Attic. e.g. Jan 2008) known for its anthracite coal. My parents had moved from Brooklyn NY when my Mother was pregnant. My paternal grandmother wanted to know if I was an American citizen, having gone from one "state" to another. I was given a wonderful set of cards as a first borne son. My initial trauma, however, included a circumcision. I do not think that ritual influenced my future work in injury control. However, perhaps the first sibling of a very continuing reinforcing nurturing family did influence such choices; as the center of attention, I learned to respond back with newer coos and woos and that developed into a very strong "people focus" and outcome oriented focus in my career and avocations, my public and self rewards were those coos and woos that I had created.
My first exposure to a fire was Thanksgiving at my "Aunt's" apartment where the oven with the turkey burn up but that really did not influence my future work or did it?
As I grew up, my first day at school in 1948 was affected by the death of a fellow first grader who fell into the coal mining stripping and drowned - what had happened- he wasn't in class the next day after I was playing with him! In primary grades, I worked on the safety crossing patrol, and later on boy scouts first aid merit badges,

How would my background finally catch up with my eventual career goals, to help people and to lead?

In 1948, the American Academy of Pediatrics, under George Wheatley's, spearheaded a national child safety education effort and opened a clinic at the Municipal Hospital in Rochester, NY sponsored by the University of Rochester Medical School and the Rochester Health Bureau to study accident- prone children and their families, to conduct investigations by public health

nurses of the home environment and to determine the causes of repeated accidents (7-9). A final consequence of this earlier effort was the establishment of the American Academy of Pediatrics, Accident and Poison Prevention Committee in New York City, and the Metro Life would in the negotiation exchange its board of director members with the Pediatrics group. (Seems the Pharaoh Ramasee II, circa 1200 BC, brokered a similar deal with the Hittites, who were some times on the same turf: He married the Hittite King's daughter to move peaceful progress. - maybe useful craft today with some groups.)

Dr. Wheatley's efforts established the American Academy of Pediatrics, Committee on Accident Prevention, in New York City, which that same year established a long and productive liaison with the National Safety Council when a member of the Academy was invited to serve on the Council's Board of Directors. The Committee has, for forty years, developed, adopted and published in the PEDIATRICS with policy statements on a wide range of injury topics including trampolines, household toxic substances, toys and its proven effective Anticipatory Guidance Training in Injury Prevention (TIPPS) to parents during periodic office visits for routine checkups (2).

Several structural and organizational changes in the New York State Department of Health favorable to "accident prevention" were reported at the Joint Session of the Public Health Education and Statistics Sections of the American Public Health Association Annual Meeting in Boston, Mass. (1948): First, Dr. I. J. Brightman, Assistant State Health Commissioner, established a safety program in the New York State Department of Health's Office of Health Education. Probably having been influenced by earlier Presidential Safety Conferences, several statewide farm and home safety conferences with state safety councils were conducted by Department health educators. Secondly, the State Health Commissioner advocated the need for epidemiological studies to focus on basic environmental and personal factors related to injury. Finally, the Legislature established a State Division of Safety to coordinate, from Governor Harriman's Office, all state agencies' safety initiatives. These three initiatives continued for about ten years until changes in the State's Governors.

Brightman translated Godfrey's descriptive approach about 'accidents" never being discussed except as statistics: He established a program structure in the State Health Department. His framework defined program responsibilities and roles of program units, including public health educators to provide inform to public and medical groups. Public health nurses interviewed family members on identifying the accident and its underlying factors. Partnerships started by cooperation and conferences with the State Division of Safety, Farm Bureaus, New York City and Syracuse Safety Councils, 4-H Groups, parents and the Federation of Women's Clubs:

> "Home accidents comprise a significant public health problem and fall within the domain of the health department. The health officer and his staff of public health nurses and sanitary engineers have frequent contact with the members of the home, and work closely with physicians, school authorities, and represent voluntary agencies, all of whom can render active assistance in a home safety program. The incidence of morbidity and mortality attributable to home accidents can be reduced by the application of the techniques of public health education, epidemiology, case finding, rehabilitation service, and research, all of which have been so well used by health departments in other public health fields. Home accident control must be incorporated as a regular function of the health department, closely integrated with the activities of many of the regularly operating bureaus, if further substantial reduction in disability and death rates is to be achieved." (10)

Meanwhile at the same 1948 APHA meeting, New York's historical development in injury prevention would be influenced by research in the Commonwealth of Massachusetts: Dr. John E. Gordon, a Harvard, Professor of preventive medicine and epidemiology, more critically analyzed and defined the epidemiology variables in "accidents." Gordon reported these as host and environmental factors with characteristics similar to infectious diseases (11). However, Gordon incorrectly perceived that there were many agents of injury, e.g., hot stoves, medicines, ladders, glass panels indoors, etc., rather than a few common kinetic energies as causes of injury. Dr. William Haddon, Jr. was the critic on Gordon's 'multi injury causative agents' concept (12) and Haddon would soon lead both New York and the nation's injury field.

The Decade of 1950-1960: Partnerships and Cooperation

The early 1950's offered additional theories that collaboration of various allied public health and medical groups could strengthen the overall assessment and policy development phases in public health practice on child safety. The framing on 'accidents' began to shift from just the nascent "human factors" school of the previous decades with its "blame the victim for accidents and causes" focus of child safety, to collection, analysis and tabulation of population- based morbidity data gathered by visiting nurses and an overall attempt to apply empirical findings to promote specific counseling or environmental changes in the child's home. What follows describes these new child safety alliances and programming hodgepodges among New York State and local health departments, the Metropolitan Life Insurance Company, the American Academy of Pediatrics, American Public Health Association and the National Safety Council.

In 1952, George Wheatley, MD, Third Vice President, Metropolitan Life Insurance Company, New York City, developed and funded for the American Academy of Pediatrics, nearly 50,000 copies of a brochure for pediatricians," Are You Using the New Safety Vaccine?". The brochure, promoting accident prevention as a new kind of immunization and was discussed with parents during periodic visit to the pediatrician. In the 1950's, pediatricians and health and safety professionals joined conferences and built and maintained new professional alliances for child safety and promoted child safety programs in communities. Dr. Donald Armstrong from the Metropolitan Life Insurance Company, chaired, and Dr. I.J. Brightman served on the planning committee of the American Public Health Association, Committee on Home Accident Prevention, for a first 'Accident Prevention Conference' at the University of Michigan on January 20-22, 1953, which briefly listed NYS Godfrey's historical influence. (4). Preventive safety options primarily focused on reviewing injury data and informing the public of its shortcomings, rather than empirically counting, analyzing, and evaluating the related environmental and agent factors. Some community projects did involve housing inspectors to correct observed risks (13).

As part of APHA's 1951 Annual Meeting (San Francisco, California) Special Program on Home Accident Prevention sponsored by the Subcommittee on Accident Prevention, Committee on Administrative Practices, I. Jay Brightman, Assistant Commissioner for Welfare Medical Services, New York State Department of Health, illustrated that NYS home accident death trends since 1932, in contrast to other accidental deaths, had not significantly decreased. He speculated that few official or voluntary agencies had accepted responsibility for control of home accidents, while the American Public Health Association and the National Safety Council had emphasized that area as a logical function for health department personnel. He then reviewed home accidental deaths, and the need for mapping just like diseases, as a secondary cause associated

with cancer in the elderly, for whom the rates of accidental death had not, in contrast to age groups 5 to 65 years, shown a downturn (14).

While the New York State Health Department and Metropolitan Life had served as primary sources on child safety data and thrusts, in the 1955 Journal of Pediatrics, Dr. Harold Jacobziner from the New York City Department of City Health Department, described the severe nature of child accidental deaths in New York City. He encouraged pediatricians to obtain information" about poisoning and other accidents," and to immunize parents and children by "safety education." (15)

But, Jacobziner's presentations fell short of a public health epidemiological approach. As William Haddon, Jr. would critique in his seminal 1964 book, Accident Research Methods & Approaches, the studied poisonings were not specifically related to a population of known characteristics or population at risk: there was no known denominator (16). However, New York City's work did promote a statewide institutional response. In 1953, the first national Poison Control Program had been federally funded in Chicago under Dr. George Wheatley, Third Vice-president Metropolitan Life Insurance Company and Chairman, American Academy of Pediatrics, Accident Prevention Committee, and later President of the Academy. Dr. Wheatley also appointed Dr. Edward Press, Chairman of the Accident Prevention Committee, Poison Prevention Subcommittee. In 1955, the New York City Poison Control Center, the second in the country, was established by the City, followed by locally funded Rochester Poison Control Center and the Long Island Poison Control Center at Mineola. The Long Island Poison Control Center medical co-directors, Drs. Howard Mofenson and Joseph Greensher, also pioneered in the activation of the American Academy of Pediatrics, Accident Prevention Committee with its policy positions routinely published in the Journal of PEDIATRICS, in early research on clinical toxicology, and in diverse scientific journals nationwide (2). In 1958, Dr. Virginia Harris, a pediatrician who directed the" Syracuse" Poison Control Center and her associates in the Onondaga (Syracuse) County Health Department published pioneering studies of the occurrence, prevalence and characteristics of accidental poisonings in a random sample of families in Syracuse. Although both population changes and incompleteness of reporting from hospitals affected findings, the authors presented preventive policy options including safe storage and safety caps on household toxic substances (17). Dr. Harris also served for many years as chairperson of the Home Department, National Safety Council, and as Onondaga (Syracuse) County Health Department participant in State-local child health and safety programs that used auxiliary public health nursing and parents' groups and a mentor to new public health practitioners in child safety.

At the dedication of the New York State Department of Health Building (1957), L. E. Burney MD spoke on accidents on the highways, in the work place, schools, and in the home taking economic tolls of life and health. Accidents are problems of the environment and are subject to the same public health research and preventive solutions. Much state and national work, mostly in traffic safety, was led by NY researchers.[8]

The New York City and Syracuse projects, first took child safety theory into the realm of child safety application, were influenced by a new national thrust for accident prevention begun in 1948 in Kalamazoo, Michigan. From 1948-1957, the W.K. Kellogg Foundation, in cooperation with the federal Public Health Service, funded experimental projects for" accident prevention" in several local and State Health Departments. In 1951, the foundation underwrote three more demonstration projects including one in San Jose, California. These projects were not very scientific in design and monolithically focused on changing just human behaviors by information or awareness on "accidents". The outcomes were for the most part not quantifiable on injury change; but, it put injury control in the public health agenda. And some fifteen years later, when I entered the field, the same approaches were being used. My goal was to produce more quantifiable outcomes not just activities that felt good to do.

While no New York State projects were funded by the Kellogg projects, the California accident prevention projects influenced the New York State and national research, planning and organizing of preventive activities for later community safety projects, and New York State influenced other nationwide programs. In 1951, Dr. Bucknall the program director, Los Angeles accident prevention program, in the Journal of the American Public Health Association commended the New York State Department of Health for its guidance in helping set up that California accident prevention program

The Final Report (1953-1957) of The California Department of Public Health's Home Safety Project, funded by the W.K. Kellogg Foundation, summarized these technical and management principles from the California Safety experience in Chapter IX," Developing Accident Prevention Programs in Local Health Departments". The study influenced New York State's individual contributions and, in fact, was served as a base for the State in its later work:

"Because of the magnitude of the home and neighborhood accident problem, there is need for the development of a continuous statewide program for control.

Fact-finding is basic to the development of accident prevention programs.

It is possible and feasible to attack the accident problem through conventional public health methods.

It is feasible for local health departments to collect and classify information on accidental injuries.

It is more expedient to direct local accident prevention programs toward one or two types of accidents known to be important in the community, rather than attempt to prevent all accidents at once.

It will be most effective to direct preventive efforts toward the particular age group or population group most concerned." (18)

The international concern on child injury was also growing and involving New York State: The Regional Office for Europe of the World Health Organization, Copenhagen, sponsored and published a (second)Seminar on the Prevention of Accidents in Childhood, in July 16-25, 1958, at Spa, Belgium, to "study ways and means of developing actions in the Region and on an international scale to prevent the widespread loss of life, injury to health, and economic damage wrought by accidents", especially to children. United States sole" Representative of Other Organizations", Mr. L. W. Mayo, Executive Director, Association for the Aid of Crippled Children, New York City and its only American" Consultant". Dr. G. M. Wheatley, Third Vice

President, Metropolitan Life Insurance Company, New York City, participated. The Annexes to the Report listed safety educational films shown at the seminar illustrating the return to public information as the key child safety tool. The two eight minute-each Walt Disney cartoons: "How to Have an Accident" staring Donald Duck and "I'm No Fool with Fire", with Jiminy Cricket.

There were other foolish things happening in the USA. The post War, Communist influence had led to building home fall out shelters to survive an atomic blast. In retrospect, we learned that it would take some centuries living in such shelters for the half-life of radiation to subside.

The Decade of the 1960's: Against Conventional Wisdom- The Haddon Influence Years

In 1960, the federal Public Health Service, Division of Special Health Services, Accident Prevention Program (with both highway and non-highway components) became a separate division due to the unwieldiness of the overall division (which included and was also duplicated in health agencies by additional 'bureaus' of radiological health, air pollution, and chronic diseases). The new Division housed the national clearinghouse used by the emerging poison control centers in NYS and elsewhere, promoted state and local health department accident behavior interventions, and financially supported research in which NYS would participate. The Division's highway safety efforts, however, in 1968 would later be transferred to the new National Highway Safety Bureau established by William Haddon, Jr. The Division would not again be unified, especially with a newer focus, not on human factors, but product safety, from the national study commission on product safety (Waller, AJPH, 1994).

Modern child safety now focused on epidemiological, environmental, agent and host determinants and the development of bureaucratic policies for federal, state and local health public health practices. The 1950's led in the 1960's to further open dialogue by Gibson, Westaby, Haddon (see below), and others who used NYS research and program seminars (20) to begin to synergize, test and market their evolving models of educational, medical and engineering theories. These then led to the State's first injury prevention pilot demonstration projects with more empirical, less emotive, but with rationally-based evaluations than in prior decades. This new framework of public health practice would be enhanced in the decade of 1970 to integrate the host and environment interventions to legislatively mandated performance safety standards for consumer and child products:

James L. Gibson, an engineer at Cornell University, Ithaca, NY, creatively integrated injury prevention into energy interchange:

> "…flux of energies which surround him -- gravitational and mechanical, radiant, thermal, and chemical --- Injuries to a living organism can be produced only by some energy inter-change. So, a most effective way of classifying sources of energy is according to the forms of physical energy involved. The analysis can thus be exhaustive and conceptually clear. Physical energy is mechanical, thermal, radiant, chemical or electrical."(19)

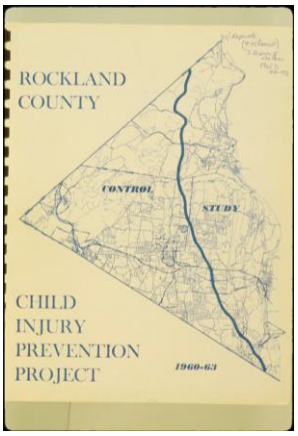
By 1961, under Dr. Berwyn F. Mattison, APHA, Executive Director, the Program Area Committee on Accident Prevention, compiled and published New York's and others' studies into a first book, Accident Prevention for Physicians and Public Health Workers, which provided a consensus-based, working standard and teaching instrument for the field. Dr. George Wheatley, Metropolitan Life Insurance Company, NYC, wrote the Chapter on "Childhood Accidents" (20-21).

Several 1960's conferences involving" Behavioral Approaches to Research on Childhood Accidents for the Aid of Crippled Children," were led by a New York City Injury Study Group that met regularly at the Center for Safety Education, New York University. Group members included Janice Westaby, NYS Department of Health; Dr. George Wheatley, Metropolitan Life Insurance Company; and Dr. Harold Jacobziner, NYC Health Department. Dr. Edward Suchman, from the New York City Department of Health, helped further define and construct a systematic" human factors" situational approach to the accident phenomenon as caused predominantly by personal decision-making:

> "While the epidemiological model serves as a useful action as a simple descriptive scheme for classifying various factors associated with accidents, it is not too helpful for analyzing why accidents happen... a much more promising approach (than "accident proneness") would be to view accident behavior in terms of a decision-making process of the individual in situations or under conditions involving risk taking". (22)

In 1960-63, Edward Schlesinger, M.D., Assistant Commissioner, NYS Department of Health; Donald Dickson, M.D., Commissioner, Rockland County Health Department; and Janice Westaby, M.P.H. Accident Prevention Program Director, NYS Department of Health (thereafter Assistant Professor, School of Public Health, University of North Carolina where she taught courses in accident prevention and published a review on fall injury and Chair, NSC- Home Section as a dynamic and provocative workshop leader and speaker), served as co - project Investigator, for a child safety demonstration project, based upon earlier projects at Washtenaw County Michigan in 1952 and Richland County, Ohio, in 1954. (13)

New York State's, Rockland County Project's technical advisory committee (William Haddon, Jr., M.D., Director, Epidemiology Residency Program, NYS Health Department with Ms. Lisel Lowen, Project Health Educator and Coordinator Rockland County Health Department), funded under the federal Department of Health, Division of Accident Prevention,(Public Health Service's Grant, # 00056-04); after considerable investigation, could not report changes in injury profiles in the study vs. control site following informational approaches, group discussions, and distribution of leaflets and newsletters (23-24). This project, a true case-control study, had been designed to test the effects of public health education for parents on habits, attitudes and incidence of accidents to children less than seven years of age. The incidence of accidents was determined in the study population before, during and after the brief exposure to the education program and in a comparable control group during a corresponding period. To measure the effect of the education program in Rockland County, accident rates were computed for each three-month reporting period, projected on an annual basis. A detailed analysis was done, and no consistent differences were found between the accident rate trends for the study and control groups during the three years of the project. The project authors concluded that a) reporting must be continued for a sufficient time after the education phase to measure true effects; b) hospital reporting was more consistent than physician reporting, and adequate rates for comparison purposes may be obtained entirely from hospital reporting. *Following the federal grant, Ms. Lowen's position continued for at least a decade; but NYS agency response to the findings de-emphasis the child accident prevention activities in the Department. One internal state memo showed non-approval of any new annual plans for child safety*.



Haddon would, as the first head of the National Highway Safety Bureau, 1966- 1969, outwitted critics by promulgating tens of standards within a few months. As a self stated 'bridge between different points of view' (Look Magazine, May 30, 1967, 101), but always for evidence research and practice, he would continue to compete with the traffic industry and after 1969 directed an Insurance Institute for Highway Safety, funded by the insurance industry, which he persuaded to become more aggressive on auto safety.

In circa 1970's, I called him. I was annoyed that lots of efforts were focused on his theory of injury control and little, it seemed to me at the time, on prevention efforts. He was quite polite to this greenhorn: "My conceptual frameworks, are just that, for consideration". Little did I recognize how important his assessment of what's been done and needed in the field of injury control would lead to major national outcome shifts - for decades.

Similar safety educational projects funded nationwide by the federal Department of Health, Education and Welfare during the 1960's had weaknesses in rationale, definition, and unrealistic, although several did show successful outcomes for reducing burns and poisoning and were later adopted into New York's child safety approaches (25-27).

In 1961, a conference for consensus building and advocacy," Teaching Accident Prevention in Schools of Public Health" at the University of Michigan, sponsored by the US Public Health Service, the US Children's Bureau, and the Association of Schools of Public Health described the teaching of accident prevention in eleven schools of public health (28). Participants included Drs. Berywn Mattison and Edward Press who were to be associated with New York State's Accident Prevention Program on drowning and carbon monoxide throughout the ensuing decade (28).

In 1962 there was a shift from just providing public safety information to requirements for warning labels on consumer products. The State Health Department Environmental Health Program's Sanitary Code had established labeling provisions to warn about the hazards of tetraethyllead, insecticides, and other hazardous substances. In 1965, the approach went one step further to designing safety into the product not simply warning the public. New York State Senator Speno sponsored and passed, with the facilitation of William Haddon, Jr. Resident Intern Program NYS Department of Health and Patrick Moynihan, Governor's Office, S-228 - Laws of 1965, with an appropriation to develop" the world's safest automobile in collision terms", the" safety packaging car", from De Haven's product safety concepts (29).

While a resident trainee for the New York State Health Department in the mid 1950's, James L Goddard, a surgeon, had established a highway safety unit to evaluate drivers with epilepsy and other medical conditions. In 1960 he became Chief of the accident prevention program (division) of the U. S. Public Health Service which promoted injury activities in state and local health departments emphasizing behavioral interventions. (Goddard JL. Accident Prevention in Childhood. PHR 1959; 71:6 523-534.) It also housed the information clearinghouse used by newly establishing poison control centers nationwide and thirdly, promoted and financed support of research projects, usually on behavior modifications. (Goddard later a civil air surgeon for the Federal Aviation Agency served as Chief, Communicable Disease Center and on January 17, 1966, headed the US Food and Drug Administration.)

In 1967, he returned to New York State and delivered the New York State Health Department Sixth Annual Herman E. Hilleboe Lecture, in Buffalo, "Public Health and the Consumer." In the foreword to his essay, Granville Larimore, President, NYS Health Department Annual Health Conference describes that Goddard in his essay" postulates and demonstrates the inseparability and the interplay of the concepts of public health protection and consumer protection, safeguarding the health of the individual and protecting his pocketbook from economic predators." His work, in part started in NYS, led to national leadership in injury control during the developing years of federal - state child safety programs; on automobile, food, drugs and household consumer products.

William Haddon, Jr. recognized the weaknesses in prior scientific design and conduct of injury research. Following medical training at Harvard University, directed the New York State Department of Health's Epidemiology Residency Program in 1957 until 1961 when he became assistant director (in 1965) of the Department's Division of Chronic Diseases. In 1962, he offered the first adequately controlled investigation of skiing injuries. Haddon's contributed greatly by adapting then recent ideas from his Harvard University medical training from Dr. Hugh De Haven, a physiologist, who studied the survivorship of falls of airplane pilots from various heights while he was at Cornell Laboratories in upper New York State and the overall energy exchange concept of the cause of injury, extended from engineering studies of airplane, then on automobile crashes.

In 1964, Haddon together with Edward Suchman, New York City Health Department, and David Klein, University of Pittsburgh, Sociology, extensive assessed child and other injury research, as a developing science. Haddon criticized the weaknesses of non-epidemiological research on injury control by Jacobinzer, Gordon and others. Thus, Haddon illustrates the conceptual and methodological advancement from one decade to the next (12, 29) because he would not accept the then current beliefs on" accident" causation or the public health preventive and protection practices of focusing only on public information and education without empirical evidence of impact.

Haddon had developed such critical skills, in large part from his observations during his avocation of skiing. He conducted the first adequate controlled investigation, funded under a contract (SAph 76291) from the Division of Accident Prevention, Public Health Service and a training grant (2G-588) from the Public Health Service,[9] on any recreational injury and found

significant injury associations with both ski binders for males and ski injury type and location. His findings and recommendations for preventive and protective strategies were drawn from motor vehicle safety and “correspond to the general levels of prevention long discussed by public health workers.” He built on the early engineering and human factors research of Gordon, De Haven, and Gibson (5, 30, 31) to show that there was, in fact, no such thing as a skiing, poisoning nor motor vehicle ”accident”, but a universal condition of a controllable flow of energy to a population at risk with employable public health strategies to reduce the occurrence of injury and mitigate its consequences- thus forming a unifying systems theory for public health practice in the protection and safety of children and of other targeted populations.

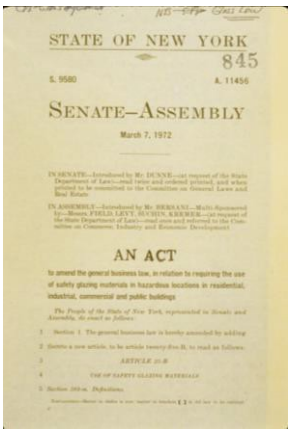
Using Gibson’s and Goddard’s earlier work, Haddon continually formulated energy transfer as a common denominator for the causes and control of health and safety conditions. He made enormous strides in public health practice in NYS and from 1966-1969, as his work in NYS began to be less appreciated by the Health Department, (and for the most part his scientific emphasis was excluded after he left NYS), he served as Director, National Highway Safety Bureau, (now, National Highway Traffic Safety Administration), and later with the Insurance Institute for Traffic Safety. In these national positions, where he separated the insurance industry’s needs and motor vehicle safety, he was able to integrate the theory of causative factors, and bridged the use of scientific knowledge and practices of medicine and engineering for various traffic safety strategies - from preventing the release of the energy to fixing its aftermath. As done while in New York State, Haddon continually asserted for proof by using epidemiological data for controlling injuries. In Washington, Haddon successfully established safety performance standards for compliance by the automobile industry, rather than just discussing what the industry needed to do to protect children and others.

Haddon had had excellent experiences for his federal - industrial assertive broker role. While in New York, Haddon was apparently unable to obtain the motor vehicle department data to study motor vehicular injuries. It very possible that in 1957, Haddon and Commissioner of Health Larimore initiatives, established Public Health Law 206.1 J. that innovative permitted Haddon to waive patient confidentiality to do research with the Cornell Aeronautical Laboratories, on the causes of motor vehicle crashes. Working with Patrick Moynihan in the Governor’s Office, Haddon and he established the Executive Department’s oversight for motor vehicle safety programs and data. By 1968, Haddon’s work had, in part, led to the passage of the Federal Highway Safety Act (PL-89-564). In New York, this federal law led to fine tuning of the earlier ‘Governor Harriman’s Safety Committee’, and to the 1956, New York State Governor’s Traffic Safety Committee, (GTSC), established by Jonathon Bingham, Secretary to Governor Dewey, following successful public attention drawn to the subject by Connecticut Governor Ribicoff (29). His actions not only helped justify the creation of GTSC; but in 1968, his seventh preventive strategy, reducing the severity of injury, helped formulate Article 30, State Public Health Law, to regulate commercial ambulances (30-31).

Primary prevention of injury and its sister discipline, emergency health services, soon became two distinct safety approaches in New York State and nationally. Both disciplines, would primarily use Haddon’s ideas; but, it was not until the late 1980’s that children were no longer considered as” little adults” and received special emergency protocols and equipment.

During the late 1960's, staff from the New York State Department of Health conducted several epidemiological studies: In 1968, under Dr. Edward Press, Illinois State Health Department, a study of 1,201 studied drowning in five states, including New York, during 12 months, showed that most individuals who drowned were experienced swimmers (32). The USA's federal government's Accident Prevention Program national drowning prevention included public brochures on" drown proofing", (attempting to float or buoy in the water). I remember one national training program several years later illustrating a case study of mis-targeting of these drowning preventive materials into YMCA's when later research showed most drowning nationwide and, in most states, taking place in lakes, streams and other natural bodies of water.

In 1969, data collected of glass door injuries handled in statewide hospital emergency departments and the application of William Haddon focuses on energy transfer rather than only changing victim's behavior were concepts that changed New York State's child safety approaches.



STATE OF NEW YORK

845

S. 9580 A. 11456

SENATE—ASSEMBLY

March 7, 1972

AN ACT

The reader's forbearance is requested: More of my Bildungsraman: These subsequent years are part of me and my own work and perceptions and recollections, built upon the shoulders of pioneers as I worked in City of Philadelphia Department of Public Health and then applied what I had learned to Albany, NY, at the New York State Dept of Health. The events, interactions and activities are mentioned in my memoirs to encourage others to do the right thing with dedication to saving live and limbs, as Covey and Senge, leadership gurus, would say to know the true North:

I had joined the Philadelphia Department of Public Health, as a Public Health Sanitarian, who assured the city health code for restaurants and swimming pools, etc. were enforced, in the fall of 1964, following graduation in microbiology. I enjoyed studying the relationships of biological processes to disease causation, similar to my future work in the etiology and prevention of injury 'macrobes'. I had reviewed my career management listing listings prepared at Penn State of my skills / crafts related careers I would be interested: science, law, working with people, being of service and helping, etc. My first job was to inspect restaurants for compliance with the City sanitary code; but my Mother wanted to know why I had gone to Penn State to be employed as a garbage collector. Years earlier, the sanitarian supervisors in the health department would allegedly take the magistrate judge to lunch in the restaurant under discussing later in "court" that same day. When the judge found out his poppy seeded bagel was not poppy seeds but mixed with similar size mice droppings; he would throw the book at them, even the supervisors. I was a

real expert on rat droppings in municipal court; "Mr. Fisher, how do you know these are rat dropping in this bottle are you an expert" the defense lawyer would examine me.

One food service held a gun out and said I should not return. My boss promptly tore up my inspection complaint. Another restaurant owner did not have his chest X-ray certificate and he said if I returned in to check him, I would be...(sic). I returned. He ran over to me. The X-ray had shown cancer beginnings and he was now OK, he thanked me, I felt really good about my public service as a Public Health Sanitarian I.

The City of Philadelphia Department of Health offered an opportunity to serve people, use my microbiology background, help protect the public by regulations, and go on for graduate school under all expenses and salary leave of absence. B Russell Franklin, Director of Training, recruited me and within a month I was asking to go to graduate school. He took this greenhorn "under his wing," gave me an exam which I scored average – but for people in the field 10 years - and when I got a letter from University of North Carolina on my birthday 1965, I was asked if I would be leaving.

Because of a freeze in hiring new staff, my position would have been eliminated; instead a full tuition/ fees and ¾ salary program at UNC, MPH program, was helpful to the City Health Department, as well. When at UNC, there was a national selective service call up to audit the number of men. I took my physical in Raleigh and then a mental exam, two columns of pictures of car parts to be connected to each other. At that time, I knew nothing about car engines, piston, etc. The exam sergeant said I failed the mental test but due to my sanitarian skills I would be cleaning latrines. I called, collect, Mr. Benjamin Franklin, in Philadelphia and when he was not in, I asked the operator for his assistant, John Locke. The operator told me to stop playing games with Ma Bell. When Mr. Locke answered the phone, I was told just to see what happens; the audit was only that. I returned with my Masters in Public Health degree, I took advantage of the Masters in Governmental Affairs program at U. of Penn as I had a two-year employment understanding, anyway. I rotated to the Accident Control Section which offered me a greater non-routine activity in poison control, lead poisoning and home safety. Philly was a great beginning to experiment and innovate.

In Philadelphia, my "heyday" accident prevention work included a voluntary recall of Zulu Blowguns, of which 6 million were sold packaged in breakfast cereal boxes, investigated by the City of Philadelphia Department of Public Health after a dozen children were documented to add pins to the dart shooter and several had inhaled the pin into their lungs (33-34). The city's private physician bronchoscopists had reported this and were more concerned that, at that time, even without the addition of a pin, plastic in toys would not show up on any X-ray; pneumonia could result. The owner of the company, my boss and I met. The owner, the head of a large national bubble gum company, advocated that his blowgun pea shooter was not a risk when a child added a pin to the end of the plastic dart, inhaling it into his throat. I slyly asked him to try the process. He did and when he began to choke, he agreed to national voluntary action.

A few days later, Kellogg Cereal canceled its promotional distribution of the toy, nationwide. The company sold nearly 6 million before it installed a safety device to prevent inhalation of the darts. (Steer Kids Away from this Toy Zulu gun. Consumer Reports. 33:572 Nov.1968 and Final Report of National Commission on Product Safety, April 1970) - A real lesson for me in my work that followed some decades later: "Brecht zich a ring tsefalt di gantsch kait"- that is, one link (the change in injurious energy) and the whole chain falls.

After that incident, my boss, Ray Tyler - we were very close friends- gently whispered to me. Ray was a very good mentor and soft talking pastor (he was an ordained minister); but, I tell stories that he never spoke to me until he then said: "Les there is a safety consultant position opening up in the NY State Dept of Health. Carmen Mandia, in the position is getting promoted to Supervisor Emergency Medical Services and Injury Control Program with the recent influx of National Highway Safety, EMS, programs; why don't you go up there and cause problems?"

My early work in Philadelphia helped formulate New York State Health Department's consumer and child health protection and safety glass doors law (New York State General Business Law - 1969). The glass law came about when my data collected from hospitals was sent to a safety glass committee of the federal Public Health Service, Accident Prevention Program, (precursor to CPSC) from which the glass industry lobbied states to require safety glass for home fixtures (see illustration-above page). New York State was one of the last states to do so. (In the Commonwealth of Pennsylvania, the Governor's wife was reported to have walked through a supermarket glass door leading to his signature on a long pending bill on his desk.) The glass industry 'rep', I learned later that he was a lobbyist, asked me to arrange a session on glass safety at the 1968 Annual Health Conference in Buffalo. He was a really annoyed when only three people showed up; but, his links to me and me to the Public Health Service, led to safety glass installation in NYS and the industry making capital on that new safety product. A second use of the "Philadelphia" technique, the data collection of eye injuries from fireworks, primarily handled by ambulance companies in New York State, helped the American Society for Prevention of Blindness upgrade federal fireworks regulations (Part 1507, 16 CFR Ch II).

Those winning injury prevention events, led to showing in the media and press that dangerous toys - that the toy industry had promised the National Commission on Product Safety to be removed from the marketplace in a few weeks - were still there. We did that by deputizing consumer group members to go into store with us and our findings helped establish the CPSC.

A next nationwide product safety impact was collecting data and solving exploding and burning roasting bags covered by the NY Times and CBSTV [10], to consumer injury complaints hot line, press interviews and journal articles, to CPSC contracts on playground injury and on community poison prevention published studies, to setting up the first state funded regional poison control centers, etc.

And here's the rest of the Philly IC story... I had returned to visit Philadelphia several years after I had resigned. I met the health department director in the elevator. Art said "hi" but then asked me: "how was his Division report doing"- on that he thought I had been working on.

Other related intimate vignettes; perhaps, the most successful injury reduction in New York State was not from glass doors. In 1969, I was requested to identify the causes of injuries in the Tuberculosis Homes. My report mentioned the chief causes of injuries as falls from beds for patients and back injuries for staff. Within one month of submission of the report the injury frequency decreased to none—as the homes were closed down, for low occupancy. This, ad hoc post hoc, and spurious, event ranks as the most effective outcome with which I am familiar; second only to the reported National Park's program to reduce falls from cliffs There it was, per

the myth, reported that fences were climbed over until signs were posted" beware of poison ivy". Safety Vs Risk reduction; Art Vs Scientific measurement must not be lost in protection nor prevention.

Year's later, when my three-year-old daughter, Michelle, fell from the sixth step on the stairs in my parent's home in Pottsville, Pa. I ran to the bottom the stairs, and with alarm asked Michelle: "Where it hurt her." She crawled back up six stairs and said "Daddy, here."

By the late 1960's, New York State public health practices effectively began to collect epidemiological data to identify and to promote new consumer product safety designs and laws, and to assess impact on adverse public health sequelae.

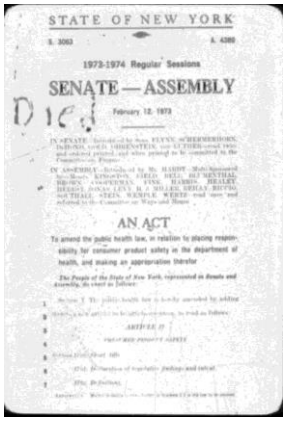
Part 3: Injury Prevention Leadership Policy (1970-1980's)

Part 2 of the Commentary offered a descriptive, analytical and dynamics assessment of NY State's organizational and individual leadership roles, 1930-1970's, in injury prevention. The thesis and evidence is to use such leadership crafts for current needs, especially during economic downturns and limited resources. Part 3 continues:

In 1969, the State Health and Law Departments linked resources when I began to share weekly newspaper accounts to Law Department staff about fires and burns, primarily from children's clothing. An assistant state attorney general had inquired to the state health department about a complaint that clothing was flammable and could seriously burn children. I had just returned from a meeting of the Informational Council on Fabric Flammability, a collegiate forum of industrial, governmental and voluntary groups that, in retrospect, greatly moderated (as needed in current safety debates) the exchange of information to reduce flame related burns. 'Industrial Statesmen' including J. C. Penney, Sears Roebuck, Montgomery Wards, several textile manufactures; US Department of Health Education and Welfare, US Bureau of Standards, states and other officials conferred on common goals to collect fabric burn data, promote educational and legislation. I estimated from national data presented at the conference that some 2000 New Yorkers ignited clothing each year. The Assistant AG then asked what type of clothing. I said: "all". The State Attorney General enabled the State Department of Law to call interagency meetings and public hearings. At one hearing, testimony of Mr. Carmen Mandia, Supervisor, Emergency Medical Services and Injury Control Program, New York State Health Department helped upgrade state and federal children's nightwear and mattress flammability standards (GBL 1969 - Chapter 1989, 16 CRF 1616, 16 CRF 1632). Subsequently, under Attorney General Lefkowitz's commitment and directive, the State Health Department investigated other fabric burn injuries, the State Labor Department tested the clothing samples, and the State Police and Fire Agencies assisted in investigations (35). Years later, significant reductions in severe child nightwear burns was observed nationwide from these efforts in New York; but only after many years of advocacy for updating the weak flammability standard and from scarred children from burned clothing shown at Congressional hearings.

Carmen was a friendly, supportive and permissive supervisor who gave me great flexibility to run my injury prevention programming. He had been a creative actor in Utica, NY and maintained his interests in good paintings which he would view after our field trips together in NYC. He had a Chrysler Imperial which he would lend me when he went on vacation. The Albany snowstorm of 1969 had 48'' of snow and buried cars on our street of apartments, but that buried Chrysler took off while other cars and trucks remained snowbound. Once when he returned from Mexico vacation he remarked how the airplane crew was so high-spirited on the flight up the mountain to Mexico City; during one such flight the cockpit door flew exposing a line of Tequila bottles on the captain's windshield.

The Decade of 1970's: Consumer Product Safety Emerges



STATE OF NEW YORK

1973-1974 Regular Sessions

SENATE — ASSEMBLY

AN ACT

Building on Haddon's work, public health theory and practice continued to consider how best to collect and use epidemiological data to identify and reduce injury and how such a scientific model could be adopted within the larger political environments of diverse organizations and groups with their own values, interactions and activities. There was still a common perception that people cause" accidents" and that profits, for the most part, were essential over public safety and protection. In June 1970, The National Commission on Product Safety (PL 90-146 of 1968) conducted and advocated with nationwide hearings, for an omnibus product safety act to identify and limit industrial abuses. These new consumer and public health protection laws were leveraged on Goddard's and Haddon's use of scientific knowledge for health protection and safety.

…….

By 1970, the New York State Attorney General Lefkowitz further enabled the New York State Department of Health to reduce burn injuries and served as a model, lost for many decades, of how to make products safer without creating a new law, a problem with gun safety today where the pro-gun lobbies control the legislative votes in States and in Congress. In 1999 the MA Attorney General was indeed able to pass gun safety regulations from his existing laws; while in 2002, the Legislature and Governor upgraded existing gun safety and "DNA" tracing laws.

The New York State Attorney General led with a request that the State Health Department start a statewide fire injury surveillance and reporting system from New York's fire departments. Collected data again showed clothing ignition burns as a primary source of injury (35). By 1978 this system had developed into the Statewide New York State Burn Incident Reporting System managed by the New York State Department of State. The Department received tens of tragic descriptions and samples of clothing on burnt children (And I many nights in my bed would in my dreamy sleep reach and shake my wife next to me, from imaginary flames.)

And the in depth, within 24 hours follow-up on site and hospital room epi-interviews, with burnt young children and their families were so emotional draining... many youngsters would be dead within 24 hours. Others, who were to live, were initially not aware of their permanent physical and emotional scarring.

Dr. McComber, a plastic surgeon pioneer in burn injury data sharing at the Albany Medical Center Burn Unit, invited me to see a debreachment (removal of dead skin on a burn, to help healing process). The plastic surgeon removed a wire support from an eight-year-old boy's burnt

finger in a pajama ignition that had played with matches. The boy was so excited to be going back to school in the next week; he could not wait to see his old friends. The tragic burn scars throughout his face left me with doubts that his young friends would ever understand his ordeal.

In the 1970's, New York State Health Department professional educational initiatives prepared and mailed a monthly newsletter on emergency medical care and injury control.

A deputy health commissioner at first cancelled the newsletter, as he had not 'approved' the concept; however, I knew him well and was able to persuade on its merit.

Monthly, for several years, that informational newsletter and The Health Department organ, also featured my Column, "Home, Safe Home" distributed to 50,000 physicians in New York (See full editions: icehs_section@connect.apha.org archives):

- A HEALTH NEWS reprint

1968

HAPPINESS IS A SAFE HOME

LURKING in any corner of your home, there may be a safety hazard—a refrigerator coffin in the basement, an unlabeled medicine bottle in the bathroom, an ashtray by your bed, a scatter rug in the hallway.

Proof of this is the fact that in New York State accidents are the *fourth* leading cause of death, and, last year, one out of every four accidental deaths in this state occurred in the home. These home accidental deaths (about 2100) ranked second to the number of accidental deaths on our highways (about 2800). In fact, at least *every hour* someone in New York State is accidentally injured at home; every day, five New Yorkers are accidentally killed at home.

Lack of Concern

Gruesome figures? Well, the tales of home injuries and deaths from falls, fires, drownings, suffocations, poisonings and firearms are even more gruesome. What is most tragic is the lack of concern—at least, until a few years ago—about the fact that children were being accidentally poisoned by detergents, insecticides, cosmetics and medicines; that teenagers were accidentally shooting themselves; that adults and children were being burned needlessly in household fires; that the elderly were breaking bones as they fell down stairs.

This lack of concern may have resulted from the feeling that accidental injuries and deaths were acts of fate . . . or "Accidents only happen to the other guy." Even today, if a child dies of hepatitis, many in the community will panic, but if a child drowns or dies of accidental poisoning, he's just another newspaper statistic.

But we do know a little better today. We know that most accidental deaths and injuries can be prevented.

Our major concern in this column will be to keep our readers informed on some of the most up-to-date ways to prevent accidents and deaths at home.

There is no vaccine, catchy slogan or startling poster that can prevent an accident. Nevertheless, most accidents and their damaging results are preventable because, without the special mixture of a "contributing thing," a "contributing surrounding" and a "contributing individual," they cannot happen.

For example, the familiar accident of the aging—the fall—doesn't just *happen*. Let's see why. A 70-year-old woman slips on a loose rug in her living room and fractures her hip. What individual factors made her susceptible to this type of accident? Poor sight? Poor coordination? Physical weakness? Possibly. But let us keep in mind that if the loose rug—the "contributing thing" had not been there, the accident might have been avoided. And, perhaps better lighting would have made it easier for her to see her "surroundings."

Three Factors

Here's another example: A three-year-old boy swallows half a bottle of aspirin and has to be rushed to the hospital. But this accident didn't just *happen*, either. The medicine was the "thing," the easily opened medicine chest may have been the "surrounding," and the naturally curious three-year-old, the "individual." And yet, a few simple precautions could have prevented this accident.

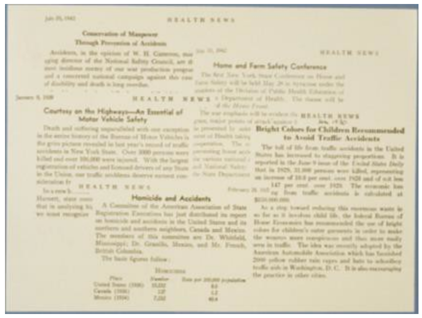
As the year progresses, we'll talk about: poison prevention, consumer product safety and seasonal home safety topics that concern us all.

+ + +

—Leslie Fisher
Emergency Medical Services

Cartoon by Mr. Schulz, by special permission of the National Easter Seal Society for Crippled Children and Adults.

Some earlier "accident" shorts from Health News archives, 1940:



HEALTH NEWS

Conservation of Manpower Through Prevention of Accidents

HEALTH NEWS

Home and Farm Safety Conference

HEALTH NEWS

Courtesy on the Highways—An Essential of Motor Vehicle Safety

HEALTH NEWS

Bright Colors for Children Recommended to Avoid Traffic Accidents

HEALTH NEWS

Homicide and Accidents

In 1969, Carmen Mandia, my supervisor, testified with our data at the National Commission Hearings on Product in its Final Report (P.L. 90-146), The Final Report of the National Study Commission portrayed the overall childhood risks and preventive program on toxic substances without safety closures, flammable fabric and other unsafe household products in New York State, and the weaknesses of state, federal and industrial regulatory responses. The Final Report established the federal Consumer Product Safety Commission (15 USC 2051) (36). The Commission then asked New York State and other departments of health nationwide to conduct effectiveness surveys of retail stores for the toy industry's promise of its voluntary removal of dangerous toys following a federal hearing on risky toys being sold. Few unsafe toys were removed from the marketplace, which moved the toy safety debate forward toward greater

federal regulations

INTERCOM

SNOWBLOWER HAZARDS: In a four hour period this winter, one New York hospital treated ten persons for serious hand injuries resulting from snowblowers. Most injuries occur when the operator puts his hand into the snowblower chute to clear packed snow or debris from the blades without turning off the motor. Anything from a scratched finger to an amputated hand can result.

FATAL FALLS: High–rise living can be deadly for the younger set. In 1966, fatal falls from fire–escapes, windows and rooftops accounted for 18 percent of all accidental deaths of New York City children under 14 years old. Most of the fatal falls affected children between two and three years of age living in poverty areas of the city.

AUTO FIRST AID: All applicants for drivers licenses in West Germany must now take an eight hour course in first aid related to automobile accident injuries.

FLAMMABLE FABRICS: Deaths and injuries caused by ignition of clothing are a world–wide concern. A new publication from Switzerland summarizes the technical aspects and legal implications of textile flammability. See, Textile Flammability and Consumer Safety, Gottlieb Duttweiler Institute for Economic & Social Studies, Switzerland, 1969. Flammable fabrics are also discussed in the January, 1970 issue of Health News, New York State Health Department monthly publication.

FREE BOOKLET: The booklet Rescue Breathing, which teaches how to revive a person who is unable to breathe for himself as the result of an accident or illness, is available without charge from the medical defense administrators in each of the State Health Department's regional offices. A wallet card for easy reference in an emergency is also available for persons who have learned the technique of rescue breathing.

FIRST AID TRAINING: Thousands of New York residents at home, in schools or at work are learning how to give emergency first aid to families and friends through the 16–hour Civil Defense Federal Medical Self–Help training program. This program is designed to prepare people to survive when a physician is not available. Textbooks and training materials for instructors may be obtained from the medical defense administrators in each of the State Health Department's regional offices.

1969 FIRE LOSS ESTIMATES: According to estimates released by the National Fire Protection Association, 12,100 persons died in fires in the United States during 1969. The total number of estimated deaths from fires remained approximately the same for 1969 as in 1968; however, deaths in dwelling fires declined fractionally from an estimated 6,600 in 1968 to 6,500 in 1969. The cost of property damage from fires in 1969 is estimated at $2.4 billion, which represents an increase of $260 million over 1968. The May 11 fire at the U.S. Atomic Energy Commission plant in Golden, Colorado, [with a loss of $45 million]was the greatest property loss occurring in a single fire during 1969.

ELECTRICAL SAFETY: The pamphlet "Shocking Facts About Electricity," which describes safe use of electricity and electrical products, is available in quantity from the New York State Department of Health. Requests should be addressed to: Public Inquiries Section, N.Y. State Health Department, 84 Holland Ave., Albany, New York 12208. Single copies of a brochure explaining the meaning of the Underwriters Laboratory [UL] label on electrical products may also be obtained.

Toy Survey Shows Dangerous Items For Sale in N.Y.

A pre–Christmas survey of New York toy stores indicated that several toys cited as hazardous in National Product Safety Commission hearings were still for sale in the State as of December, 1969.

The survey was conducted by the Department's regional emergency medical care representatives, at the request of the National Commission on Product Safety, to determine whether manufacturers had voluntarily removed such toys from the market.

As of January 6, a new toy safety bill [PL9113] became effective authorizing the Secretary of Health, Education and Welfare to ban sales of toys and other articles for children that present electrical, mechanical or heat hazards. The Secretary was previously empowered to ban toys which are too easily flammable, too highly pressurized or chemically dangerous.

Reporting on the New York toy survey, Leslie Fisher, Health Department accident prevention consultant, said, "A few toys cited by the Commission as having hazardous features were available for sale. We also observed other items, not mentioned by the Commission, which could produce injuries. Toys are only one group of products which must be designed with safety in mind if we are to reduce the estimated two million injuries per year related to common products found in the home."

Century of Service

Bellevue Hospital, in Manhattan, is celebrating the 100th anniversary of introduction of the hospital's emergency ambulance service, the first such operation in any large city.

The one–horsepower wagons of 1869 have been replaced by a sophisticated ambulance corps which is ready to respond to major emergencies carrying the latest medical equipment, doctors and nurses, as well as an administrator to direct operations at the scene.

(36).

The State Health Department survey was shared with the State Attorney General who then established New York State's toy safety law (New York State General Business Law of 1973 -

Chapter 75) and supported the federal Toy Safety Act (Federal Hazardous Substance Act, Subchapter C, 1500, 16CFR, Ch. II). During that time, Health Department studies funded by the federal Public Health Service, Accident Prevention Program (which budget by the mid 1970's had become virtually eliminated in the Nixon administration due to its non use of new scientific methods and too extensive informational emphasis (see Waller, J., AJPH, 1994, in secondary bibliography listing below); however, under a Public Health Services Contract, I and NYSDOH Glenn Fall Region staff, unexpectedly identified fire while assessing carbon monoxide risks in mobile homes, which led to the upgrading of existing regulations (Executive Law 1973) on fire resistance, multiple-exits and smoke detectors for New York State's mobile homes (37-39).

A major hallmark shift in the 1970's was from consumer to manufacturer beware:

Trends of New York consumer complaints of product related risks and injury were publicized in the media[211] to obtain more data and to offer safety guidance This efficiently linked NYS data with the new Federal Consumer Safety Act PL 92-573 Section 15, for reporting of unreasonable product risks and Section 29, State-Federal joint contracts for joint Federal and State compliance, research, engineering, educational, and overall cooperation: In 1970, New York State involvement with the federal Study Commission for Product Safety had included testimony and attendance at Congressional Hearings in Washington. *At one hearing, which I was invited, I became enthralled with Senator Magnison's ability to discuss child safety technology. My host, Bill White, Executive Director, Study Commission, explained how he had enabled the Senator, over dinner, to become aware that a new liquid drain cleaner packed in a milk container, would be distributed the next day. The publicity stopped the distribution and served as a reminder of need for governments to protect child safety.*

But what were the roles and relationships for the newly emerging federal, state and local child consumer product safety programs?

1. The National Commission on Intergovernmental Relations (1956) recommended in its report to the President: ”Leave to the individual initiative all the functions that citizens can perform privately; use a local government close to the community for all public functions it can handle; use cooperative inter-governmental arrangements that are appropriate to obtain economic performance of popular approval; reserve national action for residual participation where state and local governments are not fully adequate, and for continual responsibilities that only national government can undertake.
2. Thomas Jefferson observed that the only way in which states can erect a barrier against the extension of national power into areas within their proper jurisdiction is” to strengthen the state government - which cannot be done by changes in the federalconstitution; it must be done by the states themselves."

Therefore, if states cannot carry out necessary product safety functions, it is a prerogative of the federal government to accomplish its mandate using its own personnel, materials and methods. But, if states cannot carry out the necessary product safety functions, it is a prerogative of the Federal government to accomplish its mandate using its own personnel, materials and methods. But, where states have potential or are involved in product safety activities, those programs should be supported or enhanced with flexible overall program grants to monitor, investigate and reduce injuries and with specific contracts and project grants (40).

The State Sanitary Code was expanded in 1970 to include the labeling of leaded paints and the Childhood Lead Poisoning Control Program to screen children for blood lead levels

(P.H.L. 1970); by 1993 a comprehensive legislated and funded Lead Control Law was mandated. In 1970, the State Legislature also created a Burns Care Institute (BCI) in the Health Department (P.H.L C-806) to collect data about burns and to coordinate burn care activities in the State. The Department's Burn Institute director, Dr. Peter Greenwald also served as the Cancer Institute Director; he recruited me laterally to serve as the director of burn prevention.

Rushing to get to a BCI legislative authorization meeting at the newly being constructed Albany Empire State Plaza; I hailed a taxicab in front of the DOH building on Holland Avenue. The "cabbie" sensed my lateness and told me that new Plaza construction could hinder reaching the Legislative entrance. ; But, for me to fear not and just do as he asked of me. Upon reaching the guard at the building construction gate, he whispered to me: "Lift up your attaché case so the guard can see". I did and he then said: "Let the Senator go through." to the guard who waved me into VIP entrance.

One of the seminal studies in national cancer epidemiological research conducted by the NYSDOH Cancer Control Bureau and the BCI (with me matching burn injuries controls) in: N.J. Vianna, P. Greenwald, J. Brady, et al. Hodgkin's disease: Cases with Features of a Community Outbreak Annuals of Internal Medicine 77: 169-180, 1972). Because burn injuries requiring hospitalization are approximately ten times commoner than new cases of Hodgkin's and they are clearly non-infectious, the burns injury controls helped establish that an Albany, NY outbreak in high school class was statistically significant in a group of students, their friends and household relatives.

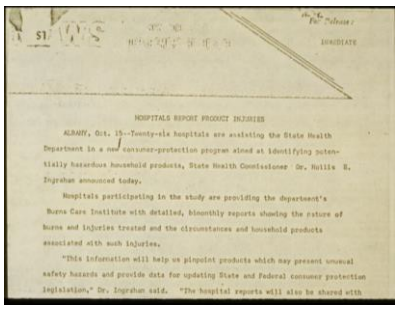
The Fourth Annual Report to the President and the Congress on the Studies of Deaths, Injuries, and Economic Losses Resulting from Accidental Burning of Products, Fabrics, or Related Materials, Fiscal Year, 1972, Submitted by The Secretary of Health, Education, and Welfare, as required under Section 14(a) of the Flammable Fabrics Act Amendments of 1967, described (page 215) the activity of the Burns Care Institute and its contributions to preventing nightwear burns to children:

"A major function of the New York State Department of Health Burns Care Institute, then, was to obtain reports and investigate home burn related injuries, particularly those associated with flammable fabrics. The Burns Care Institute personnel cooperated either by referring cases for investigation or by submitting investigated cases to FDA. Their efforts culminated in a contract being awarded to conduct flammable fabric investigations." That work led to seminal burn injury legislation and regulations.

At the request of Dr. David Axelrod, New York State Health Commissioner, I, as the Institute's Director, Burn Prevention Program (and the only professional employee, as we only had a

$50,000 appropriation!) testified as the only health agency representative nationwide before the President's Commission on Fire Prevention and Control (P.L. 90-259), which established a national fire safety agenda. My presentation described the Haddon epidemiological approach to reduce burn risk and to promote combinations of community-based education with fire departments, and engineering standards development with industry and the National Bureau of Standards, and legislative interventions.

On February 12, 1973, well publicized in statewide newspapers, the Department of Health staffed a consumer complaint telephone" hotline" to serve as an early warning reporting system for new burn and other unreasonable or substantial consumer product risk-trends and for referring substantial risks to the newly established federal Consumer Product Safety Commission. Subsequently, to supplement the data system, the State Health Department initiated a statewide, stratified sample of general hospitals as a surveillance system for consumer product-related injuries:



HOSPITALS REPORT PRODUCT INJURIES

ALBANY, Oct. 15--Twenty-six hospitals are assisting the State Health Department in a new consumer-protection program aimed at identifying potentially hazardous household products, State Health Commissioner Dr. Hollis S. Ingraham announced today.

Hospitals participating in the study are providing the department's Burns Care Institute with detailed, bimonthly reports showing the nature of burns and injuries treated and the circumstances and household products associated with such injuries.

"This information will help us pinpoint products which may present unusual safety hazards and provide data for updating State and Federal consumer protection legislation," Dr. Ingraham said. "The hospital reports will also be shared with

These and similar reports of new consumer product risks and injuries, their nature, extent, prevention and control, were discussed during many media interviews (e.g. see cites listed in References 52-53 for Part 2- 4 and at www.timesunion.org archives).

Here are some of those vignettes: Policy options for prevention were developed when the coffee industry trade group was invited to promote prevention of scalds from coffee and tea drinking when kids were sitting on parents' laps or near a table. (My proposed joint ventures never really got started). Other industries were invited, successfully, to reduce risks from exploding fondue pots (warnings added on products), shorting heating blankets (recalled), toxic school paste (reformulated), leaded glazed drinking glasses (recalled, after I took my daughter's glass away to tested it in the State Health Department Labs for lead. Years later she would remind me of my "theft" of her favorite drinking glass), flammable candle schooners (voluntarily recalled by the industry when the plastic schooner caught on fire from the burning candle), teething ring containing two interacting liquid sanitizers which leaked out (referred to FDA, NYSDOH and FDA forced voluntary recall), laundry softeners associated with dermatitis (epidemiological investigations in cooperation with Proctor and Gambles leading to independent dermatologists reports of no risk; seems in the Winter everyone in Rochester, NY has some type of rash), and dishwasher sealant with arsenic (non-toxic but what a coverage in the New York Times, Dec 28, 1976:H-4 and 12//31/76:A20) when a woman complained that her hair had fallen out.

On that dishwasher sealant: The New York Times had called me. I called first the federal CPSC who had investigated the incident and found no relationship to the use of arsenic containing sealant. Meanwhile the State's consumer protection agency also got word on the story. I had the manufacturer visit the Department and describe its safety research; while the other State agency issued a "consumer alert". After the meeting, the company, one of the largest in the Albany area,

called the Health Commissioner and said they had had enough of inappropriate government meddling on free enterprise and they would be packing up and leaving NYS. (Inter-agency negotiation cooled down the issue and a non- dangerous product continued to be used.)

Others: a cigarette smoking advertisement showed next to the smoker a highly flammable tile adhesive (at our request, ad removed voluntarily); dangerous fireworks, (data collected from ambulance companies helped upgrade federal standards); plastic cooking bags (Nationwide articles in New York Times, Consumer Reports, WCBS-TV and our work established national warnings and additives)

Oven Bags: Potential Burn Hazard?

Why Cooking Bags Explode

Which promoted my Aunt's boss, in Chicago, who happened to distribute them: "Will you stop him, he will put us out of business?" (42-47).

SPECIAL COMMENTARY, ARCHIVIST LES FISHER

HARD TIMES A COMING? … OR JUST CHALLENGING OPPORTUNITIES FOR YOU & INJURY CONTROL

Historically lacking, leadership archetypes (or modeling) that simplify and unite the diverse dialectics and promote innovative collaborations have abounded since man, environment and agents interacted; Injury Control is no exception (See: Winter 2002 ICEHS Newsletter).

For the "modern age", in 1788, Johann Peter Frank, the father of modern hygiene, first identified injury as a public health problem whose four basic beliefs still recycled into our 21st century: "ACCIDENTS" PREDOMINANTLY RESULT FROM HUMAN MISACTIONS, THAT "ACCIDENTS" AND THE INJURIES RESULTING FROM THEM OCCUR BY CHANCE OR FATE, THAT SINCE INJURY RESULTS FROM "ACCIDENTS", THE ONLY WAY TO AVOID INJURY IS TO PREVENT "ACCIDENTS" (1).

That thrust on human factors portrayed, and continues to portray, itself by the United States federal government and others for decades (2,3) until Haddon, building upon prior engineering and medical work, broadened the conceptual framework to energy exchange as the true cause and point of control of injury and other conditions. From his work, holistic/systematic empirical managerial and leadership approaches evolved and were codified to reduce injuries. In the USA, the PHS in the 1950s, 1960s and 1970s, the Department of Health Education and Welfare, Bureau of Maternal and Child Health in the 1980 and the National Committee on Injury

Prevention in 1989 continually updated earlier models of causes, interventions and federal organizational structures on injury prevention (4,5).

Particularly, Baker, Waller, Fisher, Runyan, Gallagher, et al (6-10) (including recent foundation reports, most recently (11,12) have further assessed and developed these injury control leadership (not just managerial) models. Baker highlighted key injury control pioneers, Stapp, DeHaven, Haddon, and their leadership roles for the modern science of injury control. Fisher analyzed trends in injury prevention history and derived a programmatic managerial conceptual model. Waller reviews his fifty years in the field of injury control and its political dynamics. Runyan developed an overall policy model.

All these "models" guide better decision making and problem-solving management and, at times, leadership, for the researcher, practitioner, educator in epidemiology, emergency care, prevention, or rehabilitation. Also essential are the ongoing processes of continued shared visions, imagery, continued learning, changing oneself not others, etc. which help us to reflect and act on newer sciences and arts of injury control.

Our discipline is not an eternal reincarnation of the Greek myth of Sisyphus, the figure doomed in Hades to roll, forever, a heavy stone uphill, only to roll down again!

These open communications with the press, industry and consumers helped lead to prompt federal, state and local public health practices, many in cooperation with industrial and consumer groups, especially with Judy Braiman-Lipson, Chairperson, Empire State Consumer Association (Rochester) of New York State. The focus was on the consumer product and empirically reducing any identifiable energy risk, as Haddon had postulated a decade earlier (5). By 1974, the Burns Care Institute, conducted detailed structured studies on the epidemiology of burn and of fall related hospitalizations. The federal Center for Disease Control funded these studies, which advocated an epidemiological approach to injuries and prevention (48).

The Federal Emergency Medical Services System Act of 1973 (PL 93-154) was enacted after New York State and other states recognized and reacted to carnage from improper emergency care for traffic victims and the toll of additional morbidity from crashing ambulances. In New York State, the Bureau of Emergency Care and the Injury Control Program began to focus on training of EMS coordinators to prevent or control these episodes, Haddon's seventh and eighth preventive strategies (5).


EMERGENCY HEALTH SERVICES

INTERCOM

Flammable Fabric Laws Tightened

Injury Control Seminar Scheduled

EMERGENCY HEALTH SERVICES

Senior Citizen's Month Coming, Safety Programs Needed

EMERGENCY HEALTH SERVICES

Department Studies Mobile Home Hazards

INTERCOM

Commissioner Urges Glass Door Safety

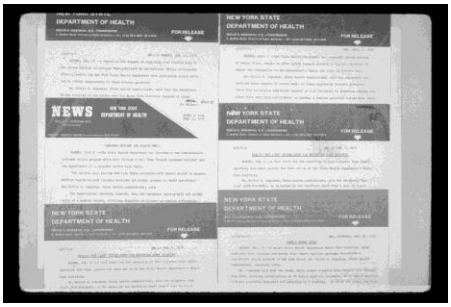
In 1974, the APHA Injury Control Section, under Janice Westaby, previously Director, Accident Prevention, New York State Department of Health (whose position and later positions were innovational funded under federal Social Security Act, Title 5, currently the Federal Maternal and Child Health Block Grant) while an Assistant Professor, University of North Carolina,

School of Public Health, published for the Section, an extensive bookshelf on injury prevention research and programs. She described the new age of epidemiological descriptive studies for reducing injuries and advocated the need for preparation and training of a variety of injury control specialists in this new field. Then, she served, as Chairperson, Home Department, National Safety Council, where her tenure was also marked by a vision for active leadership roles of practitioners in child and home safety:

"With the development of a scientific body of knowledge have come numerous side issues - the preparation of a variety of specialists to work in injury control and emergency health services, the development of data systems to define problems more carefully, the development and testing of communication systems, the need for full-time personnel in many types of agencies and institutions to plan effective countermeasure programs, and the need to define further legislative action to aid in research and development (49)."

Yearly from 1973-75, the New York State Department of Health trained at State seminars, leaders from local health and voluntary sectors and consumer groups on how to conduct federal Consumer Product Safety Consumer Deputy Programs. These leaders returned to their counties and recruited and trained other consumer volunteers and health department staffs to survey retail stores, conduct extensive published media interviews to report possibly non-complying toys, Christmas decorations and the labeling and child safety packaging on household toxic substances. In May 1975, New York State Department of Health coordinated statewide store surveys for child safety packaging for products containing sodium and/or potassium hydroxide: 142 stores were surveyed in 12 counties for which 61 possible violations were reported to CPSC (50-51). In May 1974, local health departments found 36 federally banned toys and 138 other toys on the shelves of 151 stores. Twenty-six statewide hospitals reported toy injuries for the Department's referral to CPSC and the State Attorney General (48).

When new risky toys were found, these were publicized in press releases.



Once a brand name of plastic pencil that was used to sketch on a clear plastic board was mentioned in a NYS Health Department "toy hazard findings ", press release. The company sent me its safety details showing the pencil point was not sharp but rounded. I was asked for a full public apology and retraction by the State of New York. Thankfully, instead, my industrial counterpart accepted his youthful state employee counterpart's apology. Another similar event: the federal government under industrial action had to ban the distribution of the federal banned toy list which did not list any corrected new product line.

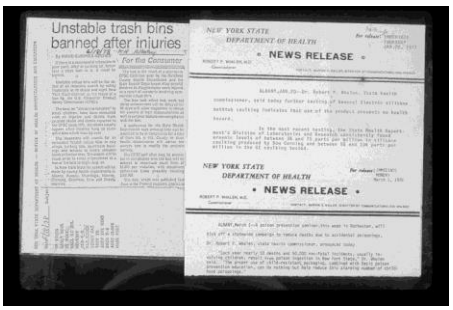
Much of the BCI's successful outcomes were obtained by my contacting heads of toy and other product manufactures by telephone about a possible risk found in the marketplace and suggesting they might want to check any problems and to advise federal regulators on how they might help.(sure:)). However, when substantial injury risks were found, voluntary action with

government support helped many times resolve the issue. (The presidents of companies were not out to kill or maim their customers and they usually appreciated the public health responsive and responsible approach, which became my repeating leadership and managerial communications tools of government-industry safety cooperation. Sidebar 2.: In the 1980's a round toy safety US Government (CPSC) promotional badge, about three inches in diameter, lettered "injuries are not accidents", with a backside pin, was recalled when the badge had high levels of lead!)

The consumer deputy retail store compliance was later adapted for toy, matchbook, household toxic substances, playgrounds and child auto restraints, with other surveillance, educational and regulatory injury prevention programs (to be highlighted in the decades to follow.) The well-publicized approach in press releases and newspapers interviews (52-53) had expanded the early single domain of using health educators to conduct informational conferences with women's and other organizations for injury prevention started by Brightman 25 years earlier. A coalition of educators, regulators and consumers, as a team, began community -based programs and assessed outcomes from pre-and post-surveys of targeted homes, retail stores or public areas for tangible risks involve improper energy release (ala Haddon) with consumer products and unsafe practices.

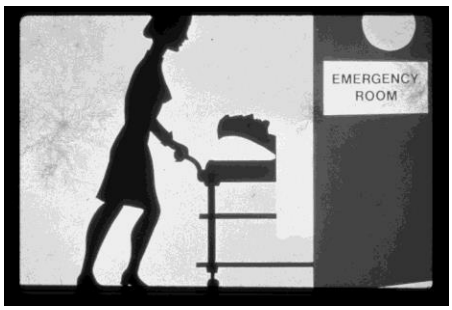
In 1977, Spiegel illustrated in her seminal article, a successful built environment, New York City program in reducing window fall injuries by 50% by installing window guards on high-risk housing, passing legislation requiring the guards, educating the public about the hazard and working with the public health nurses to provide counseling, referral and continued enforcement of the regulation (54).

More on expanding data collection: Under contract from the federal Consumer Product Safety Commission to Health Research, Inc., the State Health Department's research funding arm at that time for cancer research, the Department followed-up many injury reports from 18 New York State-based National Electronic Injury Surveillance System (NEISS) from hospitals which began in July 1972. NEISS's "hard copy paper" predecessor, the National Injury Surveillance System (NISS) was established in hospitals in New York State, with the joint visits to potential participating hospitals by federal US Department of Health, Education and Welfare, 'empowering' leadership by state health department staffs.


Unstable trash bins banned after injuries

NEW YORK STATE DEPARTMENT OF HEALTH

• NEWS RELEASE •



That successful joint federal- state marketing effort then led to a federal contract for the State Health Department to conducted follow-up eight-hour, in-depth field investigations from NEISS reports and to become aware of new trends and priorities for child product safety preventive and protection practices with the federal government. It also began the process of testing out, for the first time nationally in a least a decade, of interventions using empirically based data for assessments and evaluations of outcome. I had accomplished a goal of moving from just anecdotal injury resolution to program development and evaluation; from just the early

"accident" prevention information approach to the three E's: Education (mostly of "change agent" political and policy groups), Engineering and Enforcement.

In 1979, the NEISS system had decreased to some 30 hospitals nationwide (after federal CPSC budget cuts). Two of the remaining hospitals in Rochester- Strong Memorial and Rochester General - handled about 70% of all hospital emergency department visits in Monroe County. Into the 1990's, all product-related injuries treated in these emergency departments had been reported to the Monroe County Health Department. Once NEISS stopped in Rochester, Dr. Axelrod, State Health Commissioner, asked the county health commissioner to continue to collect the data. So, these data assisted the State and Monroe County Health Department's toy, playground, mini-bikes, racquetball, lead-glazed painted drinking glasses (remember, the one that I had to take from my young daughter, who never forgave me for breaking them up for DOH laboratory testing?) demonstration projects and outcomes using the earlier approach of the federal Consumer Product Safety Study Commission of consumer deputy surveys of retail stores. Further, coalitions of selected business, consumer, and government groups accomplished data surveillance, educational, product safety and compliance interventions (55-56). In 1991, the toy safety, as other child safety activities under Mr. Jack Van Buren, Monroe County Health Department, Public Information Officer, was cited by the Secretary of the U.S. Department of Health and Human Services in its Community Health Promotion Awards for 1990:

> "Reports in the medical literature of a high incidence of toy-related deaths and injuries (approximately 130,000 annually) among U.S. children prompted the Monroe County Health Department, a local consumer group, and the Better Business Bureau to launch the Monroe County Toy Safety Program. Emergency rooms in the county reported approximately 500 toy-related injuries per year. Program objectives are to 1) reduce toy-related injuries among children, 2) obtain voluntary removal of dangerous toys from sale and use, and 3) educate parents on toy safety include 1) using volunteers to survey toy retail outlets for potentially dangerous toys, 2) presenting retailers with the results of the survey, 3) honoring persons who play an integral role in the program, 4) asking retailers to publicize toy safety information in newspapers and other media, 5) soliciting radio and television coverage for the program, and 6) building a database of accidental injuries, including those that are toy related, reported to area emergency rooms.
>
> Toy-related injuries decreased from 256 in 1974 to 144 in 1988. Further, a 1985 comparison of local and national toy-related injury rates for all ages show 50 percent fewer injuries in Monroe County (26.3 injuries per 100,000 children) than nationally (52.1 injuries per 100,000 children). For children under five years of age, the injury rate is less than one-third that of the national average" (57).

Mr. Van Buren proficiencies in writing and human relations skills, for many years he was an aid to the county health commissioner and previously a reporter for the Rochester, New York Democrat and Chronicle, greatly translated and helped market many of my theoretical concepts on child safety. Another example of interpersonal managerial partnership proficiencies: Following a three-state region child playground equipment project conducted in New York State in 1977, there was a 42 percent reduction in playground equipment hazards and a 22.4 percent reduction in playground related injuries treated in the two largest hospitals in Monroe County sites. Knowledge about unsafe playground practices and equipment hazards improved after the workshop for playground personnel (56).

My daughter, age about three, had taken and eaten some plant from our backyard. Of course, being an expert in poison prevention and control, I administered a dose of Syrup of Ipecac, while she was swinging on the swing set playground in our backyard. It didn't make her vomit; I gave her another dose. Along came her next-door neighbor playmate, and she vomited all over him. We neighbor didn't speak for some time after that.

Equal time for my son's saga: My baby son Larry was "helping" me build the sheetrock walls in my den. I looked at him in a safer corner of the room, but he was chewing on the gypsum sheetrock. I panicked; while I had the local poison control center phone number posted on the phone; I just could not see the number. Great on the job education experiences make practical changes in public programs.

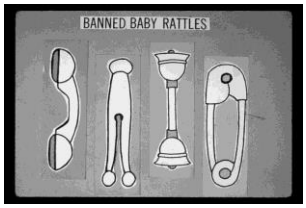
The "playground" model was adapted for many later child safety programs: poisoning prevention (58), to flame retardant tents(59);

Each showed, with the social media of the day (written press, TV commentary series reaching 260,000-See icehs_section@connect.apha.org archives Houston 3/18/76 speech, two aired scripts), the public, industry and government a substantial consumer product injury risk and then promoted a constructive solution involving collaboration among all three groups and then empirical evaluation of outcomes from the interventions. In the late 1960, Dr. John Timmerman, Chemist, Monroe County Health Department, had first gathered sample risky consumer products being sold in stores and exposed them publicly.

During the late 1970's, my New York State Department of Health television home safety series helped support enactment of a new flame-retardant tent standard (GB Laws of 1978 - Chapter 318) (59), and New York State Consumer Protection Board established an interagency panel on consumer safety to promote and aid a statewide law on proper selection, installation and use of home smoke detectors. The Board also held hearings on the fire safety from installed aluminum home electrical wiring (banned by the federal Consumer Product Safety Commission but later overturned by federal courts) (60). With consultation and facilitation of NY State Health Department, the State Consumer Protection Board, helped the Rockland County Health Commissioner, Dr. Steven Redman, petition the U.S. Consumer Product Safety Commission to reduce childhood concussions from unstable refuse bins that had fallen on two local children. Nationally, the law (CFR 116, Part 1301, Subchapter B - Consumer Product Safety Act Regulations) resulted in a virtual elimination of refuse bin concussions (61). In statewide media interviews, the Board was also successful in promoting voluntary industrial recalls of risky aerosol food propellants, trouble lights, Christmas tree decorations, and children's toothbrushes (40, 52-53).

In the late 1970's, the State Health Department's investigation of a child's near-choking episode resulted in a federal re-evaluation and upgrading of the national choking prevention regulations

for toy rattles (16 CRF 1510, Chapter C, Federal Hazards Substances Act Regulations), which led to significant reductions in choking deaths from toy rattles (62).



At a meeting with federal Consumer Product Safety Commission staff on one of these product related risks, New York State Health Department staff rode back to the Dulles International: After my meeting in Bethesda, MD with CPSC staff, I was rushing to get to National Airport and knocked on the window of a limo in front of the Westbard, CPSC building for a possible ride to the airport. The limo was for CPSC Commissioners, who told me to hop in. One was also was a Penn State University graduate, like me. I was invited to apply for a position on the National Advisory Committee for Product Safety and was appointed for a two-year term.

In 1976, the State's Public Health Law (10NYCRR- Part 72) was amended to create children's camp safety standards and a camp safety advisory council. The new standards were aggressively enforced by NY State Health Commissioner David Axelrod as a new safety systems initiative: from surveillance to life guard qualification, to public swimming pool diving areas and to overall camp safety designs. One impetus for the change was a health department aid's son who had 'accidentally' died at a camp. Dr. Axelrod had stated that no accidents were acceptable. (10 NYCRR- Part 72 Camp Safety)

Article 33, Public Health Law, in 1972, had been established to prevent diversion of licit drugs to the illicit market, to identify any such diversions, and ultimately to prevent harm to the public from inappropriate use or abuse. Under an amendment in 1978, all Schedule II drugs, those with the most severe sequela if abused, were required to be prescribed only on a State issued prescription purchased from the State by medical care providers to help fund the Triplicate Prescription Program. Dr. Axelrod amended the law's regulations in 1989 so that benzodiazepines were placed on the Program so making these drugs less available for school children and adult abuse,(as seen in the federal Drug Abuse Warning Network, hospital emergency room reporting system) and reducing excessive prescriptions for adults.

The Decade of 1980: Forging Modern Evidenced Based Prevention

Injury control pioneers such as Susan Baker, Johns Hopkins University and Julian Waller, U of California, and Leon Robertson at Yale, set the new paces from Haddon's work. It was my honor and pleasure to work with them, mostly as my part-time mentors. I was teaching at the first summer session on injury control sponsored by Johns Hopkins in 1980. Steve Teret, my host, and I had dinner with Sue Baker. I mentioned to Sue my personal concerns that it was taking me some eight drafts to get a final manuscript submitted to a journal. It was frustrating. What should I be doing better? Her wonderful caring response was: "It takes you only eight; I need some fifteen". Julian was quite active in the National Safety Council, Home Department, and we lunched together and much later in the 1980's at an Atlanta injury conference. His practical approach to injury control is well documented in his book, Injury Control and in his development of the first History of Injury Control seminar at APHA. Leon's major contribution, aside from his two books, was a continued thrust, ala Haddon, on what really works: he used many times his

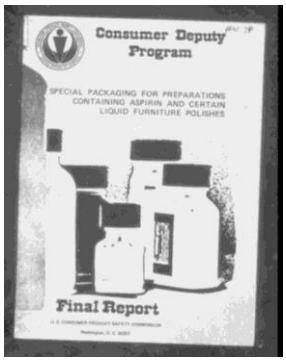
studies of the in effectiveness of driver education courses taught in schools as only producing younger drivers who would be injured or killed.

By the 1980's, staffs of the New York State Health Department with local health and consumer groups, assessed the community's child safety needs, investigated, analyzed and reported emerging injury or risks. To orchestrate conflicting safety views on consumer products risks and to obtain partners, I described new consumer injury complaints in the media. This strategy, in an open media forum, with governmental, consumer and industrial interactions led to combinations of industrial voluntary and governmental mandatory regulations, legislation and engineering controls -- unlike prior child safety work that focused, predominantly, on just more assessments and public -be-safe warnings. Standards and regulations were primarily targeted for the first time to high risk populations e.g. children using specific consumer products, instead of overlapping broad populations. For example, in 1981, following several published reports in the literature of episodes of mercury vapor exposures among infants receiving care in incubators having temperatures regulated by mercury switches or thermometers, the NYSDOH urged all hospital administrators to inspect and consider replacing these products with non- mercury (alcohol) sensors. The manufacturers and the University of Rochester Medical Center offered technical and program advice to the Department. (State of New York State Department of Health Memorandum, Health Facilities Series: H-31. Potential Risk from Neonatal Exposure of Mercury in Infant Incubators, 81-52, 6-18-81).

In 1982, NYS raised the drinking age to 21 years of age. This policy on substantial human factor risks of drinking to youth is associated with a 72 percent alcohol reduction in related motor vehicle deaths in NYS (NYSMVD) by 1994. By the year 2003, graduated driving licensure was law in NYS including zero tolerance for teen drinking and driving and.08 for adults. (see my related commentary in Times Union, Albany NY, 2000-2003).

The decade of the 1980's overall sporadic voluntary and mandatory regulatory approach was highly effective in reducing new risks and trauma in the marketplace to youth and young adults, but it did not offer an ongoing governmental, private and voluntary sector structure or program. Highlights of the 1980's follow:

Based on the toy and playground safety models, another federal Consumer Product Safety Commission contract supported the State and Monroe County Health Departments' Poison Prevention Projects, in collaboration with Regional Poison Control Center, University of Rochester Medical Center; Lifeline, The Health Association, Rochester; and the Department of Health Sciences, State University of New York College at Brockport. These projects funded, under grant support from the federal Consumer Product Safety Commission, the Rochester Area Blue Cross and Blue Shield and Health Research Inc. which served as the New York State Department of Health not for profit research arm, college graduate students interns from Brockport University to coordinate the field projects. In 1977-80 the projects used community outreach to parental and medical groups, school curriculum services, mass media and retail store inspections for aspirin, drain cleaner, and furniture polish, safety packaging.



The projects, using a fairly comprehensive model of public health practices for child safety, demonstrated significant quantifiable reductions in' unsafe behaviors, home and retail store risks, hospital emergency department visits, and admissions and increases in informational calls to the Regional Poison Control Center (58).I tooted our data driven and evaluated work to Washington DHHS,- MCH, federal CPSC and to Boston, MA where Dr Bernard Guyer, and more recently a newcomer to any injury prevention work, Sue Gallagher, were beginning to start up the Commonwealth of MA.,Child Injury Prevention Program in the basement, DOH building.

These successes of federally-funded state-local pilot demonstration projects led to the next generation of injury prevention programs.

I had to travel frequently to Rochester to manage these projects. On my return trips, my young wife, son daughter usually met me at the Albany airport. My wife had prompted my school age children to ask: "Daddy, do you have a family also in Rochester; do they have two children too?

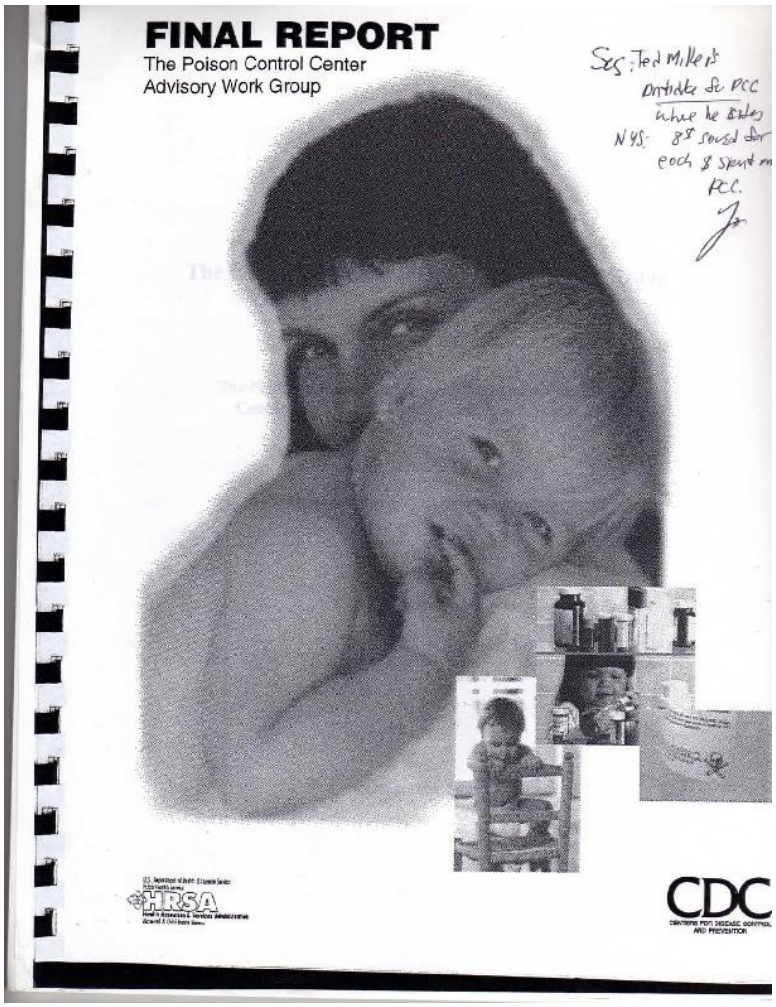
In 1982, Commissioner of Health, Dr. David Axelrod, submitted my plan to the Governor's Traffic Safety Committee (GTSC) to fund three child car safety restraint loaner programs targeted to low-income families served by local health and related groups. My assessment site visits to GTSC funded sites to learn about the preventive and protection systems useable in public health practices of staffing, procedures, equipment, had shown few loans to low income families - those most in need - at the GTSC sites. Initial meetings with GTSC could not find funds for new projects, but when key consumer activists (Mrs. Joan Edwards, President, Western New York Task Force on Mental Retardation, whose son is retarded) in child safety programs attended and advocated at a later discussion as historically proven, priorities may change. In 1980, Monroe, Onondaga County Health Departments and Western NY Task Force on Mental Retardation, under a GTSC grant to Health Research, Inc, each received $2800 of project funding from the State Health Department. By 1988, 45 county projects were economically ($2800 each) funded but also annually reporting effective public health practices and case studies of saved children's lives and injuries prevented (63-64).

Primarily under the State of New York Medical Society ongoing leadership of several decades of Dr. John States, Chairperson, Committee on Accident and Injury Prevention, the childhood auto restraint law was enacted in July, 1981. The 1981 law led to the first car occupant safety law in the nation (VTL 12229-C), 50 years after DeHaven's initially-conceptualized "crash packaging" (29).

New York State Health Department staff also assisted the federal Division of Maternal and Child Health in training and mentorship about New York State Department of Health's experiences on child safety. Boston, Chicago, Washington, and Atlanta seminars helped also to formulate and

subsequently obtain State funding and program needs from the federal Maternal and Child Health Special Projects of National Significance (SPRANS) for child safety. I spoke with the federal staff person and suggested it would be nice to fund some programs. Meetings with federal DHHS staff in Washington also led to the first SRANS funding applications on adolescent suicide prevention, approved but not funded, which two years earlier had not been considered a public health concern by the DHHS staffer. (65-66)

In 1986 New York State groups were built and united into political constituencies that, as classically illustrated, again helped formulate public health policy options, obtain political consensus and advocacy leading to new child safety prevention and protection programs. First, a Head Injury Interagency Workgroup established by Health Commissioner Axelrod from the State Department, interagency and consumer consultants published: Head Injuries in New York State – A Report to Governor Cuomo and the Legislature, May 1986. The report showed that children and young adults were the primary head injured and offered policy options in prevention and care. With the continued advocacy of the New York State Head Injury Association - whose President, Pamela Burns, herself with a head injured youngster, had initially fulminated the Governor and Commissioner's staff on why NYS had no head injury care programs - annual funding of several demonstration programs took place in head injury care and promoted the prevention. Second, in 1986, after many years of dialogue and advocacy for fiscal supports between the state health department and the directors of poison control centers, the Pittsburgh, Pennsylvania, poison control center, introduced a bill into the NYS Legislature which alleged that there had been no child poisoning deaths in the Pittsburgh catchments (there are few in any catchments in America!) and that its Mr. Yuk program should be funded to establish NYS poison control network. That bill was defeated. However, after three years of a NYS Assembly sponsor of a Center funding bill to aid NYS Centers directly from NYS coffers, one Center director asked at a hearing: "How do we get his bill passed?" He was told: "I'm the wrong party." The Center director angrily responded: "I fought in WWII, I didn't ask if I was fighting for democrats or republicans…"And after courageously giving the bill to the majority leadership, the sponsor's bill passed quickly and was quickly signed by the Governor into law. The law (Public Health Law, Chapter 70, 1986) focuses not primarily on injury prevention, but on the legislature's perceptions and focuses of medical and insurance cost containment. It provided some $3.0 million annually of Medicaid funds, set up regional poison control centers and regulations, and a formal advisory committee to the Commissioner of Health. The overall system uniquely funds public health preventive practice using insurance carrier reimbursements (as are statewide general hospitals) and requiring annual reports on benefits derived to the State Legislature (67-69). By the year 2000, the NYS demonstration projects and system had influenced Congress which appropriated federal funds to all national regional centers.



That law was a major outcome of a long process in New York State's (See, above, Part 1: Figure 2a-c or www.icehs.org Newsletter, Sept 2004 for my tabulation on selected poison prevention and control, burn and motor vehicle related injury prevention historical outcomes in NYS) timeline of poison prevention and control. *That gradient process actually began in June 1979, a federal DHHS conference, following passage of the Federal Emergency Medical Services Act for Poison Control (PL- 96-142) was held, June 11- 14, 1979, for poison control and interested State officials in Boston, MA at the Copley Hotel, Boston, MA. Dr. David Boyd, Director DHHS, EMS, was teaching what type model each poison control center might fit, an "X" or "Y," (basically centralized or decentralized system). The NYC representative said they were probably a "Z" model. Boyd mentioned that only X and Y would be federally funded. So the NYC rep said he was now a "Y." Boyd always said one had to have "Moxie" (determination, courage, expertise, know-how) to make a program dream, happen. Dr. Sylvia Micik, then Director, San Diego Regional Poison Control Center, who had prepared and presented with David Boyd, the national syllabus," Developing Regional Poison Control Centers", for the conference, just smiled! Out of those meetings, I and the reps from the NY Centers socialized evenings at the Copley Hotel and the NY Regional Poison Control Network, and subsequently its 1986 funding, were inspired and begun, with" Moxie", from the lessons of Boyd and Micik! (68)*

By 1993, federal Consumer Product Safety and Food and Drug regulations to limit the alcohol content of mouthwash and to require child resistant packaging for acetylnitrile (artificial fingernail glue removers), and limiting arsenic in latex paint, resulted, in part, from the collaboration and advocacy of regional poison control centers, the State Health and Law Departments, the American Association of Regional Poison Control Centers, local health and consumer group for new regulations on the sale of these and other toxic household substances.

Also, in 1986, the State Sanitary Code, progressively amended since 1935 to prevent disease from poor water quality, was changed (NYS 10 NYCRR - Subpart 6-1, 6-2) to require safer diving areas in public swimming pools.

From 1984-1988, the New York State Legislature and Executive Department established panels of coalitions of public and mental health, clergy, educators and others experts to prepare a statewide plan and program resource listing on how best to prevent adolescent suicides. Use of media, program and biochemical (serotonin) preventive controls were cited (69-70). Dr David Shaffer, Irving Phillips Professor of Child Psychiatry and the Director of the Division of Child and Adolescent Psychiatry, New York State Psychiatric Institute, NYC, has published sentinel, national, research-preventive studies on adolescent pre-suicide diagnosis of alcohol abuse, depression and aggressive behaviors (71). (More recent studies of media negative relationship to contagion of suicides : https://www.bmj.com/content/368/bmj.m575?utm_source=etoc&utm_medium=email&utm_campaign=tbmj&utm_content=weekly&utm_term=20200320)

The 1990's: Innovative Collaborations

The New York State long sporadic commitment to child safety with activities of advocacy, consumer safety and programming in December 1986 became a full structured Injury Control Program when State Health Commissioner, Dr. David Axelrod, after he established an intra-agency task force to review inter-departmental activity, resources and needs. The Program obtained major injury and disability prevention grants from the U.S. Department of Health and Human Services, Centers for Disease Prevention and Control, newly established National Center for Injury Prevention and Control, the third generation federal - state liaison since the 1950's Public Health Service's, Children's Bureau, the 1960's from the Division of Accident Prevention and, the 1970's federal Bureau of Community Environmental Management. The grants were then used to further institutionalize child and other safety public health practices through a State policy to supplement any local health unit's 50% State Aid Formula-Reimbursements for State approved written plans and reports on State mandated public health services, including injury control (72-76). Also, External Cause of Injury (E) coding was accomplished for hospital discharges, under Statewide Planning and Research Cooperative, (SPARCS), and the first statewide injury prevention conference, "Injury Control in New York State: Where Do We Stand', held following the formation of a steering group of New York State attendees to the first, Injury In America Conference sponsored by federal Center for Disease Control, Atlanta, Georgia, in 1987.

At that Atlanta conference, I spend some time walking over a bridge on a street near the conference hotel and discussing the future needs of injury control with a creative new young leader, Hank Weiss, from Wisconsin. He eventually formed a state program; however, our discussion was on universal (E-Code) hospital reporting, and the use of computer technology to

communicate on IC. I first had doubts on his optimism, but then saw myself some 20 years earlier. Who would have believed I had been involved in saving lives and limbs successfully?)

The bridges to transfer our knowledge and wisdom are critical in injury control, where relatively few professionals are members, and more so, to use our successes and failure and our creative dreams of the Hank Weiss's whose seminal injury control website has become the Guttenberg's press of today.

And, I must insert here an alleged vignette, related to E-Coding, from Israel from several years ago on E-Coding. I have not mentioned much about the need to collect and code data on what causes injuries. But, once there was a cleaning woman who used gasoline to make the toilet bowl shine and clean. Some of it was left when a man sat down with a lit cigar. He was seriously burnt in several areas. That is not the end of the story. The Magen David (Ambulance) arrived. The man was just too heavy and as the "EMT's" were transporting him, for some reason, his gurney broke and he fell down the steps. Now he had burns and fractures. As they took him to the hospital in the ambulance, the ambulance collided with a truck, injuring the driver and the occupant. Upon arrival in the hospital, the wrong medication was administered resulting in a toxic adverse affect… So, what was the cause of this injury? And of more import, hopefully this was not an emerging trend.)

It is too early for an adequate review of this decade; however, the limits of successes and failures will be the ability to translate the best leadership and managerial approaches that can synergized with individuals' groups' and organizations' creative values, innovations and collaborations.

Among the highlights in 1994, were passage of a bicycle helmet law for children with public educational programs and the establishment of a medical examiner workgroup to formulate standards, investigation data and early warning reporting from those Medical Examiners in local health departments funded under Public Health Law, Article 6, local health department reimbursement.

New York State practitioners have collaborated with many local, state and national groups including as an historian and participants with the National Committee for Injury Prevention, which New York State practitioners collaborated with national groups and published Injury Prevention: Meeting the Challenge, the decade's later follow-up to the 1961, Accident Prevention for Physicians and Public Health Workers (21, 77-79). *I and three other associates had conferred with our federal counter part that the recent publication of the red book,* ***Injury In America****, for the researcher, was not practitioner friendly and wouldn't a practitioner's" Blue Book" for us be just great. The later publication, with much input from associates and my suggested introductions of a chapter on History of the IC Movement and as a part of each subsequent chapter, has moved child safety from a semi-technical" be careful" and" feeling good giving out leaflets" to non-targeted groups, to public health practices in leadership, management and policy options development. Further, NYSDOH staff (me) served on the National Academy of Pediatrics and the American Public Health Association panel on developing child day care safety standards (80). And, following consultation after its first press release that it could prevent about 50 percent of all childhood "accidents" by public information, I became a first public health advisor to the National Safe Kids campaign (Washington DC) panels of industry, voluntarily and governmental groups, and as a presenter or resource expert to many other states and the federal government (81).*

Like the story of Joseph in the Book of Exodus, Pharaoh has a dream which he needed educational interpretation and then action; so, it was that I and others had become members of Safe Kids advisory group. Safe Kids with chapters nationwide is a pioneer in child injury prevention nationally and at the grass routes, led by Dr. Martin Eichelberger (who was distraught, as many of his physician predecessors, to continually treating injured children - instead of having 'docs' focus on preventing the fall from the cliff not just having the ambulance in the valley).

Child public health protection from violence, especially with firearms and controlled - prescription drug abuse, remain among newly developing teenage and young adult safety concerns and programs of the Winthrop University Hospital on Long Island and the Long Island Chapter, American Academy of Pediatrics, State University of New York at Stony Brook, Long Island; Harlem Hospital, New York City and the New York State Office of Alcohol and Substance Abuse Services (79) (82-84). In February 1993, the New York State Strategic Plan for the Prevention of Disabilities: 1991-92, New York State Department of Health, summarized the progress in the implementation of a 1991-1996 Strategic Plan, a framework for education and training for health and related groups and for statewide coalitions for local disability prevention programs (85) and in June 1993, NYS Division of Criminal Justice Services with the State Health Department, and the Division of State Police.

Part 4

Then and Now: More on the Past History, Overall Discussion and Recommendations and Perspectives for Present and Future Histories withAdvocacy on Prevention of Injury

Part 4 continues a memoir, and a descriptive, analytical and dynamical review of NYS peoples' and organizations' leadership values, and roles. Much of the NYS Department of Health's fine histories are not included; however, those can be web searched. This Part attempts to answer the thesis questions originally posed in Part 2 of this paper. This Part, later also focuses on mostly just my own printed written press commentaries – many others also had published their opinion pieces - on the epidemic of gun violence, in the Albany, (NY) Times Union, the NYS Capital's Press organ, and read by the NYS legislative, judicial, executive leaders, on the public health epidemic of gun violence. Complete archival references follow. (Citations of current references and resource updates are published in my Archivist 's Attic and other commentaries).

If rendezvous with the destiny of injury or gun violence research and prevention, we better not be late. (Based on 1940's quote by Rabbi Mordehei Kaplan).

In 1993 the New York State (NYS) Governor signed the Comprehensive Poisoning Prevention Program to limit lead content in consumer products.

In 1996, the NYS Departments of Education and of Social Services, and the Martin Luther King, Jr. Institute for Nonviolence and Commission, published its annual progress report on strategy for action against gun related violence, which several pilot projects were reported (86).

In 2000, two significant State laws were passed by the Legislature and signed by the Governor. The Flame Proof cigarette law and the Gun Safety Law: The former, supported by Assemblyman Grannis, over two decades had been opposed by the cigarette industry. However, when Governor Pataki first vetoed the bill and claimed it needed some amendments to assure that cigarettes could not be purchased without NYS taxes over the internet, his hometown fire department and many other fire officials rebelled". The Governor's father was a fireman; the story goes that how could the Governor not support such a life saving bill? And he signed it the second time around but delays took place in implementation.

Below are more details (8/25/03 e-mail) from the Trauma Foundation, San Francisco. Which director, Andy McGuire, over some twenty-five years pioneered for this national and New York State law and regulation. [212]11

Update on the Fire-Safe Cigarette– How New York State Legislation Will Lead to the Availability of Fire-Safe Cigarettes Across the Nation

"Cigarette-ignited fires are the leading cause of fire deaths in the United States. Approximately 1000 children, adults, and elders are killed annually due to cigarette-ignited fires and an additional 3,000 are burn injured.

Because the Consumer Product Safety Commission (CPSC) can regulate fabric and furniture standards, but not cigarettes, injury prevention advocates have been forced to take their demands for safety from cigarette-ignited fires to the state and federal legislatures. As reported on this web page before, the tobacco industry has long known how to create a cigarette that will not ignite bedding or furnishings, causing deadly fires. However, fearing the admission of culpability and litigation, the powerful tobacco industry and its lobbyists have been largely reluctant to produce such cigarettes and to let state and federal legislatures impose standards on their deadly but profitable products.

The tobacco industry, as indicated in some cigarette manufacturer documents, is keen to rearticulate the debate and focus not on the data that show the causes of fire death, but on redirecting attention for a demand that the CPSC better regulate furniture and fabrics. For example, in one of R.J. Reynold's (RJR) documents available for viewing at UCSF's Tobacco Documents Library, the company states one of its strategies in this way: ”continue to encourage regulatory attention to the smolder-resistance of upholstered furniture and mattresses” and RJR goes on to say that one of its chief strategic objectives is that there will be ”no fire-related federal, state or local regulatory authority over cigarettes or smokers involved in fires.”[Tobacco Documents Library document number: 522573948/3952]”

First New York, Then the Nation

The year 2000, though, saw two groundbreaking events: New York State passed the nation’s first law requiring the establishment of a fire safety standard for cigarettes sold in the state that was due to take effect July 1, 2003, and Philip Morris began the mass production of a cigarette (its Merit brand) that is significantly less likely than conventional cigarettes to ignite furniture or bedding.

In New York, the proposed safety standard recently underwent a period of comment from advocates and the tobacco industry. Advocates are now awaiting the New York Secretary of State’s promulgation of the standard, which, once promulgated, will take effect within 180 days. The Trauma Foundation believes as it has for the last 25 years, that once the tobacco industry is required to create a fire-safe cigarette to do business in a state such as New York, these fire-safe cigarettes will become available across the nation. In turn, this probably will result in a substantial drop in deaths from cigarette-ignited fires. And then, as sometimes happens, the interests of public health will triumph over corporate executives who knowingly engage in murder:

As to NYS’ gun safety bill, it was a controversial enactment. Opponents said the bill did little as it mandated child safety latches, research and testing of smart gun technology, limited guns already banned by federal law, raising the gun purchasing age to 21 years and required DNA testing of guns’ bullets, and banning selling of guns at gun shows without federal checks. The side benefits of the law is how it may influence the need for passage of omnibus gun safety law, probably under the Treasury Department, although some legislation would be under the federal Consumer Product safety Commission. The major cause of gun related deaths is suicides.[213]

Another example of NYS leadership: The New York State law is gaining national attention as a model for other states in regards to the importance of carbon monoxide detectors,:http://www.aboutcarbonmonoxide.com/standards/newyork.htm. Starting February 22nd, a New York State law that requires most homes in New York State to have a carbon

monoxide detector. The law is named after Amanda Hansen, 16, of West Seneca, New York, who died on January 17, 2009, reportedly due to a carbon monoxide leak from a defective boiler while she was sleeping at a friend's house.

Overview, discussion and recommendations follows; after which are examples of written press advocacy, in New York State's Capital of Albany, read by legislative staffs, industry and consumer advocates, on firearms injury prevention a resonating 21st century injury challenge. Here are found nascent leadership leveraging, partnerships, systems considerations- not just parts - imaging and knowing the" True North", lifelong learning, (ala Covey and Senge,[12] [13] the modern leadership gurus), and history to support resolution of current events and to challenges of revisions in the history of injury prevention- for all of us students of injury control:

Discussion and Recommendations

I had chosen the title and theme "health protection" with its dominant antiquity to 1830's paradigm that "diseases and injury may be prevented by enforced regulation of human behavior, mediated through its social structures"14. (That choice was more related to my last position, before retirement, Assistant Director, Research and Policy Development, New York State Health Department, Division of Public Health Protection). However, 'health protection' is only one of the many leadership streams in injury control (see Part 1 or www.icehs.org. Fisher L. Rivers and streams of injury control history. In: Injury Control and Emergency Health Services Electronic News Newsletter, 9:6, Oct. 23, 2002) and that heath protection thread interacts and serves as a legacy with other diverse leadership paradigms and archetypes.

The French historian Valery in History of Politics, once wrote that there are no lessons from history because times and technologies so greatly change; while I prefer to take warnings from those lessons. While primary sources were used for this paper; nevertheless, even professional publications were written by political survivors (non-published correspondences suggest a fluid, less structured events) and are somewhat biased to advance legitimacy of political agendas: In history, perceptions and beliefs are more important than the actual events. (For as Oscar Wilde declared more than a century ago:" The only duty we have to history is to rewrite it.")

Within such limits, let's proceed:

Three questions were posed at the beginning of Part 2, in this paper. (Did my brush stroke impressions on the values, events and personalities in child and home injury prevention in NYS, from circa 1800 - 1990's, actually provide any evidence for present and potential future histories

of injury prevention? *Or like in the 1940's RKO movie news clip at the Chicago Museum of Science and Technology, showing planes dropping DDT over Chicago in 1930 to control Polio, are my reported small outcomes and processes insignificant. Instead, have I, like the State of Georgia in 1970, tried to prevent drowning injury with its swimming safety informational programs at YM and YWCA, when the major drowning was in rivers and steams?)*

Here are my attempts at answering those three original questions from Part 2 of this commentary:

1. What concepts were envisioned and reported on "child safety"?

This annotated bibliography and review has confirmed the extensive national leadership in New York State in child safety (87). And, for the first time, offered extensive public health practices on assessment, policy development and assurances for child safety in New York State since 1937, when the country has shifted much from its major agricultural life to one moving toward a war footing.

Initially, applied preventive ASSESSMENTS were limited, in etiology of injury, only to surveillance of death certificates data. In 1940, Metropolitan Life successfully documented injury data from its nursing clients; by 1970 with Haddon's, Gibson's and De Haven's attack, the focus on" accident prone" children and families shifted to measurable environmental and agent determinants. In the late 1970's the State began to document clothing related burns and other household product injuries using fire department, newspaper clippings and consumer reports. These assessment tools combined with New York State's testimony from various market place studies of risks from toys and household chemicals, and the State Health Department in setting up of nationally population-based hospital reporting systems on consumer products, offered new empirical risk and morbidity data. Further, New York State marketplace surveys and on -site in-depth investigations moved forward national identification and control of childhood injuries.

POLICY DEVELOPMENT during the last seventy years, government, industry and not- for -profits had 'generally' reacted to" putting out fires" on arising public health injury epidemics and not attempted to assess various possible alternative policy options by weighed concrete standards of expected outputs nor outcomes. Consequently, a chosen option, perhaps not the best option, may have excluded decision parameters such as potential effectiveness - for example, not using history as a guide to improve child safety i.e. since 1947, the distribution activity of only safety leaflets (isolated, not part of a system, distribution without evaluation of impacts), efficiency (an over-productive effort to expected cost; re-creation of new and extensive surveillance studies instead of using existing data sources when resources are limited), and policy (not using best policy leveraging expertise nor enabling policy makers to support concept).

The primarily POLICY DEVELOPMENT emphasis from 1937 to recent decades was limited (and shown generally ineffective, by itself) to the classical "human factors" interventional leg of the prevention triad, of also engineering and legal preventive processes. A positive policy development for New York State, by 1940, was beginnings of alliances, partnerships, mentorship and dialogues among public health, medical, industrial groups. Then, with newer data from nursing visits and emergency departments, funding sources were brokered for resources which led, to the seminal professional literature on reduced child safety risks and injuries. Effective data assessments were applied and focused on empowering both state and federal health agencies and legislatures, industrial statesman and consumer groups toward child safety and public health

protection. The technical policy options, developed from the model by Dr. William Haddon, Jr. offered preventive measurers which included reducing the likelihood of energy transfer and the chance of injury when energy transfer does take place (12, 30, 31) - but generally excluded the political options of" how" to change societal norms.

Since the 1960's, effective MANAGEMENT (better measure is 'leadership') of child safety; applied by design or art, the competing values framework. In this framework, four contrasting perspectives on organizing leadership roles are defined: human relations, helping and mentorship involving interpersonal communications, team building, conflict management, focusing on systems not just parts.) open systems (innovating and brokering for power base, negotiating, presenting effective oral presentations on ideas); internal process (monitoring, planning, organizing. and controlling) and rational goal models (personal productivity and motivation, stress management, goal setting, taking initiative, and delegating effectively). The essence is to synergizes each contradictory frame together and not over or under exaggerate any one or more models (88). This dynamic framework requires a focus not on technical but on complex interpersonal and conceptual leadership skills and crafts. (Surely, I note in my assessment that there is my historiographer flaw of my using current historical 'prisms' to explain the past; however, the potential historical lessons seem of greater import than that analytical error.)

ASSURANCES have been more difficult to document, primarily because of the recent growth of child safety. However, through site visits to programs and from reviews of reports of activities, qualified technicians and managers moved child safety into the overall realm of public health administration with the real-world dynamics of diverse beliefs, values, motives, and interactions in internal and external bureaucratic and organizational cultures (75-76).

Another theoretical model for public health practice for child safety and health protection may be temporal, from the 1937 beginning of our substantial NYS review to present or from individual decades. In this scheme, plotted on a normal growth curve, public health practices can be tracked. The growth curve for child safety effectively starts with an innovative leader with an idea for change. He or someone else may follow by ASSESSING child safety more rationally, developing POLICY OPTIONS, and building program supports. Then he or someone MANAGES or administers. At first, only coordination may take place. In later periods a mix of competing managerial styles must be effectively used or abused. The decay phase in leadership roles may result from no follow-through after assessments and investigations (Godfrey, Brightman) or after advocacy (Wheatley, Westaby) or, up until Haddon, no assurances to see what makes a difference. (ICEHS Section Newsletter Sept 2003 archivist attic, 'sine curves')

Graphic profiles of the historical performance of each public health function of public health practice can be further explored. But, more difficult to graph are over- aggressiveness or excessive administrative or bureaucratic weaknesses of working harder but not smarter or competitively over- excluding peer inputs, discarding history, over-evaluation without any application, or maintaining secrecy (89). One of the major needs is to understand that there are insecure, easily staff intimidated managers who will make any underling look bad; as many mentors advise: avoid these jobs and check out career management resources, especially articles in the WSJ. The underling will tend to always look bad with bad bosses; but, the underling should first make the boss look good! [214]And even larger political overlays, as Haddon might say, its all on the leveraging or controlling the (managerial/ leadership) energy: Within the assurance phase, ineffective leadership practices, that can destroy people and programs, may include abrasive coordinators with excessive data or production monitoring and self-serving

roles, (depots, castrators, weasels) drowning workaholics (mill toasts) over kindness (over nurturers). See Part 2: Endnote: 89).

My close friend, a veteran state manager, Larry, shared with me his quips on leadership leveraging, feedback and transferring negative roles into the positives. He usually arrived late morning and worked to about 8pm. He would resolve consumer complaints for his agency by phone calls to homes those evenings and the consumer was usually impressed to hear a state worker, working then; it was great PR, too. And if an associate was acting too negative: his memo to the colleague, nicely outlining the problem was cc: to the agency commissioner- but the cc was never sent!

Perhaps dysfunctional leaderships relate to parents making kids feel guilty? In any event, weakly integrated managerial roles except for just continually producing, marketing, creating, documenting, nurturing rigid domains during program growth to decay, may destroy programs or people. (See Part 2-4: Reference 88). Nevertheless, the proper use of fear and embarrassment toward those who do not support" public health" practices, historically as cited above, has been a most positive attribute in passing new laws and in reducing safety risks in the marketplace. As with Haddon's preventive strategies, it may be just, how and where the preventive energy is directed or controlled.

This history of prevention leadership skills might be fully taught at Schools of Medicine and Public Health. (See Part 6- Below). In contrast to New York State theories or practices in child safety, few other states have maintained <u>any</u> concern or activities during the four national recreations of the child safety (87).

A deputy commissioner called me into his office. My program proposal was on his desk as he, in fun, pushed a lever on his 2 x2 box. Out came a white ball. "Guess your plan works. We decide things up here, with our box!"

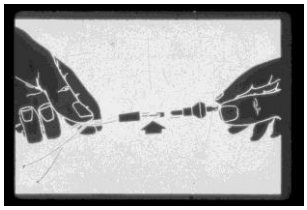
And New York State's theories and actions ranged from Godfrey's vision and advocacy at national workshops in the 1930's about the "spot mapping of injuries, like we do with disease" to Brightman's decade of an organizational structure for" accident prevention" education by the health department. Armstrong's and Wheatley's formulation and coordination in the 1950's coalitions of pediatricians to empower protection of children from dangers, to Gibson's and Haddon's innovation and integration of analytical frameworks from the disciplines of engineering and medicine; to Moynihan's empowering; to State Health Commissioner David Axelrod's sentinel advocacy and enabling of public mandates for prescription drugs, day camp, poison prevention, and child restraint and other child safety, public health protection programs. John States' continuous directorship from the NYS Medical Society, Accident Prevention Committee, and Howard Mofenson's and Joe Greensher's New York State leadership at the American Academy of Pediatrics illustrated personal commitment, many times quietly, for child safety. These leaders held visions. They wanted not to take from society but to give back. They were usually able, sometimes with personal abuse by peers, to move their agenda forward for effective public health practices for safety and health protection of children.

2. To what degree did the developed child safety preventive practices or strategies succeed orfail and why?

Other writers have reported from the work of New York State and other national leaders in child safety, a wide range of current successful public health practices, and barriers for child safety (74-78, 87). [15]

This next segment supplements those reports by using the proceeding historical review and assessment of long-range trends:

While many theories were derived, several landmarks for public health concepts in child safety took place in New York State from earlier work. New York State and national assessments, many times of just isolated early warning newspaper accounts or reports, led to federal and state epidemiological studies and, usually with industrial statesmanship, to flammability standards for children's nightwear, tents and mattresses; safety glass in doors; banning of cigarette advertisements of flammable tile paste, small parts in toys, fire risks in trailers; and to recalls, regulations or bans of mini Christmas tree lights, refuse bins, mouthwash, and artificial finger—nail removers— highly cost saving interventions.



New York State leadership in public health practice for child safety have reduced severe risk, trauma and costs (never fully reduced from national background effects) of childhood poisoning, drug abuse from controlled substances, burns associated with tents, mattresses and child clothing; adolescent suicides, falls from windows, and involvement as passengers of motor vehicles. Further, specific product safety concerns of broken mercury thermometers in hospital incubators of infant intensive care units, toys with choking risks and other home consumer products were also documented. The proof of a causal relationship between safety outcomes and a related regulation, engineering design or professional educational program, may be too difficult to show except anecdotally, under limited resources that better could be dedicated to Increasing proven effective coalitions to link private and public child safety alliances and leadership across groups and organizations which choose to use prevention, protection and safety strategies shown effective elsewhere (76, 77, 78, 80).

In reality, completed national public health protection really has not, yet, taken place for child safety. The limiting factor may have included a limited dedicated nationwide policy toward children, generally, and child safety particularly, as roughly $100 million expended yearly by federal government alone for the safety of children, and yet the total related costs of injury to children and young adults, exceeded some $700 billion! (90). [16]Health care financing focus on

managed care must better highlight need for population — based wellness prevention and control for child safety.

And in "down sizing" environments those cited proven effective and most efficient safety approaches should not be eliminated with the “bath water.”

Today, public health and allied practitioners in all disciplines and sectors should be trained, especially within Schools of Public Health, Child and Young Adult Safety Research and Leadership Institutes (to be created) for assessing, dialoging and using historical and newer integrated technical, interpersonal, managerial, conceptual leadership proficiencies and alternatives, from our rich archives, to help mold political—acceptable public health policies (87-91). See Part 6, below, nascent School of Public Health, Syllabus).

Furthermore, perhaps, newer teenage and young adult drugs use or violence will be, in part, limited by looking at the past successes, for examples: limiting violence from firearms related to childhood abuse of prescription drugs or illicit street drugs, poverty, obesity, recreational playgrounds, etc.[17]

APHA. ICEHS Newsletter July 2006. ARCHIVIST'S ATTIC: "DO NOT TAKE DRUGS”. Page 8ff

Samuel ben Meir (1085-1158) commentary on the Talmud tractate Pesahim, page 113a Drug abuse, violence, homicides, and suicides: Many surveys on drugs and violence (e.g. Simon-Wastila L, and Strickler G. Amer J Pub Health. 2004;94:266-268) show relationships to risks of drug abuse and injury from drugs. Homicides are primarily drug trafficking and weapon related (Fisher L. Editorial: Dissent - traditional public health injury control does not apply to violence. Injury Prevention 1999;5: 13-14.). Thirty one percent of police chiefs believed reducing drug abuse would have its greatest impact on reducing violent crime (Center for Drug Abuse Research, University of Maryland, College Park, MD. April 10, 1995). In the November 2005 ICEHS Newsletter, I mentioned the FDA's Oct 2006 warnings on antidepressants associated with childhood suicides and cited an historical review on bio amine serotonin controversial relationships to violence. While much of the other related literature cites alcohol and injury, the injury control professional can help with any newest national drugs and injury studies; including the latest Meth Amphetamines. Some earlier archives: About ten years ago, I prepared a white paper, TEENAGE AND YOUNG ADULT DRUG ABUSE VIOLENCE & INJURY: AN APPLIED DEVELOPING FRAMEWORK FOR PUBLIC HEALTH PREVENTIVE PRACTICE FOR STATES, on the relationships of controlled substances, licit and illicit, prescription drugs (benzodiazepines, opiates, barbiturates, etc.) to injury. While alcohol is well established on injury relationships, prescription and illicit drugs are not. Below, for space savings is my archival abstract (the full unpublished paper in 1995 is limitedly available) followed by a few older findings, for skimming interest. "Nationwide homicides for age 14-24 males are a leading cause of death and prominent disability. And yet, little research or forums prior to a

decade ago took place on the relationships and causes of juvenile and young adult violence and injury to abuse of prescription and illegal drugs. My original review and "white paper" on public health practices promotes such attention and action. Sources, types and limits of data; etiologic relationships and recommendations follow for an integrated public and private preventive response from the current concepts, while a separate review of historical work by scientists and practitioners assesses earlier promising approaches." General : (Remarks, David Sachter, Director CDCP, Atlanta, Georgia, "Protecting our Youth: Preventing Deadly Choices and Exposures National Press Club Washington, D.C., May 16, 1994, 5): "The use of alcohol and drugs is associated with the leading causes of death and injury (motor vehicle crashes, homicides, and suicides) among teenagers and young adults." (Reiss A. and Roth J. Understanding and Preventing Violence, National Research Council,1993): The connections between violence alcohol and other psychoactive drugs -primarily opiates, cocaine, amphetamines, PCP, and hallucinogens- have rarely received much weight in developing national policy. Even today violence remains a secondary condition in formulating drug policy despite anecdotal and research support for some connections between illegal drugs and violence and despite reports of dramatic increases in drug-related deaths. (Arubler R, 1987; NIDA,Monograph #103: Drugs and Violence,1990; Injury Prevention Meeting the Challenge, 1989; Bench T, 1990; Christoffel, KK, 1990; Sullivan L, 1991; Brownstein HH and Goldstein PJ, 1990; McGinnis, JM, 1993): Nationwide about 20,000 (20%) total deaths were caused in 1990 from illicit drug use.

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Understanding Violence, op cite: The link of psychoactive drugs and violence is not straight forward causation, but rather a network (Kirby JM,1992; McKinnis): About 10-20% highway crashes associated with illicit drugs; Weiss RD, Mirin S, Bartle RL, Cocaine, American Psychiatric Press, 1994. Martzuk found 18% of motor vehicle fatalities in NYC had cocaine in their bodies at autopsy; both cocaine and alcohol were found in 10% of these cases, meaning 8% had used cocaine alone. (Weiss RD, Cocaine: Some cocaine and (other drug users) become suicidal because of neurochemical depression caused by the drug and because of the hopelessness that they may experience after repeated unsuccessful attempts to stop their drug use.) (Fisher L. The Governor of New York State's Final Report from the Youth Suicide Prevention Council: Some Frontiers for Public Health Considerations of Etiological Research and Prevention of Intentional Injuries, APHA Annual Meetings, New Orleans, LA., Oct 21, 1987): serotonin screening research.

Child Abuse: (Reider, EE, 1989; Leonard KE, 1990; Gabel S. 1993): Children in parental incarceration group were significantly more likely to experience parental substance abuse than those whose parents had not been incarcerated.

Domestic Violence: (Kantor, GK, 1989: Most important variable in wife abuse are husband's drug use; A Gorney B, 1989; Roberts 1988; Blane HT,1988) Wife or girlfriend may seek excessive prescription drugs.

Other injuries: Falls, hanging, burns, asphyxiation, etc. (Gold,1991)

Arson: (Virkkunen, M, 1989: Lower mean bioamines in violent offenders and impulsive fire setters who had history of suicide attempt (Linnoila,M, 1992)

Violent Deaths in General: Cocaine Use, Risk Taking and Fatal Roulette, (JAMA, May 20, 1992,2635- 2637): With the exception of alcohol, no other drug of abuse is so closely linked to violent premature death. (Tardiff K, Gross E, et al. Analysis of Cocaine-Positive Fatalities, J Forensic Sc, Jar. 989,.53-63: In addition to cocaine, heroin, and other opiates in 39% of persons and ethanol in 33% and barbiturates and minor tranquilizers in only 2% of the deceased. (Weiss RD, Cocaine:) "High rate of death by homicide among young African Americans and Latinos may be due to increased involvement with both cocaine use and firearms": Tardiff K, Marzuk PM, Andrews L, Hirsh CS, Homicides in New York City, JAMA, July 6,1994, 43-46. Cocaine users also take cocaine with valium and other controlled prescription drugs. Depressants/Sedatives/Hypnotics: Barbituates, Benzodiazepines (hostility/ attacks/violence direct or from withdrawal; mix of non-intentional injury) (Vuror and Klaukka, Benzodiaepines and Violent Death, Lancet, March 14, 1992, 676): an unambiguous assessment of benzodiazepine violence controlling efficacy as well as their so-called paradoxical aggression - enhancing (with certain epileptics and panic disorder patients) effects is urgently needed. Pharmacological probes of the GABA A Benzodiazepine receptor complex should be investigated for its utility as a diagnostic tool in those with a propensity for violent outbreaks; (Understanding and Preventing Violence, 1994, page 278).

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Narcotics/Analgesics/Opioids: Codeine, Oxycodone, Propoxypyhene-violence/hostility/robberies (Hammersley R, 1989), heightened aggression in animals from withdrawal (Reiss AJ, 1993); Marijuana and opiates temporarily inhibit violent behavior, but withdrawal from opiate addiction tends to exaggerate both aggressive and defensive responses to provocations (Roth, 1994).

Anabolic Steroids - attacks (DuRant RH, Multiple Drug Use Among Adolescents Who Use Anabolic Steroids, NEJM, April 1, 1993; Yesalis CE, Anabolic-Androgenic Steroids Use In US, JAMA, Sept 8, 1993) Committing of violent crime including murder: (Pope HG, Katz DL, J Clin Psych, Jan 1990, 28-31; Bioscience 43:202): Studies of testosterone and violence have just begun and face difficult methodological problems. In general, most investigators conclude that there can be an influence of androgen on violence, but it is only one component accounting for a small variance against environmental and hormone influences: Understanding and Preventing Violence, 1994, 7)

Among the successful injury control projects involving drugs has been: Harlem Injury Prevention Project - pushed drug dealers out of playground areas by continually reporting to

NYC Tactical Narcotics Control Group; taking press pictures, etc.
~ opinions are mine alone ~ Les Fisher

The leadership models and archetypes, above, can assist the transfer of previously successful public health practices in injury prevention and control to current needs for public health practices. A brief menu follows on teenage and young adult drug abuse, violence, and injury:

In NYS, homicides for age 14—24 males are the leading cause of death and a prominent cause of disability. NYS juvenile violent crime arrests, many drugs related, 52 per 100,000 for 1985-91, led the nations. These probably are related to crack cocaine trafficking, but this remains to be fully researched. What is known is that the crosscutting patterns of the adolescent and young adult drug abuse, violence, and injury epidemic can, as earlier child safety epidemics, be assessed, managed, and evaluated with public health practices:

From my (written in 1990's) perspective, some of these are in process, today: e.g. the national violence reporting system) ADOLESCENT AND YOUNG ADULT, VIOLENCE AND INJURY ASSESSMENT should involve the state or federal government to integrate existing single purpose data systems (Drug Abuse Warning Network, National Electronic Injury Surveillance System, Medical Examiner's Coroner's Alert Program, SPARCS, Poison Control Centers (TESS) etc.) by electronic mail to one or more clearinghouses that can be taped for specific and overall data. That has started nationwide. While the complex association of child use of drugs to violence and injury is somewhat speculative, (see also: Fisher L. Traditional public health injury control does not apply to violence. *Injury Prevention.* 1999:5:13-14.): Drug use and weapons are strongly associated in other studies, although these are self-reported. [18]

We lose too much causation, violence, drug data without linkages from statewide medical examiners, poison control centers, hospitals, police and even newspaper accounts of violence and injury. My review shows that a crude early warning alert system may be as a simple a procedure as calling the governmental" telephone hot line" when a new imminent injury clustering of diverted drug related deaths or a newly noticed serious drug abuse, violence and injury trend takes place. Effective electronic surveillance models, adaptable for a NYS mini—stratified electronic data transfer system to federal, state, and local health units are on the drawing boards. Selected early alerts (and annual tabulations of State) priority focus data would be followed-up with hours in-depth epidemiological investigations of host, agent and environmental aggregate determinants, like the Cornell Aeronautical Labs historical work or The National Traffic Safety Board current procedures - for immediate local—state federal- industry actions for bans, recalls, alerts, warnings, or studies- all as part of policy development for controlling unintentional, intentional or terrorist injury. Certainly, a considerable cost; but perhaps exceeded by the political value of innovative federal, state, and local agencies cost sharing- as done initially and ongoing by NHTSA and CDC.

POLICY DEVELOPMENT on alternative options and expected standards for outcome, can begin even without the "never" complete data. Options can include: (1) Link intra and extra-agency teams to review current causes and preventive options — their weaknesses and strengths - from existing publications and kits of the American Academy of Pediatrics, handgun control groups, and federal agencies from CDC, DHHS—MCH, National Clearinghouse for Alcohol and Drug Abuse, the Children's Network, FBI, and Justice Department. These reviews must include the need for clinical and preventive research systems efforts to identify the highest risks (for nutrition, obesity or disease entities that possibly relate to violence -attention deficit disorder, Huntington's Chorea, low levels of the bio amines such as serotonin and other neurological transmitters or psyhio1ogies). Interventions should link to both the (energy gone wrong) agent tied to human factors, and societal values, as feasible.

All must emphasize open communications, shared values and continued education of the organization systems and exclude JUST the policy option of public information and training resources. That limited option of just information, as in earlier child safety decades, may in fact, adversely backfire or not even effect any changes, as seen in the DARE Program[19]. Secondly, maintain professional education and policy statements in professional journals e.g. on reducing drug demands, for selected drug therapy for adolescents with risk of overdoses, to promote new linkages with other groups and to support mandated protection options (using Haddon's strategies of prevention) for new crime (and terror) prevention regulations of bullets or guns including child resistant triggers, the monitoring of young adult drug diversion in prescribing or purchase of controlled drugs with an early warning surveillance on these and other newer emerging child safety and public health protection needs. Thirdly, environmental changes in the lighting of "drug—demanding" public areas seem essential.

Fourth, as in other public health practices, violence prevention programs must be linked to current broader mandates. We might investigate with state regulated controlled substance laws, deaths and abuse suspected to be related to terror or child violence; test out national demonstration projects on AAP anticipatory guidance counseling to reduce violence in state funded programs for children to link substance abuse and other related maternal health community programs.

MANAGEMENT - LEADERSHIP of any national, state, or local policy options for changes inprofessional knowledge, behavior, or reductions in risks, injuries, deaths, etc (76) - especially based on US Public Health Service's **Healthy People**, drug, violent and terror prevention and control - will require leaders well educated not in just administration but in technical, leadership—management practices (88-89). Leaders must be capable of not only technical decisions but interpersonal skills e.g. to negotiate from strengths, as for the 1970's InformationCouncil on Fabric Flammability and by the 1950's American Academy of Pediatrics under Wheatley, by coalitions even with opponents.

EVALUATION is critical; we must learn what works. Process should lead toward outcomes or promising efforts - Haddon would say, today, as well.[20]

On the other hand, a real criterion for effective public health practice in successful development and implementation of child safety programming is not the many cited (in this essay) theories, public health practices, project grants, subcontracts, nor laws enacted. Instead, it is essentially long-range integration of the child safety public health protection process through federal, state, and local public health legislative, programming and funding main streams for the overall well-being of children, regardless of budget cuttings, regulatory reform or "down sizing". Can political changes still support safety?

Thus, "what lessons have we learned to fiscally institutionalize primary prevention for" child safety, especially during down sizing. Certainly, for almost a century, political different criteria for good government have either maintained or lessened child safety - but which mixes of those have had the most efficacy? [215] [216]

Four promising state / national institutionalization processes, all adopted in New York and possibly other states, were briefly described in the text. What follows are additional details on their potential public health practices for uniquely institutionalizing primary injury prevention, injury research, education, and advocacy with practices of epidemiology, emergency care, biomechanics, and rehabilitation services.

3. What lessons have we learned to institutionalize child safety?

French historian, Paul Valery in his History of Politics said the only lesson derived from history is that there are no lessons because changes are constant. Conversely, while human nature may be the constant, we should not err to see how others handled the values and practices of their day and perhaps overcame their problems. And those problems usually involve values on funding support and continuity of funding.

While government alone is not the only 'actor' in child safety; it does guard the 'body politic' for public health protection / child safety, must be in partnership with private and voluntary groups and organizations. What follows, (based on my 1997 MS), are some of my funding options from historical child safety models with a focus on need for newer innovative collaborations and, at least, alliances:

National Highway Safety Act

Among the most successful institutionalization of safety in New York State has been the establishment, as directed by the federal Highway Safety Act, (PL 89—564) of a NYS Governor's Committee on Highway Safety, which links the infrastructure of federal, state, and local community resources for motor vehicle injury prevention. The approach may serve as one institutionalization process, especially when linked to the NYS Municipal Health Plan and national model standards processes to assure continued policy—support of non-vehicular child safety in agencies once federal grants end.

Another option could be modeled after the current Center for Disease Control and Prevention, and the National Highway Traffic Safety Administration co-funded traffic safety programs in state and local health departments. That "codependency" with shared public recognition for both, joint funding public health practices of assessments, policy developments and assurances in

traffic safety; offers another promising efficient partnership for funding public health practices in the 21st century by leveraging with the federal Consumer Product Safety Commission, the Substance Abuse and Mental Health Environmental Health, National Institutes of Health ,US Justice Department (Byrne Funds) and the Food and Drug Administration, foundations, and resources from private associations.

Special Revenue Funds

Another corollary creative approach for funding child safety programs, probably in combination with other mandated options may include special revenue funding from taxes on toxic substances home equipment, alcoholic beverages, cigarettes, charges for prescription drug scripts or other consumer products involved in child safety and protection. In today's counter, regulatory environment, tax deduction incentives or privatization of child safety (for retrofitting or building community playgrounds or other safety initiatives) seem promising with government-industry partnerships for responsive and responsible leadership.

The Promise of Health Insurance Funding Linkages

Another legislative funding model with any new national Health Reform legislation and regulations, may be the Regional Poison Control Network Act model in New York State which funds preventive and protection programs in public health practices, and could fund other preventive services, using reimbursements from Medicaid and other health insurance carriers. The national and state agenda on new ways to provide health care insurance should include, in ongoing deliberations, reimbursement for States' child safety programs and payment for the selection, use, maintenance, storage, disposal of child and family safety products (carbon monoxide and smoke detectors, window guards, child gates for stairways, ground fault interrupters, safety latches for cabinets, etc.) that reduce hospital treatment costs and morbidity. The obesity prevention 2010 federal health reform proposed funding is a start. Federal funding for poison control systems, are now managed by Federal HRSA. 21

The New York State Legislation had developed neither its Assembly leadership support for poison prevention center program funding not out of a value nor concern for prevention or control of injury, but for cost containment. When a parent first calls a poison control center, instead of rushing to the Emergency Department, hundreds of dollars are saved in unnecessary medical care. Lesson here for any bill; focus on broader issues not just the injury prevented.

The bill became law very quickly when then the key Republican sponsor, Assemblyman Hoblock, with leadership and statesmanship, turned over the bill to the Democratic majority. By the year 2005, only two of the combined eight regional centers remain.

(Federal and state designated program funds, for regional poison prevention centers and for setting up CeaseFire programs have innovatively- for some moderate period of time permitted IVP evidence-based interventions, when few funds exist for new IVP initiatives.)

Federal Maternal and Child Health and Preventive Block Grants

For more than 35 years the federal Maternal and Child Health Block grant (previously Title V, Social Security Act) have funded full-time State professionals in New York State and other states. My own prior State position, safety consultant, under Title V funds lasted through “ups and downs” of economics and policies - over some 40 institutionalized years.

Formal federal affirmative requirements that State Block or health care reform grants, as negotiated by interested States, can institutionalize public health practices for child safety. Public health core funding in health care reform may result instead in only funding of all direct health care dollars and no “earmarking” nor guaranteed appropriations for public health practices for heath targeted groups. However, the only long-range essential policy ingredient for reducing IVP is persistent will power health. Logically, IV and disease prevention is the upstream protector of health care costs Evidence-based prevention is an essential partner in a comprehensive ‘managed care’ political package.

More about Leveraging with Private Foundation Funds and Industrial Leadership

Federal funds to study and reduce firearm related injuries have diminished by Congress at the lead of the NRA. More and more private dollars continue to support those areas of controversy and debate (e.g. Cease Fire, Robert Woods Johnson). Reform, as it did for kids as coal miners, and kids employed in firetrap sweatshops, will come, as much as that of the institution of slavery did, when public outcry succeeds. But that reform historically starts with advocacy, outrage, and lobbying. The outcome may not happen in a decade. Sometimes the best leverage is for an industry to accept its responsibility years later, like lead battery contaminated sites to fire safe cigarettes.

KEEP DREAMING: THE DREAM ON NEW LEADERSHIP IN INJURY CONTROL: INTEGRATING MORE RECENT APPROACHES (First published as part of ICEHS Newsletter March 2006)

Sometimes new ideas and revelations of unifying principles take place in dreams. The German chemist, Frederick Kekule spent years trying to understand how benzene, the parent substance of a host of useful chemical compounds, was structured. One night in Ghent, where he was teaching, he dreamt of a benzene molecule as a snake biting its tail while in a whirling position. He quickly made notes of his dream and realized that Benzene was structured as a ring of six carbons. And with that knowledge, new product developments could begin (13).

It's 4am and I, too, am now awake after a strange dream, perhaps an oracle:), on the history of the progress of injury control with still another leadership skill model. The "vision, I just wrote down, integrated a growth curve, like one plotted out in any biology or medical school class, with the concept of public health practice and skills in leadership, not to be confused with management. The curve is in harmony with life's ebbs and tides but plots many "watersheds " from principles of leadership, management and policy practices of injury control and public health, by integrating an overall system's image, as Haddon combined and adapted for injury control from medicine and engineering, broader managerial and leadership theories. I had a

vision last night of a "growth/ decay/ regrowth curve" on injury control historical leadership progress, successes, and failures (14).

The" model" curve would plot against various public health practices, (e.g. assessing, policy developments, managing, assuring (15) and leadership skills/roles (e.g. directing/producing, monitoring/coordinating, innovating/brokering, facilitating/mentoring) (16). I dreamt that I might help guide future generations of IC practitioners, researchers, and educators, even legislators, on the never-ending journey to find a magic
bullet on leadership to save lives and limb from injury.

While I am a bit more awake now, let me attempt reconstruct the points on that " normal growth curve "and offer several of many examples from my various manuscripts: In each "generation of IC efforts" there are some common IP process/management phases of circular and repeating managerial / leadership processes. One paradigm is a sine (growth) curve that "begins" at the base of the growth curve with An ASSESSMENT PRACTICE PHASE.

Here, some critical or emotive thinker, "ahead of his/her time" scientist and artist, combined - ala Haddon in America or, a Chadwick in England, reports that something is drastically wrong with society's way of looking or doing business on Injury. But that actor may not have the next curve point skills, the CREATIVE THINKING/INNOVATIVE POINT on the curve to translate, advocate or broker the idea into something called a better condition In child injury prevention, the documented success of the pediatrician practitioner (17), who is not just a researcher, is well recognized in the professional literature in both the critical ASSESSMENT, POLICY OPTIONS and other PREVENTIVE PRACTICES PHASES, below. But it is common, that the original idea is rejected or lost for months, or years until the same or another leader (with BROKERING PHASE SKILLS) translates the perception of need into broader societal options. S(he) does this by translating injury data into broader issues (by inclusion of effects on more jobs for the economy or cost containment for insurance or society, not just "cold injury data quotes", the bricks of a house but not its essence as a house.) and may offer diverse preventive options The uphill on the curve MONITOR/ COORDINATOR phase for the original idea, in successful outcomes, then requires critical thinking (not just the previous creative thinking) for presenting information, some muckraking writing for public embarrassment of adversaries on their data (e.g., by newspapers stories, by leverage with consumer groups or , by coverage of public hearings, by companies in the same product line who disagree and liberally break forward for changes). We see this happening in the USA where sports groups seem to be more liberal for gun safety than the main line NRA.

More public embarrassment takes place on the past failures, reform on issues becomes a public concern. Successful scenarios may include human relations of FACILITATING/MENTORING AND BROKERING with negotiating, compromising, and building and maintaining power bases,with opponents; not just arguing with them! When this fails and no voluntary actions take place,regulatory negotiation phase may begin, under suitable political conditions, on litigation, regulation, legislation. (Today, government staffs may be restricted more so from that role. But, usually, after the proceeding phases, the IC community unfortunately first gets involved?)

If you are still with me, on our growth curve of new PROTECTIVE CHANGE, we have reached the peak of achievement for needed change x, as a regulation or law or standard. This change is activated after lobbying, and negotiation. To me, this is true 3E, EDUCATION: promotion of a new effective law based on engineering design or performance.

Action starts a DIRECTORSHIP/PRODUCER phase of taking initiative, goals setting, delegating, based on skills, background, experiences, training, resources, politics, and personalities not just science. The condition of injury is MANAGED and hopefully ASSESSED again. If an action is believed by the authority or the oversight group to be effective by its '"value judgments" then the action may continue or it may die from bureaucratic neglect; but usually it dies indirectly from lack of funding to carry out the mandate of the agency.

AND NOW THE DOWNSIDE OF THE CURVE may follow at this point as new ideas brings different reforms, repeals, or inactivation. The fluid cycle of growth, and decay continues with repeating phases and processes. (e.g., the repeal in the USA of the children's flame retardant sleep wear fabric standard)

While rather than a growth-decay curve, repeated every two decades, the curve should be not cyclic (as the Greeks would view life) but opportunist to learn and build upon our IC History personalities, events, and values. This curve would maximize all phases on the growth curve and enable those skilled leaders, to use all leadership skills, not under-using any one phase. With change there is just the addition of three letters to get to a "challenge" - and real leadership opportunity!

WAS I JUST HAVING A WISH DREAM AFTER THAT BIG PIZZA I HAD LAST NIGHT? (the dream is fictional, BUT THE HOPE IS NOT)

DREAMS REQUIRE ACTION

I invite our readers to work with their history of IC to help guide current efforts. Associates may also wish to view and use the experiences of the History of IC in America video tapes that I helped establish for the American Public Health Association, Injury Prevention and Emergency Health Services Section. Carol Runyan of the University of North Carolina Injury Center and I worked together to produce these tapes for in-service training or review. Of more importance, other uniting theories on injury control leadership practices will always need closure; these must be proposed, tested, and carried out from our history and current work: I propose we need a History of IC Leadership Institute in some SPH. We have relatively few members in our disciplines of IC; assessing and modeling with our history for current needs should be most effective, efficient, and productive- hope to see the RFP!

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Opinions are the author's only and not APHA nor ICEHS Section.

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Below are my written press opinions (see also www.timeunion.org archives: Les Fisher), read by NYS governmental leaders in the New York State Capitol, Albany *Times Union*, which for the students of injury and violence control may guide their own advocacy practicum.

:

Kudos to writer for ski, snowboard story

Times Union, Albany, New York: Editorial page March 3, 2000

Congratulations to Al Wechsler, Times Union staff writer, for his fine coverage in "Injuries outpacing growth in sport" (Feb 28, Page 1).

He illustrated a common thread in the effective historical leadership for the prevention and control of injuries that rank as one of the nation's and the state's most pressing health problems.

Mr. Wechsler described how physicians in local hospital emergency departments not only completed medical records, but acted to prevent or reduce a trend of carnage they continually treated. They compiled and organized the data, studied the nature and extent of the injury types,and assessed how to promote that injury's reduction or prevention.

In 1961, there was a similar local story published in the November 1962 Public Health Reports. It was a seminal investigation conducted by Drs. William Haddon Jr., director of the epidemiology resident program, state Department of Health (and the father of modem injury prevention and control); Arthur Ellison, an associate in orthopedics at the student health services of Williams College Williamstown, Mass.; and Robert Carroll, a student at Albany Medical Center.

Dr. Haddon and his associates showed scientifically that certain release binders limited the serious injuries. They studied of all persons purchasing tickets to ski on the four consecutive weekends from Jan. 28 through Feb. 19, 1961. Releases for ski-binders may continue to help reduce these snowboard related injuries as well.

The descriptive work on snowboard-related injury, published in the Times Union from local pioneering docs some 40 years later, is a first step toward that injury-reduction tradition.

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Delmar, NY

The writer is an archivist for the American Public Health Association and a management/safety consultant.

On Thu, 26 Jul 2001 08:40:55 -0700 Leon Robertson e-mailed:

(http://www.amazon.com/Hillbilly-Harvard-Yale-Leon-Robertson-ebook/dp/B004CFB6WK)

> “Those of you who have seen the New Yorker article on seat belts and air bags may be interested in my response.
>
> I am a retired injury epidemiologist whose background includes appointments at the Yale University School of Medicine (1978-1998), The Insurance Institute for Highway Safety (1970-1978) and Harvard University Medical School (1966-1970). Most of my research was focused on road injuries. During 1970-1978, I worked with William Haddon, Jr., M.D., about whom Malcom Gladwell wrote in “Wrong Turn” (The New Yorker, June 11, p. 50).
>
> Aside from the distortions of history in Gladwell’s article, noted in the published follow-up letters, his writing is misleading in several other respects.
>
> During the years of the hottest debates on seat belts and air bags, I never heard Haddon voice opposition to seat belt laws. I would appreciate a reference or documentation for Gladwell’s assertion, in response to the letters, that Haddon opposed California’s seat belt law. Institute personnel were prohibited from lobbying because of our nonprofit research status. We did a lot of research on attempts to increase seat belt use and the effects of use laws, the results of which were supportive of the laws and released to news media. For example, while at the Institute, I published the enclosed paper regarding 80 percent belt use

in Australia and New Zealand as a result of Haddon's insistence that I go there and study the matter.

Gladwell's repeated characterization of those of us who were guided by Haddon's intellect as "Haddonites", blindly following some ideology, is offensive. "Beliefs" did not lead us to say that it was difficult to persuade people to wear seat belts by traditional advertising and education. Those conclusions were based on impeccable research. In fact, I know of no competently designed study that found seat belt use rose substantially by other than laws requiring use.

It was the auto industry, not the "Haddonites" that claimed seat belts and air bags were substitutes, one for the other. Indeed, General Motors produced about 750 cars in the 1970s with air bags and no seat belts, in foolish disregard for benefits of seat belts in other than frontal crashes. And, as was predicted from the physics, air bags are more protective in higher velocity frontal crashes than belts alone.

Gladwell's portrayal of Haddon as a giddy, uncritical supporter of air bags is simply not true. Enclosed is an excerpt from an article in The National Observer that was reprinted in the Institute's 1971 newsletter "Status Report" in which Haddon urged the testing of air bags similar to what one would do with a drug or any public health measure before adoption for general use. Haddon was the most objective, honest scientist that I have known. His views of public policy were driven by objective evidence of what works and what does not to improve public health, not some ideological preference for one approach over another.

In that regard, the quote from Leonard Evans on passive approaches is outrageous. He derides the analogy of chlorine in water and passive approaches to motor vehicle injury, he says, "Because there isn't any chlorine for traffic crashes." Thus, he tries to make a technology passive only if it is a panacea. There are dozens of passive approaches to road safety that are substantially effective but not panaceas (chlorine in water and many other passive approaches to public health are not panaceas either but one would hardly abandon their use on that basis). Energy absorbing steering columns, intact passenger compartments in crashes, energy absorbing crush zones in the vehicle outside passenger compartments, roadside energy absorbers, guard rails, and improved sight distance are important examples. Evans spent most of his career publishing essentially the same paper over and over in which he demonstrated that passengers of heavier vehicles had less injury in crashes than passengers of lighter vehicles, which was hardly news to those of us who understood physics. It is no coincidence that his employer, General Motors, made, on average, the heaviest vehicles on the road. What Evans left out is the damage that heavier vehicles do to the occupants of lighter vehicles that they strike. Among the reasons that the U.S. fatality rate has not moved lower in recent years is the wide range of weights of vehicles on the road, at least partly the result of heavy promotion by the manufacturers of heavy SUVs that, in addition to the weight penalty to smaller vehicles in collisions with them, roll over more frequently because of instability.

Gladwell rightly notes that Evans' claim that changes in the U.S. death rates compared to other countries were attributable to belt laws must be moderated by other changes in the countries compared. Also, any trend in any phenomenon that begins from a higher base will usually decline more rapidly than one that had the lowest base to begin with. Despite

> Australia's pioneering of seat belt laws and drunk-driving legislation (some of the latter found unconstitutional in the U.S.), its road deaths per kilometer still slightly exceed those of the U.S. Evans' claim that the U.S. is in eleventh place in road safety is not supported by OECD death rates per kilometer as of 1999, the latest data available. Only the U.K and Sweden have rates that are significantly lower than the U.S. and the rates of Finland, the Netherlands, and Norway are virtually tied with the U.S. Other developed countries such as Austria, Belgium, Denmark, France, Germany, Japan, and Switzerland have rates ranging from 12 percent to 70 percent higher than the U.S. rate and the developing world's rates are even worse.
>
> Haddon did have a problem. Far from being the gentle fellow described by Moynihan, he had a very nasty personality and loved to bait people when their logic or research methods did not measure up to his standards. Nearly everyone in the injury field, including me, had encounters with him that were extremely unpleasant. Many of us learned to separate the brilliance from the nastiness and to forgive and forget the latter. The Haddon haters, like Evans, Campbell, and Graham, quoted in the article, who didn't have the guts to debate himwhile alive, have been carrying on a campaign to discredit him after his death. I do not know how they came to Gladwell's attention but it is they, not Haddon, who took >"The Wrong Turn".
>
> A question for editors such as you is how to reduce biased reporting based on biased informants. It seems to me that words such as "Haddonites" should be a red flag. "
>
> ….

Taking Leon Robertson's e-mail lead, I, too have responded to the New Yorker's, June 11, 2001, trend at revisionism /polarizing our injury control history:

"As a retired safety official over some 35 years in injury prevention and control and currently serving as a national consultant and historian, I take exception to the June11, 2001, Malcolm Gladwell's commentary "A Reporter at Large: Wrong Turn. How the fight to make highways safer took the wrong turn." While Gladwell does almost recognize William Haddon Jr.'s seminal legacy in the history of injury prevention and control, he offers an inaccurate negative spin. Gladwell's report excludes the earlier motor vehicle industry's lack of promotion of automobile safety seat belts. The writer effectively revises history. In fact, the motor vehicle industry itself delayed promoting and manufacturing of seat belts, not Haddon.

Archives of Congressional Testimony show how progress on seat belts laws in America was slowed by the industry. As late as 1959, (well before Haddon's work in Washington, but after his medical training at Harvard University when he joined the New York State Department of Health's Epidemiology Residency Program in 1957 until 1961), Congressional testimony by the Automotive Manufacturing Engineering Advisory Committee, cited that the industry was still resisting suggestions that seat-belt fittings be made standard equipment in all automobiles (1) (2). The industry's economic interests and its passive reliance on the public acceptance of safety superseded making safer cars. in testimony of General Motors Chairman of the Board. (3). we know the rest of the story once GM was exposed for trailing a lawyer - advocate by the name of Ralph Nader who published **Unsafe at any Speed (1965).**

Quotes that there are" no chlorine for traffic crashes" also historically revises the major success of passive injury prevention practices of energy absorbing passenger compartments, better

engineering of highways, and evidence based educational programs, which as most things are not panaceas, but do prevent if not reduce serious injury. These successes, especially passive injury prevention and control involving energy exchange preventive strategies focusing on the pre-episode, episode, and post- episode, continue to promise to save lives and limbs from not only oldbut new emerging serious risks and injuries in homes, public places, schools and highways (4).

(The opinions above are mine alone and not any organizations.)

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Bush too quick to dismiss gun safety restrictions

Kudos to Boston Globe writer Derrick Z. Jackson (Times Union commentary, March 30) for opening up another dimension of the gun safety debate. He agrees with President Bush that we need more 'values that respect life" and that '... we all have a duty to report trouble signs." But Jackson also questions the President's supportive actions: 'So take back the $1.6 trillion tax cut to increase sales at strip malls and instead spend it on reducing class size. Spend it on extracurricular activities" -- both proven violent injury preventive strategies.

The most proven effective injury control approaches still involve not relying on changing people's or society's safety values or behaviors, but building improved safety into society's use of any highly lethal consumer product.

LF

And here is one for safety humor escape, from my Clowning, A Day Camp Safety Report, (ICEHS Newsletter, Archivist Attic, May 2008), followed by more written press, safety opinions and commentaries:

Hi,

Please consider this “stringer” reporter’s notebook, Best wishes, LES

International Clown Week: Known Safety Report from Bethlehem (i.e. New York) and the Heidelberg's:

Today, August 6, Les the Klown, alias" Les the Kvetch" made kids at Camp in the Heidelberg's smile. He also tried to go fishing in the Camp's pool but was advised by an astute life guard that no street clothes nor clown costumes (even one with a bagel shaped life preserver around the neck) were allowed on the decking of the pool, under State Health law. So, what's a clown to do if he wants to go fishing in a swimming pool? He tried to remove the deck with his tweezers. Even his handing a letter, to the lead camp leader, from a non-diplomatic copy of an International Clown's Certificate of Diplomatic Immunity (A regulation under Public Law 91-433, National Clown Week) printed from Fuddi Duddy's e-mail), didn't hold water. :) But, skits, games and fooling around made up for it all... and he did later catch a whale in the pool's outlet. But this is not the "Kvetche's" end report; he will contact the American Embassy Office in Albany to keep the State's safety code the same and the rights of clowns maintained!

The Kvetches' second report deals with his improving auto safety during International Clown Week by creating miles long traffic delays from the Heidelberg Mountain Camp through the Town Of Bethlehem and all its Hamlets of Delmar, Elsmere and Slingerlands. Pedestrians were waving to this clown - in-costume, as he drove his new 1988 Toyota; other drivers and pedestrians slowed down and even (more safely) dropped their cell phones, and stopped their cars, to Kibitz and talk. What an improvement in auto safety we have seen! The clown has been also seen in Delmar McDonald's entertaining the youngsters and trying to win a new Volkswagen car in its Monopoly game by drinking gallons of soda with the winning coupons.

Finally, town walkers and joggers were gently greeted, as the Kvetch drove home, with his suggestions to some of them to safely walk facing the traffic, not with it.

Oops, this klown string reporter must stop his international clown week, safety report as his computer is not smiling back anymore and his makeup needs refreshing.

For more information on the Electric City Clown Alley and its International Clown Week activities please contact. And smile!

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Applause for year of action by safety advocates

Kudos to the Times Union, fire officials, New York's State Against Gun Violence and other consumer safety advocates, the governor, the Legislature, and industrial statesmen, all and others,for outstanding leadership in home and public safety during the 1999-2000 legislative year.

Watershed bills and laws were proposed and the first state nationwide, fire-safe cigarette (Assemblyman Grannis), pending gun safety (Governor's Program Bill) and those on school safety laws extend now even greater protection for reducing injury risk and severity from burn- and gun-related trauma.

Charles French, Jr., August 25 Commentary, gun laws won't cure social ills, serves as another example of reducing gun safety and gun violence to “all or none” conclusions. By the process of not fully assessing the pros and cons, impacts are excluded and then advocacy for only a few pre-chosen options remain. The article, and many others published nationwide, also shows an incomplete understanding of the nature and extent of the gun related injury and deaths.

I would first agree that gun laws won't cure (all) social ills. Violence has been a round probably longer than Cain and Abel. However, even if the cause of gun violence were just social ills (which it is not, but a combination of a high energy lethal product with substantial unreasonable risk in the hands of most consumers; of little gun safety design, performance laws or penalties; and of a public and home environment highly susceptible to severe injury to young children, adults, and the ill elderly), the most proven effective injury control approaches still involve not relying on changing people's or society's safety behaviors but building improved safety into society's use of the consumer product.

Also, incorrectly, we may focus only on preventing the episode (the” accident', better stated as the unintentional or intentional injury) and loose sight of how to not only prevent but to limit or control the harmful flow of energy leading to the injury, not just prevent violence. In many disciplines, we attempt to prevent the onset of problems. However, when that fails we try to limit or marshal the dangerous affects of the energy involved. In medicine and public health, the law requires vaccination, a lowering of the toxic energy of the disease-causing microbe, regardless of the social or personal factors related to the cause of the disease. In civil engineering, we raise high amperage electrical energy in street wires well above the street level rather than having them accessible down the middle of the street where kids will play. In our retail stores, warnings on many drug bottles are not only posted but the young child's ingestion of chemical energy is limited by” safety caps". Our dairies pasteurize our milk supplies to kill many harmful bacteria that can cause the diseases from toxic biological energy. Our waste supplies separate in different conduits our drinking and sewage water. And our auto engineers also under government regulations build a “crash compartment” between the driver of an automobile or the airplane pilot and the road or airspace, to limit the mechanical injury threshold, as done by seatbelt restraints, as well. However, only the firearm, of a multitude of consumer products, is currently free from harsh penalties for improper sales violations and mostly free of governmental standards for performance, design, and storage. Proven safety regulations and laws, tied to provensafety and educational programs are usually more effective than just changing people and society's ills and behaviors.

Dear Associates,

Possible interest. One of a series of my dozen letters / commentaries published in the press on the shootings / firearms safety. While empirically little is knowing about the impacts of such efforts, short run; in the long” thunder of history” of social reform, embarrassments with face savings in the public media, have moved forward national actions. In NY State the Governor was to veto a prior bill on fire safe cigarettes, and then his hometown fire officials got publicly angry; it passed and so was a one, cited earlier, on gun safety. Historically, safety glass bills in Pennsylvania became law when a Governor's wife walked through a super market glass window.

In Derrick Jackson's Boston Globe commentary, he used an assertive leadership skill of agreeing with the ' loyal ' oppositions. In mine, I technically focused on the silent suicide injury and grieving epidemics (see my related testimony, attached) and the need for some feasible gradient

transition to an omnibus national safety act. The newspaper editor, for space, cut my comments on Haddon's" energy transfer" as the cause of injury and my references to the lobbying successes in limiting some federal research funds and laws.

In the historical process of social reform, the translation of science into art of injury control must be better taught at Schools of Public Health and Social Work. Should not each student know and apply IP theory, by at least writing one letter to a newspaper editor on what (s)he believes should be some" uniform" national message/ advocacy for IC leadership polity on a leading cause of death, disability, and grieving? We are all students.

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Bush to Easy Rejects Gun Safety- excerpt Boston Globe

All in all. Mr. French represents those who oppose the NYS's gun law, which I respect. However, he critiques, and only one sided, only three or four of the law's nine provisions. He is correct in that, in many situations, bullets will be deformed when fired for" fingerprinting", but also that deformity should be traceable according to state criminal justice officials. He is correct in that there are already strict national laws for purchasing guns but does not mention that the black-market sales of guns continue by second party sellers and the penalties remain very much misdemeanors, as promoted by the gun lobby when the law was passed. He may be correct that because the new law raises the age requirements from 18 to 21 to purchase handguns, little will change. I, unlike him, have no crystal ball to project if the new laws will or will not "work" better, indeed, there seems to be little comprehensive built in state evaluation to attempt to assess and report the crime and injury impact of the new law, especially because the comparative national and other state data collection may be difficult to assess as there are no national injury surveillance systems. National and state surveillance systems, gun safety studies and severe penalties for gun dealer trafficking or illegally selling guns have been cited in studies as controlled by the gun lobbies. Yet, there is developing collegiate positive outcomes as some gun manufacturers have attempted, with sanctions from others, to work with the government. If there are "gun rights"; then must be gun groups'" social responsibilities" not yet achieved, either. Progress by the debates is helping on both sides. The results of the November national elections are just being awaited

It may be surprising to him and others that most of the gun deaths are not criminal homicides; they are suicides, and these are greatly disproportionate in our young adult and elderly populations! Effective trigger locks or "smart gun" technology may not work here; nor unless they are better built into the product. Newly published peer reviewed research in the Journal of the American Medical Association, funded by foundations because of reported gun lobby activated laws by Congress that CDC can not do/fund gun research, suggests that the waiting period to purchase a gun (e.g. the Brady Law) may actually reduce elderly suicides. Possible surprise, number 2, is the focus on just "accidental" (they are not accidental) deaths nor on violent firearms deaths. Most are not deaths but injuries. And many of those injured are substantially non-fatal disabilities. For each death, three or more-gun related brain and spinal cord injuries abound, especially for young children, for the rest of their impaired lives. Surprise

three: it is not a matter of Mom and Dad to blame for carelessness, neither should it be the gun industry or its supporters, either, who are working to help solve this travesty by changing and adopting promising life and limb saving approaches. Moreover, it is not fair nor just per Mr. commentator:” The truth is that none of the recent laws signed by Governor Pataki will do anything to reduce crime or make our children safer from gun” accidents” (quotes are mine)

The ancient Talmud suggests that we, alone, can not solve all problems, but we are not free either to not be involved toward solutions. Mr. French certainly has his own solutions. For others, NYS's gun law certainly is promising for ballistic fingerprinting, promoting better standardized safety locks, limiting gun show sales, and other provisions; we all hope these and other needed responses, such as home storage and a injury surveillance and early warning system, will be effective, too, to limit the travesty and epidemic of suicide, homicide and unintentional injury and deaths related to guns.

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Graduated licensing can cut teen car 'accidents'

First published: Monday, January 14, 2002, Time Union, Albany, New York, USA

Kudos to the Times Union opinion page ("Stop the Carnage," editorial, Jan. 6), to reporters Jacquelyn Swearingen ("Community recalls classmate," Jan. 5,) for sensitive reporting of the local tragedies, and James M. Odato, for thorough investigative reporting of unnecessary fatal injuries ("Driver in crash had limits on license," Jan. 4).

Alcohol-related teen driving tragically costs not only New Yorkers' young lives and limbs, but among young adults, for all types of motor vehicle-related deaths, in excess of $2 billion in mortality costs. For teens, the excessive frequency of alcohol-related death to the number of teen licenses remains a substantial but preventable risk for New York legislative and societal action.

The Times Union's advocacy for a strict graduated driver licensing law, in effect in more than 32 other states, should also be a state Legislature's and governor's program priority. Published evidence based on injury control research -- see http://www.InjuryPrevention.com (InjuryPrevention.com) Dec. 2001 or http://www.NHTSA.gov -- include findings not only from Texas, as cited in the Times Union editorial, but also from Kentucky, where difficulties for local judges and police to enforce and for parents to understand graduated license restrictions were identified; from California, where significant lowering of injury and deaths in the teen population took place, and New Zealand, where the nighttime curfew showed some success. These results should prompt New York State to adopt a graduated license.

Unfortunately, instead, the state Legislature seems to spend too much of its energy in a non-evidence research based repealing of fireworks safety laws, now hopefully facing a governor's veto. Such proposed repeals, based upon the law being” unrealistically restrictive," not only open

the dikes and lower the threshold for repealing other effective safety laws, but also seem a bit like putting profits over safety for children's eyes and limbs from the high temperatures of sparklers and related” less dangerous" fireworks.

The fireworks law has served for decades as an effective and promising educational tool for parents.

Tell your senator, assemblyman and the governor's office not to wait for tomorrow's next teen alcohol motor vehicle related injury or death. Let's instead get an effective joint GDL for New York State. And let the governor's office know, today, to NOT repeal the state's fireworks or other safety laws.

LES FISHER

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Many myths surround guns and gun control

First published: Wednesday, December 4, 2002, op Ed Times Union, Albany NY (ww.Timesunion.com)

The urban myth that gun laws subvert the right to self-defense (letter, Nov. 14) abounds.

While successfully challenged routinely in the lay and professional literature, the NRA and its advocates offer little, if any, constructive common ground for protection of children and gun users, instead of protecting guns. At times neither does the anti-gun lobby.

Does the NRA cause sniping and murders? Of course, not. Is there a strong association? Possibly, but there's no evidence. A created gun culture instead has advocated for gun immunity laws and the weak enforcement of the penalties in existing laws.

What explodes the myths that gun possession ultimately protects users and that criminals cannot be controlled by gun laws? Good research shows the gun user's family is at greater risk, of an adult suicide or unintentional child injury, than any intruder. New research shows that college students who own guns at college are more prone to the high-risk behaviors of binge drinking and driving a motor vehicle after binge drinking. However, the U.S. population seems to oppose “gun control” more and more.

But let both sides call a brief truce and consider “Bowling for Columbine.” While professionally I must mildly criticize this fine, questioning film on its anecdotal responses to the causes and prevention of gun-related injuries and deaths, and at times its possible insensitivity to families who have lost loved ones, all in all it moves constructively to the need for some reform and to begin negotiations between pro- and anti-gun advocates.

I credit Kmart for its leadership in this film. Besides, the humor during interviews with students, Charlton Heston and gun dealers is exceptional.

Then go to the State Museum, together, and appreciate the fine portrayal of the use of guns in the Revolutionary and Civil wars, and appreciate a balanced spirit of America's freedoms and rights. And then let's go to a house of worship together. But unlike our founding fathers, do not always take up the firearms at the door when leaving.

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Safety should at center of gun-control debate

First published in Albany, NY, Times Union, Opinion Section: Tuesday, December 16, 2003

Warren Redlich “hope(s) to present a rational response, on behalf of a lawful gun owner, like myself” ("Focus on causes of violent crimes, not guns,” commentary, Nov. 22).

His theme -- that a ban of firearms is not reasonable -- is correct, but the rhetoric serves only to evoke a one-sided strategy from gun lobbies for no other purpose than to be against any gun bans.

We need to consider the safety aspects of this debate as well. Indeed, other potentially dangerous products are not banned, including automobiles and alcohol. Today, we raise electrical wires onto high poles and don't leave them in the middle of the street; we standardize our fire hydrants and hoses, we pasteurize our milk supply and separate and chemically treat our potable water. We don't just rely on a toddler to not be near a flame or household toxic substance, but respectively purchase only flame-retardant nightwear and safety capped household products and medicines.

On the road, we use auto restraints and automatic airbags rather than relying on humans to stop accidental collisions, etc. and hopefully take the hand-phone law, and penalties seriously. While we no longer permit young children as injury canaries in coal mines, gun advocates seem to be less concerned about protecting kids' experimentation with weapons and thereby effectively limiting gun deaths and injuries at home than protecting their guns. Only the gun does not reflect government or industry safety-engineering design as a regulated consumer product.

The most significant issue not usually discussed by gun supporters is that the leading cause of gun-related death is not from or to the criminal who “can get any gun anywhere, anytime,” but to the gun owner and his family from suicides or, second, by unintentional injury to the home occupant. It may be very surprising that the largest cohort of gun-related suicides is doctors, not an uneducated or criminal class.

We can all agree that no one should take any gun rights or liberties away, including the right and liberty to know all sides of a debate, not just one or two.

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The writer serves on various national and local injury prevention panels and advisory groups.

Facts show that guns pose serious social risks

First published: Friday, May 7, 2004

Kudos to the Violence Policy Center (".50-caliber rifles pose clear danger to public,” May 1), which, with our state legislative leaders, supports a ban on these guns reportedly purchased by terrorists and used on firefighters and police officials.

There seems to be no limit to what some overzealous persons will accept, promote, or lobby forwithout a second thought to balanced facts. So here's a balanced look at the facts:

More guns now are in schools under states' promoted loopholes.

While nonintentional, gun-related injury, disability and death are commonly reported, the largest gun-related deaths are from suicides to gun owners.

Guns are involved in the majority of domestic killings. Abused women who were threatened or assaulted with a gun were 20 times more likely than other women to be murdered by their intimate partners.

The appointed federal Alcohol and Tobacco and Firearms Bureau's director seems less serious about aggressively enforcing the federal gun laws on the books. Besides, the U.S. Supreme Court has affirmed earlier decisions that the Second Amendment protects a collective right to guns, not an individual one.

The Bureau of Alcohol, Tobacco, Firearms and Explosives is no longer releasing gun-source data under the Freedom of Information Act.

While the federal assault-weapons ban has been effective in keeping some weapons off the streets, it has not stopped gun-makers from making copycat assault-style weapons that can be found in gun stores nationwide.

Regardless of where one is in the debate, I encourage all of us who support gun safety to attend Sunday's Million Mom March 2004 in Washington to again draw attention to the 30,000 deaths and 75,000 gun-related injuries in the U.S. each year, a major personal, societal, and economic loss to America.

LES FISHER, M.P.H.

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Bipartisan study panel needed on gun safety

Kudos on your July 19 editorial, 'Mr. Ashcroft's gun view," which criticized the attorney general for unilaterally and quietly reversing his department's long-standing Second Amendment position on individual rights to bear arms.

He seems to now establish his own law for individual rights. And, rightly so, his positions are being challenged on legal and ethical grounds in the courts as outright politics supported by President Bush.

To read the rest of the article, go to:

http://timesunion.com/ss.asp?s=62809&c=O

America tolerates far too many gun deaths

First published: Thursday, July 15, 2004 Times Union, Albany, NY. Copyrighted 2004

In response to the recent letter criticizing the Times Union editorial position on Second Amendment rights: I commend the Times Union for its balanced letters and views. Gun safety is not just a matter of rights of gun owners, but of responsibilities for preventing minor, disabling and fatal gun-related injuries.

Unlike other high-income countries, the United States does not have national requirements for a good national etiologic and preventive data system for firearms injury, firearms training, licensing registration and safe storage. Instead we have a patchwork regulatory system that

seems to work for reducing problems caused by machine guns, sawed-off shotguns, silencers, plastic handguns, and cop-killer bullets.

The U.S. child death rate from unintentional, suicidal, and homicidal gun injury still exceeds most other countries; our country has the most handguns and the weakest laws in the industrial world. And yet, some continue to accept high levels of lethal violence -- much of it to the home gun owner and his family -- as an inevitable product of free rights in America at our work, in our homes and at our schools.

The Second Amendment's alleged right to bear individual arms is part of that deadly myth promoted in our culture. Indeed, public health emphasizes prevention rather than fault-finding. This approach has had some success in changing views on public spitting, smoking, automobiles, flammable children's night wear, toxic dosages of aspirin, drain cleaners and thousands of other consumer products.

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First published: Sunday, September 12, 2004, Albany NY Times Union

I encourage all sides of the gun safety debate to contact our President, congressmen, lobbies, andothers, immediately, not just to continue, but to strengthen, the federal ban on assault weapons.

There is now a short window of opportunity for political leaders, industrial statesmen, gun owners, gun victims, the public and others to come together to also protect America from terrorists and terrorist weapons.

All came together in prior historical safety debates on autos, household chemical, flammable children's night wear, and sweatshops. Why not now?

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Focus on prevention of gun-related injuries

First published: Sunday, November 14, 2004 Albany, NY, USA, Times Union at www.timesunion.org

Kudos to the Times Union (Oct. 17 and 18) and reporter Jordan Carleo-Evangelist for the fine, balanced, and focused” Guns and Crime” series.

We all will reach a new safety watershed, as has been done during the history of the prevention of other injuries (from autos to aspirin), by not only preventing gun-related criminal homicides, but also by limiting the less cited and larger, more-prevalent spinal cord, brain, and other seriousgun-related injuries -- and not just from criminal actions, but also from the greater number of family-member suicides and accidental gun-related injuries.

Eventually, the nation will lead with better-funded and promising evidence-based preventive safety practices, and maybe even new public, private and governmental leadership alliances that

make a priority of gun-injury prevention and focus on our young children, adolescents, and seniors. The press remains a major, long-successful catalyst toward such public health and safety goals.

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ICEHS Newsletter Jan 2007 Suicide Prevention History

Archivist's Attic: A Selected Nascent Timeline: Historical Streams and Rivers in Suicide Prevention Leadership Systems (with annotations and personal perspectives) .

Three high school age suicides, over a few years, in my small community, Delmar, NY, have led to greater local and state awareness and actions (see: Bethlehem NY, Spotlight Nov 2004 articles and opinions, including mine: Screening of students promoted; A mental health task force expands to community information meetings) . Just today, Dec 14, both houses of our state legislature passed (A. 12080/S. 8482) , under the leadership of a statewide coalition , Timothy's law, a bill to provide costs of treatment for mental health related conditions ,(as done already for physical health conditions) , for suicide prevention and control... So, I dedicate my commentary to the prevention and control of this suicide epidemic, now also *associated* with certain prescription drugs, as well as the firearm vector…. Unsuccessful and completed suicides and other forms of violence are repeated weekly throughout other communities nationwide. My nascent timeline, redacted from much of my prior published and non-published work , might now be helpful for national and state associates to assess, plan , develop, organize and evaluate new and older potentially evidenced-based or promising federal- state-local activities and programs ,or for "educating" for Congressional allocations for collaborative systems learning leadership by federal agency research (CDC surveillance or the more expensive onsite, within 24 hours , epidemiological investigations of the interacting injury violence behaviors, environments and consumer product vectors or for new early injury warning systems ; NIH on serotonin and other bio pathways; FDA on Rx drugs availability controls ; HRSA on death investigation teams or applied use of incident data from poison control centers); or for *more broader* injury programmatic or research prevention and control funds to universities and states, in part from the new Suicide Prevention Law signed by President Bush , early November 2004, (see Archivist's Attic Commentary ,(AAC) , Nov 2004, Nov 2005 , ICEHS Newsletter at www.icehs.org , and see also: http://www.sprc.org.)

In the American Public Health Association' s Injury Control and Emergency Health Services Section, (ICEHS), (www.icehs.org) September 2002 Newsletter, I, as Section archivist, published my selected Timeline on the overall history of injury prevention that was adapted in various national publications. I now offer a nascent, side " rivers and streams" timeline of our discipline (see AAC ,ICEHS Newsletter Oct 2002) of selected highlights in suicide injury prevention and control historical leadership which supplements several recently published national studies with histories (see e. g. Institute of Medicine of the National Academies of

Sciences .Reducing Suicides. A National Imperative, 2002 limited space on that historical leadership)

What follows, adapted from my invited testimony before the Surgeon General's Hearing on National Goals and Objectives for Suicide Prevention and Control, Boston, Nov 2000: An historical review and assessment of earlier national programmatic successes and failures in suicide prevention and control, tabulated against those national objectives proposed in the year 2000. These and other past efforts can guide the present and future learning on similar challenges that faced earlier workers:

My Nascent Selected Timeline (includes national and New York State annotations- first published. In APHA ICEHS section newsletter, archivist attic Jan 2007

Biblical impacts - Suicide was considered a violation of sacred Old Testament Law. In practice, burial was in different part of a cemetery. This injunction was modified (in the Talmud and later and in modern times by clergy) as the victim was now recognized as "sick". Also, his or her family should not suffer even greater after a loved one's death; the victim is dead and only the living, really grieve and suffer.

1821 - Grand Dictionary of Medical Sciences, notable psychiatrist Henri Esquirol, "A people for whom life has become a shame and death plight (Voltaire) .. frequency of suicide will multiply". (for details and references to these and several citations below see: Chapter 16: Suicide Prevention. In: Injury Prevention -Meeting the Challenge, The National Committee for Injury Prevention and Control. Pages 252 - 260. Oxford Press. Supplement to Amer J of Preventive Med. 5:3. 1989.)

1845 - Aramiah Vrighm, founder of the Annuals of the Insanity, no fact is better conferred in science that suicides are often committed from imitation (yet to be proven fully)

1897 -Emil Durkheim - reaffirmed the influence of moral attitudes on the occurrences of suicide but even greater so from social disintegrating forces and a consequence of them.

In the post -Durkenheimian era, of suicidology, many authors have contended to pay attention to the attitudes for suicide prevention but empirical substantiation of this relationship has been virtually absent- (Suicide and Its Prevention, the Role of Attitude and Imitation, Edited by Rene Diekstra, et al, Report of WHO, EJ. Britt Leiden, 1989)

Circa 1960's - Suicide and non-intentional CO2 deaths associated with gas ovens in British homes decrease substantially with the use of natural gas and a warning odorant. (Kreitman N. The Coal Gas Story: United Kingdom suicide rates, 1960-1971.Br J Prev Soc Med 1976;30:89-93.)

1960-1970 – Crisis Intervention (suicide hotlines) services centers. Little evidence on impact on reducing suicide rates but offer an introduction into the mental health system (see: Injury Prevention. Meeting the Challenge, page 257)

1960-1980's - Dr. William Haddon, Jr. (various publications, while at NY State Department of Health and over decades) -the cause of injury is not a consumer product, (see: Gordon JL. Epidemiology of accidents. Am J Public Health. 1949; 39:504, who claimed accidents were caused by various products.). but a mix of kinetic energy transfer 'that goes wrong' > Extrapolated: suicidal relationship relates to human (depression, genetics, etc.) and environmental (mobility, family separations, publicity, etc.; vector factors (availability and lethality of weapons, etc) Injury control requires more than information, education, or conferencing, but mixed with changes in design / performance of energy release. Haddon revolutionized the "human factors school" with his tabulated of nine strategies for energy prevention, control and minimizing effects of the energy release. These approaches seem more difficult in violence prevention arenas (See: Fisher, Injury Prevention, Dissent; Traditional public health injury control approach does not apply to violence, April 1999; 5: 13-14 (www.injuryprevention.com) than in non-intentional child poison , burn, auto, etc injury prevention.

I979 – National Institute of Mental Health, Center for the Study of Suicides, sponsored a suicide national conference in Phoenix, AZ, which report, Suicides in the I970's (1973) contained more than 20 research and intervention goals. By 1986, few goals were met (Comtock, BS. 1979) and only unproven and ineffective crisis hot lines were established.

1980 – US Public Health Service key goal includes suicide prevention in Health People. Goals and Objectives, as today's thrust, were to be coordinated with federal agencies; and NJ and California did benefit from such work. (In: Injury Prevention Meeting the Challenge, The National Committee for Injury Prevention and Control. J Supplement to Amer J of Prev Med. 5, 3: 1989.)

1983 –The Centers for Disease Control and Prevention (CDC) (www.cdc.gov) established a violence prevention unit that brought public attention to disturbing increase in youth suicides rates.

1985 - I was most directly involved in suicide prevention: prepared two NYS federal grants on suicide prevention, which were federally approved without funding. I met with federal health officials to learn that suicide prevention was not a public health issue!

1985 - In my research review and thesis, " A possible biochemical basis for the prevention of adolescent intentional and non-intentional injuries" University at Albany, SUNY, my assessment, and speculations on biochemical pathways toward violence risks, for speculative and controversial preventive research. (see: AAC, ICEHS Newsletter 2005)

1985- 87 - I arranged for meetings with state adolescent health medical providers and others to review the suicide problem, presented papers at American Public Health Association Annual Meetings in Anaheim and New Orleans and the Governor's Youth Suicide Prevention Council. Objectives included a statewide plan, greater interagency cooperation, biochemical research, development of a State plan. Few were done, and probably few in any other states.

Feb 1986 - Albany, NY Times Union interviewed: "Suicide research investigates copycat characteristics" a key concern

1986 - NYS established first regional poison control network law, funding, standards, and guidelines, and annual report to the legislature. Suicide prevention new risks demonstrated and controlled (acronitrate glue remover for finger nails) and drug suicide data potential to target programs. (In I950's PCC responded to suicide attempts not only poisoning calls. Today, there's a useful TESS (National Poison Control Center incident data) surveillance and early warning data system.) See also: National Academy of Sciences. Forging …Poison Control Centers. 2004 (see AAC, ICEHS Newsletters, March, and Sept 2004)

1989 – Publication of the US Secretary of DHHS multi –year task public private force Secretary's Task Force on Youth Suicides to review what was known about risk factors to youth suicide and promising interventions.

1991 - Rosenberg ML, Fenley MA. Violence in America. A Public Health Approach. Oxford University Press: New York. 1991.

1992 - Intentional poisoning deaths took place to depressed patients within 30 days of a visit to the doc. Tricyclic anti-depressants Rx in large quantities and the depressed person overdosed. Drug Abuse Warning Network (DAWN) and Poison Control Centers data (TESS) used. (Kapur S, Mieczkewski T, Mann J. Antidepressant Medications and the Relative Risk of Suicide Attempts and Suicide. JAMA. Dec 23/30, 1992; 268: 3441-3445 Cited in: Fisher L. Public Health Linkages : Presentation before the New York State Association of County Coroners and Medical Examiners . Holiday Inn, Seneca Falls, NY, March 21, 1993)

1995 – Fisher L. Drug Abuse, Violence, Injury. An Applied Developing Framework for Public Health Preventive Practice. A Review and Assessment. (See AAC. July 2006, ICEHS Newsletter)

1999 - Jamison Redfield K. Night Falls Fast- Understanding Suicides. Alfred A. Knopf, NY, 1999, ISBN 037540145 (See: Fisher L. Book Review In: Injury Prevention Dec 2000: 6:312. see: www.injuryprevention.com)

2001- National Strategies for Suicide Prevention. Goals and Objectives for Action .US Department of Health and Human Services (See : Fisher L. Book Review . In: Injury Prevention. June 2002; 8:171. see: www.injuryprevention.com)

2001 – School Health Guidelines to Prevent Unintentional Injuries and Violence MMWR. Dec 7, 2001.50. No. RR-22 (see: www.cdc.gov and see ICEHS Newsletter Nov-Dec 2006)

2002 –Institute of Medicine of the National Academies of Sciences. Reducing Suicides. A National Imperative. (see: www.nas.org)

2002 - Several federally funded, state, community suicide prevention demonstration projects started in Maine and Colorado (see: www.cdc.gov)

2004- Certain anti-depressants Rx for children associated with increased risk of suicide. Also, one study suggests those given those Rx's later in life have greater chance of suicide. This is a controversial issue but England banned use of certain anti depressants for children; the FDA only gave a "black box warning". (see AAC,ICEHS Newsletter. Nov 2005)

2004 - Gould MS. Greenberg T. Velting DM. Shaffer D. Youth suicide risk and

preventive interventions: a review of the past 10 years. Journal of the American Academy of Child & Adolescent Psychiatry. 42(4):386-405, 2003 Apr

2004 –. Suicide Prevention Law signed by President Bush, Nov 2004. Funds forthcoming to states in 2005-2006.

2004 – Firearms continue to predominate in suicides. (Here's one excellent review and research paper: Dahlberg LL, Ikeda RM, Kresnow MJ. Guns in the home and risk of a violent death in the home: findings from a national study. Am J Epidemiol 2004; 160(10): 929-36.) (see: AAC, ICEHS Newsletter Feb 2005)

2005- Mann, JJ. Apter A, Bertolote, et al. Suicide Prevention Strategies. A Systematic Review. JAMA, 294(10), Oct 26, 2005:2064-2074

2005-2006 – New York State Department of Mental Health publishes monograms on suicide causation, prevention, and control, that leads, in part, to state programmatic funding.

Dec 2006 – FDA cites suicide risks to young adults of certain antidepressants prescription drugs;

controversy continues on these serotonin uptake inhibitors. New York State, Timothy Law, bill passes both legislative houses, expects the Governor's signature. The bill (A. 12080/S. 8482) would permit mental health, including suicides prevention and control treatment expenses. Led by a major statewide coalition.

These are only a sampling of national and one state's history of injury prevention and suicides. The continued need to refine our historical prism glasses and see what really works, what didn't and what has potential offers a sea change and linchpin to help limit suicides. Moreover, building toward successes takes decades. Again, the value of this historical review for the present is to show the past's challenges and outcomes.

LeslieFisher

Opinions are mine alone.

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Anti-armor sniper rifles need to be banned

First published: Friday, February 18, 2005, Albany, NY, Times Union

Several writers have perceived History News Service's Saul Cornell's commentary," Distorted history to change gun law" in the Jan. 31 Times Union as" anti-gun." Let my response to be perceived as pro-people's injury prevention:

Relying on medical and public health related Web sites (www.juno.com, www.vpc.org) and books, not only the views close to the NRA's, I find the latter still sings a blind song, focused on membership revenues and lobbying for what it does not fully understand, as it leads to the substantial risk of more suicides to gun owners and their families, especially in rural areas.

The larger cause of gun related death, especially to kids, is not from criminality, (see New York Times, Feb 14) but to irresponsibility in not supporting an updated effective Congressional assault weapons ban (Hudson Valley Mall, Feb. 13, and the terrorist availability even of.50-caliber sniper rifles that can shoot down commercial airplanes.)

Support proposed federal legislation, H.R. 654, to ban these anti-armor sniper rifles. The views in those recent letters offer only the same" song" with no empirical evidence -- just morally wrong diversions from any debate about private guns -- public health partnerships.

LES FISHER, M.P.H

Safety management consultant and historian

Delmar

Gun makers, dealers should not get a shield

First published: Sunday, August 7, 2005 Times Union www.timesunion.com Albany NY

Kudos to the Times Union for the July 27 editorial," Off Target: A Senate bill goes too far in shielding gun manufacturers and dealers from liability."

Your sharp criticism, along with other editorials across the country, illustrates that the National Rifle Association and its membership have little regard for preventing or reducing risks from firearm-related suicide, homicides, and injuries -- even to its own membership -- but only is concerned for membership revenues.

The NRA practices of stopping any effective ban on assault weapons sales, cutting national firearms research funds, and delaying our national defense spending (so as to obtain a uniqueliability shield) only exceeds their violations of conservative ethical religious tenets.

"When you build a new house, you shall make a parapet for your roof (where people used to socialize), so that you do not bring a blood guilt on anyone should fall from it,"(Deuteronomy 22:8). The rationale of this commandment is that one must anticipate the dangers and damages that might be caused by you or your property.

Yes, let the courts decide. Do not set an example for every other industry. All other consumer product industries are regulated for safety. How many guns come to our Albany region for use in drug trafficking sold by gun dealers or open sales auctions?

California showed gun dealers are in a direct line.

LES FISHER

Safety/Management Consultant

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Illegal guns are getting serious consideration

First published: Thursday, January 12, 2006, opinion pages, Times Union, www.timesunion.com Albany, NY

Kudos to the Dec. 23 Times Union editorial, "Action in Albany"(on state law for illegal guns and shooting and killing police officers), and to the 2004 special series on gun violence; to the state Legislature and governor on the new gun trafficking law; to Fred Lebrun, for his Jan. 3 column," Chief seeks to secure city's future"; and to citizen-advocates Leonard Morgenbesser and 1st Ward Councilman Dominick Calsolaro for their focus on gun violence prevention -- a task begun with Morgenbesser's collection of gun violence incidents reports.

However, recent letters to the editor continue to focus on an image of protecting legal gun owners by, unfortunately, touting outdated myths on gun" rights."

These writers would like to entirely separate criminal control from gun control. Similar NRA, congressional and presidential platforms uniquely legally shield gun industries.

Indeed, thanks to the Times Union and citizen and governmental advocacy, illegal gun possession is now being taken seriously and counted because it is a common precursor to serious assaults, murders and major health care and related local, regional, and state economic costs.

I would like to see" pro gun" writers recognize the burden of firearm- related serious morbidity (brain and spinal column injuries and deaths) -- especially to their associates -- and the substantial threat to public health.

I am not against guns, but I am for the public health related practices of collecting and assessing data, of policy options and for assurances for the prevention and control of firearm- related public morbidity.

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Window guards add a layer of security

First published: Monday, August 7, 2006

Kudos to the Times Union on its continued fine coverage of the trends of tragic childhood falls from apartment windows and the proven injury prevention strategy of approved window guards in New York City and Boston.

Children's falls from windows are a well-recognized imminent preventable risk. The fall control solution is much broader and more practical than blaming the victim or his or her family for the injury and economic loss to anyone. And any child can just not be supervised all the time.

Supervision must be reinforced by proven and reasonable safety engineering and legislation -- as cited and proposed by the Times Union.

That's not only the best use of science but ethics as well. LES FISHER

Delmar

The writer is a safety consultant.

First published: Friday, September 29, 2006

Firearms involved in a large number of suicides

Kudos for the Sept. 16 front-page story, "Hidden demons shatter a bright life." However, not mentioned is the major vector of firearms, not only in unintentional or homicide injury, but in suicide attempts and completions.

It is not a matter of banning firearms but of assuring responsible effective storage, safety lock selection and use.

Independent research confirms that programs such as the NRA's Eddie Eagle just do not have any empirical evidence of working.

The Institute of Medicine's “Reducing Suicides, 2002,” just published, confirms that firearms are the most common method of suicide.

Harvard's School of Public Health recently confirmed earlier studies that changes in household firearm ownership over time are associated with significant change in rates of suicides for men, women, and children. Their finding suggests that reducing availability to firearms in the home may save lives, especially among youth.

Furthermore, the presumption that anyone serious enough about suicide to use a gun or jump off a bridge will inevitably find another way to take his or her life is fundamentally undercut by this research.

That proper firearms storage message, while not the “complete” answer for saving lives and limbs, should be made clear in media coverage. Congressional funding cuts continue for CDC national firearms research and for applying known promising preventive practices. Meanwhile, however, the President's Suicide Prevention national program funding has made headways, nationally and here in New York State.

However, with more guns there are more suicides. Certainly, all sectors of the” gun debate” should endorse promising and evidence-based home gun storage strategies.

LES FISHER

Delmar

The writer is a safety expert and a member of the Bethlehem Mental Health Task Force.

The safety of the public comes before 'rights'

First published: Monday, April 23, 2007, Albany Times Union

Reactions to the Virginia Tech massacre focus primarily on the behavioral characteristics of the perpetrator and the responses of university leaders. But some commentators have also reopened the debate on gun rights --” rights” that perpetuate myths that improving gun safety is a matter only of protecting one's home and public from illegal gun users or other intruders.

Controlled research, not quips and anecdotes, show collectively that homes with guns are more dangerous than homes without guns. Where there are home guns, the rate of gun-related suicides, homicides and injuries is significantly higher for owners or their family members.

Public statements that focus only on protection from criminals coming into homes help no one. A useful response from those who do those” guns don't kill” quips has yet to be forthcoming.

Will the Virginia Tech massacre lead Congress to return funds to the U.S. Justice Department's juvenile job mentoring programs and to CDC for gun-related research? Will it lead to reinstating a longer, national government review period of gun-purchase applications that can be shared again with local police and for national gun safety research (cut for its fifth year)? Will it prompt repeal of state laws protecting gun liability? Will it lead to youth violence screening programs known to be effective (few, if any, are) to get effective mental health services to adolescents?

I am neither for guns, nor anti-guns. I am for the public health and safety.

LES FISHER M.P.H

Delmar

The writer is a safety consultant.

Kudos to state for identifying hazardous toys

First published: Thursday, November 29, 2007, Times Union, Albany NY,

Kudos to state Attorney General Andrew Cuomo, the state Consumer Protection Board, the Agriculture and Market Department, the Health Department and PERB for their state and national leadership on recent toy safety.

Too recently, the motto of consumer protection been shifted to “consumer beware.” The use of state risk and injury surveillance data, and enforcement of consumer protection related regulations, is needed in the market place.

History repeats itself: In 1970, the President's National Study Commission on Product Safety staff asked the state Department of Health to verify that the toy industry's promise of commission's identified dangerous rattles and other toys were, in fact, as promised, actually removed from the market. They were not. The Health Department's statewide initiated survey findings of market with local health and consumer groups were shared with the state attorney general.

The close effective collaborations of state agencies had developed a few years earlier, when the attorney general, the Health and Labor departments joined efforts to limit annually hazards of federally legal, but highly flammable, children's sleepwear.

Unfortunately, the federal Consumer Product Safety Commission under current laissez faire leadership remains purposely ineffective and underfunded; consumers are left with substantial risks and injuries.

LES FISHER

Delmar

The writer is former director for Consumer Product Safety with the State Consumer Protection Board.

History of NYS CeaseFire (CureViolence) Statewide Program Funding

In Nov 2007, the City of Albany NY created a Gun Violence Prevention Task Force, with members appointed by the Mayor and the Common Council, to give its report within a year. (see www.timesunion.org for historical progress). With my expertise in public health injury control and group leadership, I serve on that panel. The greater promise in limiting the gun mechanical and users’ biological energy that can go wrong is by separating and embargoing the impulsive perpetrator/victims from the gun and environments – as done in Operation Cease Fire, Chicago, (using Haddon strategies # 3-4). Cease Fire was a primary Recommendation in the Task Force Report: http://www.albanyny.org/Government/CityOfficials/CommonCouncil/GunViolenceTaskForce.aspx See TF members comments, including mine and related testimonies before Albany Common Council.

While Albany city law makers continued to deliberate on the initiation of the Gun Violence Task Force Recommendations; NYS legislative leaders, in April 2011-2015, had re appropriated Operation SNUG /Chicago Cease Fire’s (now Cease Violence) $4 million state funding into six

regional Operation SNUG/ Cease Fire programs, initially started with a Robert Wood Johnson Foundation's demonstration grant to CeaseFire.

The prevention process for NYS program funding of Cease Fire, is the gradient outcome (see below examples and www.timesunion.com SNUG news archives) for successful advocacy for ongoing NY State funding.

Here are eight detailed primary and secondary source documents on those cited historical dynamics that led to the federal Justice Department / NYS Corrections Department discretionary Byrne funding in NYS of the national public health evidence-based " CeaseFire " programs:

1/. Projects to see state money to fight gun violence
Albany will be a pilot site for $4M prevention program:

By ***JORDAN CARLEO-EVANGELIST***, Staff writer
Click byline for more stories by writer.
First published: Thursday, April 30, 2009

ALBANY — Eleven months after 10-year-old Kathina Thomas was slain by a stray bullet in West Hill, Albany has been selected as one of eight pilot sites for a $4 million anti-violence program. The city could receive up to $500,000 for community-based violence prevention programs based on CeaseFire, a campaign in Chicago that has been credited with steep declines in shootings and other violence.

New York's effort, spearheaded by state Senate Democrats, has been dubbed Operation SNUG (for "guns" spelled backwards).

The announcement, made Wednesday at the Capitol, comes as Albany moves to form the team that will implement recommendations of the city's Gun Violence Task Force, whose work gained new urgency after Thomas' murder at the hands of a 15-year-old last May 29.

One of the task force's 16 recommendations to city lawmakers was to implement a CeaseFire-like program in Albany, to treat gun violence as a public health threat, like AIDS, rather than just a law enforcement problem solved through increased policing and prosecution.

In Albany, among other things, that would mean using "violence interrupters" to intervene in the crucial moments after a shooting, sometimes even as the parties remain in the emergency room, to head off the threat of retaliation, said Common Councilwoman Barbara Smith, who represents part of Arbor Hill and has been closely involved in the discussions to bring the program to Albany.

Smith said the programming would also mean boosting outreach — including by people such as former gang members — to community members most likely to become drawn into violence.

"We plan to be in the hospitals, at Albany Med ... we will be in the schools, because we know that a greater part of prevention is to educate our youth, get them ready to be productive members of society by giving them that educational opportunity, and we will continue to be in

the streets," said Smith, who called the CeaseFire the "gold standard of violence prevention and intervention."

A vital component of the program is that it remains steadfastly autonomous from law enforcement, said Candice Kane, chief operating officer of the Chicago Project for Violence Prevention.

"If there's a conflict brewing, we get to folks and talk to them about a different way, a peaceful way, of resolving the conflict," Kane said. "There has to be an arms-length from law enforcement. We can't be seen as informants. We can't be seen as snitches. Not only would it undermine the credibility of the program, it would put the safety of our workers at risk."

Detective James Miller, a spokesman for the city's Department of Public Safety, said the police force supports of the effort.

The program in Albany will be run through the University at Albany's School of Social Welfare, which has been involved in the city's violence-prevention efforts.

The money will be awarded through the state Division of Criminal Justice Services, said Senate Majority Leader Malcolm Smith.

The other pilot areas are Buffalo, Rochester, Syracuse, New York City and Westchester County.

Mayor Jerry Jennings said the money will link together well with state-supported efforts to fight truancy and violent crime.

"Anything we can do to be more proactive than we are right now is going to help all of our communities," he said.

Jordan Carleo-Evangelist can be reached at 454-5445 or by e-mail at jcarleo-evangelist@timesunion.com.

(LF Note: Senator Majority Leader, Smith was later convicted for bribery for a NYC political position; however, his earlier work, serendipity, favored NYS public health injury and violence prevention histories!)

2/. NYS Legislature, Senate Majority Leader Malcolm Smith's Sponsored Meeting with Chicago CeaseFire Staff:

THE SENATE
STATE OF NEW YORK
ALBANY 12247

MALCOLM A. SMITH
NEW YORK STATE SENATE
DEMOCRATIC LEADER

MEMORANDUM

To: Community Leaders and Operation S.N.U.G. Task Force Members
From: Office of Senate Minority Leader Malcolm A. Smith
Date: August 1, 2008

We write to invite you to a gathering of local civic and religious leaders, law enforcement officials, religious and community leaders, educators, public health officials, youths, business executives, neighborhood activists, human service providers, entertainers and others next **Friday, August 8, at 11:00 a.m.** in the **Legislative Office Building, Room 211**, located on State Street in Albany.

We know that you share my interest in stopping the shootings and killings that have taken the lives of innocent children, disrupted our neighborhoods and torn apart the fabric of our communities. And we know that many of you are working hard on new solutions to reduce the violence, support youth and begin the healing.

As part of Operation S.N.U.G. ("guns" spelled backwards), our statewide anti-gun violence initiative, we have begun work with **CeaseFire**, the gun violence reduction effort currently operating in Chicago, Baltimore and other U.S. cities.

Next Friday we will have the opportunity to meet with representatives from CeaseFire and discuss their model, which has been proven effective at reducing shootings, killings and retaliatory murders while making gun violence "hotspots" cooler.

CeaseFire works with police, prosecutors, government and community leaders to make neighborhoods safer – we've been working to see if the CeaseFire model may make sense for New York, and we hope for your time and input next Friday to continue this discussion here in Albany.

Please contact Keith St. John in the Office of the Senate Minority Counsel at 518-455-2842 or stjohn@senate.state.ny.us, to confirm your attendance. (Because of the scheduled Senate session on Friday Mr. St. John will be facilitating the meeting for Senator Smith.)

Thank you for your time and your leadership.

2/. ICEHS Section Newsletter, Archivist ‘s Attic: Oct 2009 Overall Summary of historicalstructure, organizations and dynamics of Albany, NYS Communities’ Funded Gun Violence Prevention Programs:

Against Historical Rapids and With Momentum Toward Upstream Stepping Stones for Prevention of Urban Injury Violence: One State’s -City's Collaborations in Kayak Steering * My commentary below, from meeting minutes, my prior testimonies before the City of Albany, NY, the state capital area written press, journal and memoirs; serves as one nascent ongoing case study for possible role playing by injury control policy makers, researchers, practitioners, educators and student leaders, particularly, with a formative, ‘out of the box’ linking of gun and violent injury prevention to broader urban public and public health themes (e.g. Like “Water and Public Health”, the theme of this year’s Annual APHA Meeting or WHO’s traffic safety or violent injury prevention in the national health reform advocacy agendas. Injury control research and practice agendas have been re-leverage and reset with broader social, economic, and cultural issues.) Secondly, this commentary, catalyzed from the recent City of Albany, NY, Gun Violence Prevention Task Force Report, (TFGV) Final Report and Recommendations, offers from the TFGV, a useful review and footnote bookshelf for “what works” or is promising in urban violence prevention. That review was done with the cooperation of national, states and local resource expert consultations from prior work: (http://www.albanyny.org/Government/CityOfficials/CommonCouncil/GunViolenceTaskForce.aspx). The TFGV Recommendations have led, subsequently, to broader academic and community- based collaborative violence prevention program planning and funding options. Thirdly, I invite public health injury control and policy students to apply Team–Based Learning (TBL) about my commentary, as a case study and for role playing, to the public health policy and injury control systems professional literature (for excellent examples, see: Brownson RC, Chriqui, JF, et al. Government, Politics and Law. Policy, Politics, and Collective Action. Understanding Evidence –Based Public Health Policy. Amer J Public Health. 99:2009; 1576-1583 and Runyan CW. Introduction: Back to the Future – Revisiting Haddon’s Conceptualization of Injury Epidemiology and Prevention. Epidemiologic Reviews 2003; 25:60-64.; Fisher L. Childhood injuries - Causes, preventive theories, and case studies; an overview on the role of the sanitarian and other health professionals. Journal of Environmental Health 1988; 2:123-6.). Finally, our teachers may also apply other recent leadership literature framings of the process and outcomes for TBL to enhance present and future injury control leadership competencies: These framings use newer modern archetypes leadership systems during formative injury prevention evaluations for best practices. This is in contrast to some currently used ‘snapshots’ of components of classical formative evaluation planning, organizing, initiating, directing but also include real world vagaries and contradictions especially on the limits of evidence-based science during fluidity, dynamics of leaders’ values and competencies, and gradient powers and influences (1-5).

Abstract of Commentary

Background: In April 2009, new momentum for four nascent urban New York State regional violence prevention initiatives began under then NY Senate Majority Leader Malcolm Smith's, Member Initiative. His sponsored SNUG violence prevention program law appropriated, Statewide, $4.0Million linked to violence prevention outreach consultation from evidence-based Cease Fire, Chicago funded by Robert Woods Johnson. As of mid July, this bid to cut statewide violence was 'held hostage' due to a June 10 NY State Senate leadership coup that relieved

Senator Smith of his Senate leadership. In August, request for proposals were issued by the NY State Senate and applications are now under its review.

Methods: I will describe, in part from our Albany, NY, meeting minutes and my memoir, as a public health seasoned veteran participant, sample fluid applications of the public health practice model - assessment, policy options and assurances - for several key system components. More details are reported in www.timesunion.org archives (search: guns, gun violence, SNUG, Cease Fire)

Results: These components include: The ongoing collection of shooting data for advocacy ; the establishment and actions on The Final Report and Recommendations of the City of Albany (NY) Gun Violence Task Force that reviewed and adapted prior and new nationwide and local effective or promising prevention strategies ; the creation and programming of the community stakeholders' Community Coalition to Prevention Violence, specifically its lobbying of the State Legislature for passage of the State Majority Leader's $4.0 million funding law ; and the subsequent State University at Albany four graduate school collaborative steering committee program planning, under the University's administration, pending state funding.

Conclusions: Parts of this leadership archetype may be transferable to other injury control coalition programs to prevent, reduce or ameliorate - upstream - the flowing rapids of urban violence - especially during current states' and national economic and political turbulence.

A. Background

CDC's 2007 Fact Sheet: Total costs associated with nonfatal injuries and deaths due to interpersonal- self-directed violence in 2000 were more than $70 billion, 92 per cent was lost productivity; about $5.6 billion was spent on medical care for the more than 2.5 million injuries due to interpersonal and self-directed violence. Substantial cost savings of 10-40$ are predictable from many known evidence-based violence prevention strategies. A most significant urban injury death is homicidal shootings; in the City of Albany, NY, about 30-40 shootings take place yearly.

B. Methods: Preventive Components - Albany

1. City of Albany (NY), Task Force on Gun Violence (TFGV) Report and Recommendations.

For many years, Albany City Common Council (ACC) lawmakers, Dominick Calsolaro and Barbara Smith advocated for City actions to prevent gun related violence in low income areas. Leonard Morgenbesser, a City resident and criminal justice expert, continually researched and reported the number and types of shootings reported in the Albany Times Union (TU) written press. Due in part to that advocacy, in May 2008, the City's Common Council established the TFGV to report within one year on its findings on the causes of the City's shootings and recommend appropriate policy options. The 13-member research-practice panel was appointed by the City Mayor and ACC from applicants. I served, as the only non-City-resident. Diverse member perspectives included: three local clergy, and the County District Attorney, two private attorneys, the City Treasurer, the City Chief of Police, a criminal justice professor of State U of NY, Leonard Morgenbesser, a mother whose child had been shot, and Hon. Barbara Smith, liaison to ACC, etc. (I was reported in the TU as an group organization expert and I prepared at the TFGV chair, Rev John Miller's request, the initial meeting agenda, moved for an elected vice chair, Rev. Edward Smart, and helped with group interpersonal dynamics of collaborations. In truth, I primarily offered the public health VP prospective and my resource expertise tracked

and shared similar historical national and local task reports and reviews of the latest evidence-based and promising literature and related dynamics in actual program activations. I also served in each preventive component (below) as that public health, injury control and leadership models expert. With the help of national resources, I tried to leverage any, conflicting though complimentary local power and influence (1) with newer public health prevention models from my almost half century of seasoned veteran experiences.

The TFGV Report (http://www.albanyny.org/Government/CityOfficials/CommonCouncil/GunViolenceTaskForce.aspx pages 25ff): “We met as a Task Force semi-monthly, with a regular two hour meeting ... bimonthly ..., for a total of 25 meetings, all but ... which was open to the public... we allowed for public comment at other meetings and in many instances throughout our meetings, and not only at their conclusion. The recorded minutes of these meetings are included ... We held four public forums for ... community input ... in different locations across the city, to facilitate participation by different segments of the community, but especially those most directly affected by gun violence ... On Feb 18, 2008, then NYS Senate Majority Leader Malcolm Smith, at the calling of Len Morgenbesser, because of his major interest in violence prevention visited the TF meeting expressing his support for gun violence prevention with his SNUG proposal ...” From the minutes of TF Meeting 2/18/08, Senator Smith: “Part of the reason why it's important I got this invitation and decided to come today is because we recognize that this gun problem is a major problem in this state. What affects Albany effects everywhere. We had a summit recently where we had members from Chicago Ceasefire and we have a plan called Operation SNUGS' four components: 1) Site intervention, which involves the community partnering up with law enforcement 2) National, State, and local funding initiatives we have project ceasefire that can do pilot program with intervention in the hospital 3) Use of Celebrities and centers, we have engaged a number of celebrities from the Youth summit to say that guns is not something that is attractive and shouldn't feel good about it Centers, there are a number in our community public and private 4) Gangs, guns, and gainful employment we are looking to got to companies where they are receiving state funding and state subsidies and ask them to make a serious effort to provide gainful employment ... the SNUG program in all NYS regions.” I had connected the TF by conference call with Cease Fire staff.

On Aug 9, 2008, Sen. Smith, the Senate Majority Leader, held meetings with three Chicago Cease Fire reps who later toured Albany areas with John Cutro, Youth Violence Intervention, Restorative Conferencing, Violence Interrupter. Cease Fire founder, Gary Slutkin, MD, an AIDS medical epidemiologist practitioner in Africa observed that the prevention or control of spread of AIDS - and violence- relied on keeping a separation, an embargo, between the source and a subsequent carrier. He concluded that if you stop the infection at its sources you can interrupt the incident spread ... Cease Fire has five core components, linked to SNUG.

2. The Community Coalition to Prevent (all) Violence (CCPV). By February 2009, that Coalition of community-based stakeholders was established and named (per my suggestion initially as ad hoc) to maintain an independence from any government agency. It met twice a month, under Chair Hon. Barbara Smith and formulated a main goal to lobby key NYS legislative leaders for passage of a member initiative bill to fund NYS Senate Majority Smith's $4.0 Million appropriation. The CCPV legislative expert members, David Kaczynski, Exec Director, New Yorkers for Alternative to the Death Penalty and the veteran state budget leadership of Dahlia Herring, then Inner City Youth and family Coalition developed, brought together and we framed

talking points that successfully guided us during meetings each key legislative leaders of ways and means finance, health, and criminal justice committees.

C. Results: Process, Content and Outcomes

1. TFG Violence: Process

From the TFGV Report (pp4ff) : "The Data Committee gathered information on the incidence and type of violence in Albany and other cities, and assembled information on the effectiveness of various measures to control and prevent gun violence. The Prevention Committee identified root causes and immediate causes of gun violence in Albany and investigated prevention and intervention programs in other cities. The Community Action Committee held conversations with people in the community to hear their concerns, experiences, and ideas about gun violence. One such meeting was with youth who attend Teen Night at the YMCA on Saturday evenings. The Task Force has endeavored to take full advantage of information - including but not limited to scientific research – on violence-reduction initiatives in other U.S. cities, at the same time that we tried to take account of the potentially unique elements of Albany's patterns of violence and Albany's history and existing structure of community and governmental programs and resources."

"We did not wish to reinvent any wheels, and we did not presume that our individual and collective experiences and perceptions are superior sources of knowledge and insight about violence reduction, but neither did we presume that we should overlook our experiences or those of others who shared them with us, in favor of only research-based evidence. We have, therefore, drawn eclectically on accounts of the causes of violence and the effectiveness of violence reduction initiatives that can be found in scientific literature, on information about other promising but unevaluated programs, on the information provided by invited guests and other members of the public at Task Force meetings and public forums, and on our own backgrounds and experiences."

"We reached out to the community as much as practicable. Many Task Force members reported conducting outside reading addressing gun and other types of violence. We have, then, sought to include invited guests..... including John Cutro (Albany Restorative Justice), and Dr. Mark Gestring (Trauma Surgeon at Strong Memorial Hospital) that understand gun violence in statistical, scientific, and human terms, and to use all available information to formulate recommendations for its control and prevention."

Dr. Robert Worden, SUNYA criminal justice professor and TF member, prepared the TFGV Report and Recommendations.

Early on, the TF was shown epi-type spot maps done by a ACC student intern of 2-3 highest violence areas of the city and overlays (of lacking) public services in those areas. I had asked for overlays of both maps for our TF Final Report. Our list of 18 Recommendations was not done with a formal Delphi facilitated technique (as I had proposed) but by going around the room and listing our priority recommendations. In that Report, CEASE FIRE is recommended with other strategies including hospital and community –based universal violence prevention education in public schools, use of public health nurses' visits, etc.

The TF members differed at what we had totally done. Some wanted more passion in the Report, (ergo, our member commentaries in the first section of the Report) others more data, etc. All was included making the Report extensive but separating out the Recommendations that most others

would actually read. Of course, interest group wanted to appear more prominent in the work they and done. Wisely the TF Report writer and the group chose many evidence-based findings, in spite of the given potential for no real City quick responses to the Report and Recommendations. Seven months after the TFGV Report, late June 2009, the City started to solicit for members of a TFGV recommendation for a City Initiation Committee. In my interview, I restated the essential first need for the City to review, reallocate and restructure its organization on urban violence; I was not chosen.
http://www.timesunion.com/AspStories/story.asp?storyID=839708&category=REGION

2. CCPV: Development and Planning

CCPV lobbying action planning that began 4/21/09, led to passage of Malcolm Smith's legislative “member initiative” (not to be confused with a “member item’) legislation- law (line 29ff) in the State Budget. It applies, $4.0 M federal Byrne funds: Public Protection Appropriation Bill. A.150-C/S.50-C. March 29, 2009. SNUG: State Operations Aid to the Division of Criminal Justice which would develop a type RFP and then disperse the funds for expenses of establishment of regional Operation SNUG. Legislative Responses: “Tough year can't do; great resource talking points including the TF Recommendations Report handout ...”

3. State of NY at Albany SNUG/CeaseFire Planning and Initiation

Nevertheless, the bill passed with the Senate Majority Smith’s leader leverage and our background message of cost savings and cost containment; (from my prior journal papers, and experiences in passage of the NYS 1986 $6.0 Million hospital increased Medicaid rate reimbursement, Poison Control Center Network Law - I handed legislators' take-home stickers for National Poison Prevention Week

Sen. Malcolm Smith and his aides had kept in continue contact with Barbara Smith and the CCPV as he approached members of the State Senate and Assembly for a member funding initiative, SNUG line item, while the Coalition members carried out lobbying in the NYS for all regions of the state. The SNUG line item passed the State legislature and the Governor with the Division of Criminal Justice anticipated funding of $500T per site (Rochester, Buffalo, Syracuse, Albany, Westchester, and three sites in NYC); the law also links to the Chicago Cease Fire funds to conduct the statewide regional training and accounting- needed for any next years NYS restoration funding.
e.g.http://www.timesunion.com/AspStories/story.asp?storyID=795410&category=REGION

Barbara Smith, Chair CCPV, suggested a follow-up debriefing session with the CCPV. Her strategic recommendation, partnering with the University at Albany, SUNY School of Social Work, (SSW), received enthusiastic support from SSW, Dean Kathleen Briar-Lawson who quickly “went shopping” and obtained the University administrative support for SNUG from the deans of the Schools of Public Health, Criminal Justice, and Education, a similar administrative model of the University Chicago's Cease Fire. Operation SNUG/Cease Fire meetings, started April 21, 2009, are jointly chaired by Barbara Smith and University at Albany School of Social Work, Dean Briar-Lawson and developed written goals, measurable, specific, doable objectives, activities, outcomes and time-lines from four subcommittees and for nationwide funding sources.

D. Conclusions

The leadership, gradient steps of the momentum of the City of Albany GVTF Final Report and Recommendations, especially on Cease Fire; of the grass route Coalition's role with the State

University's steering and subcommittees and of NYS Majority Leader's leveraged forthcoming 4.0M$ funds; were nascent stepping stones for injury prevention and cost containment in rough state and national economic waters affecting emerging and longstanding effective regional violence prevention programs. As of late August 2009, the described formative momentum process is the outcome.

Injury prevention for Johann Frank, in 1788, the father of public health programming, was the newer “injury scourges on the land” (6-7). However, it was borne malformed and took decades of gradient historical reforms in public and professional health acceptance. In that history, our field has not been effectively linked with other external systems and happenings. Where rare systems’ challenges of changes agents have invented the better future for injury prevention, evidence-based linkages to interventions took place but usually a ‘step child’, disproportional to societal losses and costs, on major institutionalized national, state and local funds.

Today, even during major sea changes, various navigating leaders’ temperaments continue to trump over all. And the 'thunder of the history' from effective public health and injury control can and will tower over the present fluidity for long term gun violence and injury prevention outcomes, like a mountain.

Back to the APHA Annual Meeting theme, “Water and Public Health”: One of our greatest ancient leaders, Moses, started his career in the water currents of the nourishing Nile. His journey, as ours today, was not to complete the work but, for us, to move our IP leadership systems research, practice, teaching and rhetoric, forward.

*My views are mine and do not necessarily represent others’.

Eternal thanks to Dr. Sandy Schuman at the State University of NY at Albany for his endless help in word processing, et al. For the rest, thank you, John Lundell, Editor, ICEHS Newsletter!

Les Fisher M.P.H. Archivist, American Public Health Association, Injury Control and Emergency Health Services Section, at www.icehs.org and extranet.icehs.org - see my monthly newsletter commentaries, Archivist Attic, my monographs on the histories of injury prevention leadership at icehs section website, members only, and related written press opinions, at www.timesunion.com archives. For specific ‘Archivist Attics’ on the above system archetype themes in modern IP leadership dynamics, see, for examples, my ‘Archivist Attic’, injury prevention leadership commentaries in ICEHS Newsletters- Sept 2003; May and Sept 2004; Feb, March, June 2006; March, Aug 2009 and: Fisher, L. Editorial: dissent - traditional public health injury control does not apply to violence. Injury Prevention 1999;5: 13-14.

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3/. Talking Points during visits to NYS Legislative Committee Chairs:

LEGISLATIVE VISITS
TALKING POINTS

A. Who we are and why we are visiting you:

- We are members of the Community Coalition to Prevent Violence based in Albany (briefly provide individual introductions)

- We are here to ask you to support Majority Leader Malcolm Smith's *Operation SNUG initiative.*

- Operation SNUG:
  - Guns spelled backwards
  - Provides coherent series of interventions to address violence, especially among youth and in economically disenfranchised neighborhoods.
  - SNUG Coalition are community organizations in "The Big Five" cities (NYC, Buffalo, Rochester, Syracuse, and Albany).

- Our plans in Albany to implement Operation SNUG at this time. We have a two-pronged approach based on best practices in the nation.
  - Violence prevention/interruption on the streets (place where it is occurring) (Chicago CeaseFire model)
  - Violence prevention through a hospital-based program (work with victim in the hospital setting to prevent retaliation).

- Our long-term vision is a holistic approach of education and community services for children, youth, and families in poor neighborhoods. (Harlem Children's Zone model).

- The context of our work in Albany to-date.
  - The City of Albany's Gun Violence Task Force recently issued a report and recommendations on the CeaseFire model, hospital-based violence prevention and other evidence-based, public health violence prevention/intervention strategies.

- The Community Coalition to prevent Violence is a grassroots organization made up of community leaders, and violence prevention practitioners. The Coalition is concerned about all violence in the City (not just confined to gun violence.)
- For a number of years, we have operated a violence interruption program on a "shoe string" with practitioners working at the epicenter of violence in our challenged neighborhoods. This violence interruption team, supported by meager grants that have now dried up, work with the victims, offenders and their family and friends to put a halt to the cycle of retaliation.
- A new hospital-based program at Albany Medical Center brings in a team of violence interrupters, grief counselors and others to support the victim and his/her family.

B. Prevention/Interruption of violence (Project Ceasefire model)

1. What it is:

- Our purpose is to reduce and prevent violence especially shootings, stabbing and killings.

- From 2006 through 2008 Dr. Leonard Morgenbesser, using media sources, recorded 100 civilian-on-civilian shooting incidents, 128 civilians injured by gun fire, 12 of which were fatal. During 2008 there were 31 shooting incidents, 41 civilians injured, 6 of which were fatal.

- Our goal is to implement Chicago's Project CeaseFire Model in Albany.
- CeaseFire is the gold standard by which other violence interruption programs are measured.
- President Obama has included CeaseFire in his urban policy agenda and has identified it as a model for ending the "dangerous cycle of youth violence."

- CeaseFire has five core components:
  - Mobilize the community by building neighborhood-based coalitions of local law enforcement, community-based organizations, residents, and others.
  - Launch a public education campaign to change behaviors and promote nonviolence.
  - Build strong partnerships between the community and local law enforcement.
  - Involve leaders and members of the faith community.
  - Directly reach out to youth using paid outreach workers.

- Outreach workers are street-smart people with credibility in their local neighborhoods. They build long-term relationships/trust with at-risk youth, and work on the streets at all hours to prevent or interrupt violent incidents.

2. **How it addresses public safety issues:**
   - Law enforcement has a crucial role to play, but its primary function is to intervene at the point when the incident is already in progress. Often the damage is already done.
   - We need to prevent the violence before it occurs.
   - The research by the Chicago CeaseFire Project - estimated 461 shootings were prevented directly as a result of the program.

   - Baltimore has a program called Safe Streets, based on the Ceasefire model. The Johns Hopkins University assessment of this program shows promising impacts.

   - An interim, independent evaluation conducted by a Johns Hopkins University team found that in a 15-month period Safe Streets prevented four homicides in one neighborhood (McElderry Park) and significantly reduced homicides of victims under 30 years old in other areas of Baltimore. (From Johns Hopkins University, January 20, 2009, article by Greg Rienze, *The Gazette.)*

3. **How it addresses public health issues:**
   - Project CeaseFire applies the principles of public health to street violence.
   - Gary Slutkin, its founder, is a doctor who worked in Africa for 10 years to battle infectious diseases.
   - He concluded that if you stop the infection at its sources you can interrupt the spread of the disease.
   - In a *New York Times* magazine article Dr. Slutkin stated – "Violent activity predicts the next violent activity like HIV predicts the next HIV." (from Alex Kotlowitz article, *New York Times,* May 4, 2008) Epidemic levels of violence have numerous negative effects upon the overall health of those communities where thy most frequently occur. These include permanent disability, social and family disruption, and psychological trauma.
   - Therefore, interrupting one violent incident will have a multiplier affect in preventing future incidents and in curtailing the detrimental effects of rampant violence upon the health of the community.

4. **Why funding is an investment:**

   - The cost of violence is much greater than its prevention or interruption.
   - On average every incident of violence costs from $15,000 - $25,000 in hospital costs, $57,000 in lost productivity,
   - The average cost to incarcerate a youth in a DFY facility is $125,000 for 10 months.

- In addition there may be associated costs for the judicial process, and mental health costs for all of the parties affected, etc.

- The best predictor of future violence is past violence. In other words each shooting or stabbing incident that is not interrupted often results in retaliation, which then can produce a chain reaction of violence.
- Therefore, the interruption of one single violent incident prevents future incidents.
- The multiplier effect of prevention translates into a significant return on taxpayer investment in violence interruption.
- The Chicago CeaseFire Project indicated that from 2000 to 2004
    - 461 shootings were prevented
    - Total cost savings $81 million ($18 million in medical and $63 million in criminal justice savings.)

C. Hospital-Based Violence Prevention

1. What it is:

- Working with Albany Medical Hospital Emergency
- A team of grief/trauma counselors, social workers, and outreach workers are on call.
- The team works with the victim to mediate conflicts, prevent retaliation, andfacilitate the victim's access to other needed services.
- Two ultimate goals for this program:
    - Prevent retaliation against the perpetrators of the violence.
    - As appropriate, help victim to re-examine his/her own situation and consider better alternatives

2. How it addresses public safety issues:

- Research shows that people involved in violence are significantly more likely to commit further violence.
- There are various points when an intervention has proven to be the most successful.
- One of those points is immediately after the incident occurs and before the victim is released from the hospital.
- Research on the Baltimore and Chicago hospital based programs has shown that those victims who received these kinds of services were less likely to be hospitalized in the future for violent injuries than the control groups. (Albany Gun Violence Task Force Report, Appendix D, p. 3)

6/.
Read more: ***http://www.timesunion.com/default/article/Anti-violence-program-gasps-for-life-1313771.php#ixzz1I5Ka5c2S***

7/. September 27, 2011 at 6:00 am by TU Editorial Board, Times Union, ALB NY

Our opinion: Killing anti-gun violence program that has barely gotten started in cities around the state is shortsighted. Money could be found if the Legislature's priorities were straighter.

It's easy to be skeptical when a program comes along promising to be the next big thing in fighting crime. But when there are early signs that an effort might be helping to save lives and giving neighborhoods hope, letting it die for want of money would seem to be, if not criminal, certainly negligent.

Here's Operation SNUG, stripped of state funding after only two years. The money dried up not because of any apparent failing on the program's part, but because this $4 million anti-crime effort didn't rank high enough in the priorities that shape a $131.7 billion budget.

With SNUG relying on funding pushed by the heavily urban Senate Democrats, it also didn't help that control of the Senate shifted to the largely suburban and rural Republicans.

Yet, no matter who's in control, a Legislature that is still sitting on $124 million in discretionary funds, and spending the money on things like a zoo tram in Binghamton and a music festival in Westchester County, ought to rethink its priorities.

To be sure, SNUG is not a panacea, and its brief track record is mixed. The 22 shootings Albany saw in the first seven months of this year are on par with 2009, the year in which SNUG was first funded. But compared with 2010, shootings are down by about a third. In other cities where SNUG was also implemented, they're down by 5 percent in Buffalo, 40 percent in Rochester, and almost 42 percent in Yonkers. They rose, however, by 18 percent in Syracuse.

Based on an acclaimed Chicago program called CeaseFire, SNUG treats violence as a public health problem, identifying causes, potential shooters, and likely victims. "Violence interrupters" try to preventshootings, which are often retaliatory, before they happen. The local program, run by the University at Albany School of Social Work and the non-profit Trinity Alliance with support from the Albany Police Department, also seeks to change the mind-set that gun violence is a norm.

There is much more to be done, of course, in getting to the root of crime in poverty-plagued neighborhoods like West Hill. As Albany Police Chief Steven Krokoff puts it, "If you're growing up in a community where you have no hope and you feel it's almost your destiny to either be dead or in prison by the time you're 25 or 30, deterrence has almost no effect."

But what's promising about SNUG is that it appears to be the kind of program cities like Albany need as they shift from traditional law enforcement to community policing, and develop strategies that go beyond patrols, investigations, and arrests. Participants in the program say there is growing community involvement, with more people showing up at public anti-violence demonstrations, a sign both that it is resonating with residents and that they are feeling a sense of safety in numbers.

While SNUG might well be able to operate on a leaner budget, the question for the city and the Legislature is whether they can afford to entirely abandon a program that has barely had a chance to try to help save lives — not just the lives of people intentionally shooting at each other, but innocent victims who get caught in the crossfire.

It's the kind of program that could actually give pork a good name.

8/. See also: Sh'ma: A Journal of Jewish Responsibility (November 2009), the full issue ongun control, www.shmadigital.com, published my perspectives on page 2.

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Continuation of subsequent related letters to Times Union editor:Redirect money from buybacks

First published in Albany, NY Times Union: Tuesday, March 16, 2010

Kudos for your fine March 10 story, "Anti-violence tool, or just window dressing?" about the gun buyback program in Albany, and to Albany County Legislator Wanda Willingham for her comments and vote.

While the intentions of some Albany city and county leaders in supporting gun buyback programs are admirable, feeling good about such actions is not the same as investing in what really works in violence prevention.

I am a former member of the City of Albany Gun Violence Task. Many of the recommendations in our report cite very promising, effective, and potentially cost-saving interventions. Gun buybacks weren't considered an effective recommendation.

Reports in international and U.S. scientific literature show that the guns bought back are not those that pose a risk of violence. Nor are the numbers of guns collected statistically large enough for any direct impact on violence.

Why not use the $10,000 that the Albany County Legislature approved for the buyback program for effective program planning or creative collaborative matching grants with local, state, and national governments, business and foundations for the promising or effective efforts cited in the task force report?

This includes work being done by the Coalition for Violence Prevention and the State University, changes in curricula in low-income area schools to universal evidence-based violence prevention and home visits by trained community health workers.

Les Fisher, Bethlehem

Unused pork can help fund SNUG

Published 12:00 a.m., Saturday, October 15, 2011. Times Union, Albany NY Opinion

Kudos to the Times Union for its news coverage of the critical need for continued state funding of Operation SNUG, and to the editorial board for its advocacy for the program ("SNUG deserves a chance to work," editorial, Sept. 27).

SNUG, a community- and hospital-based violence prevention program, follows the model of Chicago's CeaseFire, which has been documented by the U.S. Justice Department and universities for its significant cost-savings and cost-containment.

During the Great Depression, state Health Commissioner Edward Godfrey published a seminal article that reflects today's need for the Legislature to continue funding SNUG.

"Few... are displaying any interest in prevention of injury and death. ...They are content that statistics shall be tabulated and published, leaving prevention entirely to other agencies or the will of God.... It is the field of home and public accidents however, that I believe ...has the greatest responsibility and opportunity," he wrote.

Today, it's gun violence for which we would rather report stats. As in Godfrey's day, we would rather blame the victim, when in reality we are the victim. In our cities, it's homicides involving illegal guns. In our suburbs and rural areas, it's gun-related suicides.

Godfrey's advocacy as health commissioner and president of the American Public Health Association offered a legacy for subsequent state and national collaborations to attack the injury scourge of that time.

Today, we need the state to continue funding SNUG. This is not about gun rights; it's about more responsibilities and rights for the state, not the federal government which cannot under law fund such effective programs.

If we are concerned about the economics of government programs, consider that for each state dollar spent on SNUG, many more will be saved by significant decreases in serious injury and related medical costs often paid through Medicaid.

Start writing the history of an effective, cost-containing violence prevention program in New York now. Continue funding SNUG, especially with unused legislative "pork."

Les Fisher, M.P.H.

Delmar

The writer is a safety/leadership consultant and archivist for the American Public Health Association, Injury Control and Emergency Health Services Section.

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And, in memoriam of Albany, gun homicide data collector, Leonard Morgenbesser:

http://www.timesunion.com/opinion/article/Letter-Thanks-for-tribute-to-Morgenbesser-4410331.php

Work is needed to prevent gun suicides

By Letters to the editor ,Albany, NY. Times Union on October 23, 2016 at 2:36 AM

I will not argue with Russ Williams on the right to bear arms (“A clear call for arms,” Oct. 2).

I will, however, mention that, although the nation was founded on the Constitution and freedoms for all, founders recognized the need to serve more than themselves for our free society to function.

In Colorado, a nascent collaboration is attempting to reduce gun suicides. There, gun shops in collaboration with university public health workers are attempting to better inform purchasers to consider, for example: Off-site storage if a family member may be suicidal. I am hopeful many other gun shops are doing, or will be doing, the same within some evidenced-based, gun-suicide-prevention framing.

To those who wish to reduce the argument to simply gun freedoms and rights, I challenge them to volunteer and link with other diverse groups to collaboratively innovate to limit death and injury, using best practices framed by the broader societal and personal costs of gun suicide and homicide.

Restoring federal funding for gun-injury prevention research, cut for over a decade, will not take place soon. However, some interim, volunteer actions by industry, government and consumers may just lead to historical impacts in future gun suicide prevention.

Les Fisher

Former member, City of Albany Gun Violence Prevention Task Force

Delmar

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Letter: Gun violence needs prevention research

To the albany ny Times Union editor. Published 5:25 pm, Monday, June 19, 2017

There has been more gun violence. A congressman, staff and Capitol Police were shot and, then, in California, there were job-related gun deaths.

Yet, there remains a ban on any ecological studies of causes: What did the shooter eat at his last meal? Why so many employee shootings in postal environments? Is there a history of family, weapons, injuries, etc.

There is little national focus on prevention research on the interacting causes, and Congress does not lift the federal ban on studies involving public health, including the National Institutes of Health, National Institute of Mental Health and the Centers for Disease Control and Prevention. There also aren't joint criminal justice and public health site studies, within 24 hours, about these incidents.

Historically, it's time to move ahead.

Les Fisher

Delmar

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My commentary:

http://www.timesunion.com/opinion/article/Trump-s-unwise-public-health-cuts-12238331.php

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More sample resources:

1. APHA Nation's Health editorial. Also, gun violence prevention resource listings are at www.apha.org site:

http://thenationshealth.aphapublications.org/content/43/3/1.2.full

2. See also my ICEHS Section Newsletter archivist attics comment on gun violence prevention history:

March2015 - "Putdowns" archetypes and gun violence

June 2013 (V20No4) – Use of Progressive context, commissions on guns

July 2012 (V19No2) –Silent Spring's, Cold War 's, gun violence contextual paradigm

3. My review of related gun violence prevention histories:

http://www.amazon.com/Lead-Wars-Politics-Americas-California/dp/0520283937 and links to the gun violence history

See my book review at: https://www.amazon.com/Teaching-about-Future-Peter-Bishop/dp/0230363490

4. http://www.timesunion.com/opinion/article/Trump-s-unwise-public-health-cuts-12238331.php

5. Finally, NYS' (gun) S.A.F.E Act, 2013:

Challenged in courts; the law cannot limit the amount of bullets in guns and gun sales:

http://blog.timesunion.com/opinion/the-year-of-doing-nothing/26931/

http://www.timesunion.com/local/article/Gun-law-survives-test-5105927.php

http://blog.timesunion.com/opinion/round-two-for-the-safe-act/27096/

http://www.timesunion.com/default/article/LeBrun-Gun-rights-folks-in-a-good-place-5114328.php

In 2017, NYS Governor Cuomo established a Suicide Prevention Task Force. I provided resource expert archives of my related work to the Office of Mental Health, the lead stateagency. https://www.governor.ny.gov/news/governor-cuomo-announces-launch-suicide- prevention-task-force[217]

Recommendations and Conclusions

In Toto, over decades, the dynamic interplay of theory, facts, values, and actions of public healthpractices by individuals, groups and organizations on injury prevention continues on accessing needs and values, develop policy options, planning, initiating and evaluating programs.
Reviewing and acting of these concerns will require our best mix of public health practices and leadership proficiencies during the 21st century for child safety, especially from violence, firearms and drugs during even greater economies, efficiencies and possible downsizing of overall public, private and voluntary budgets, and resources. The role of personalities trumps all.

And sometimes that same context of leadership personalities relate to somewhat serendipitous, future positives (*Dec 2016 ICEHS Section Newsletter, Archivist Attic)* for injury and violence prevention, as cited above : Fulfilling a SPH graduate school leave of absence (or job loss due to cuts by city government of new unfilled positions, from austerity) from the City of Philadelphia, Department of Public Health; appointment to the CPSC Advisory Committee following a limousine car ride with a fellow Penn State University alum, a CPSC Commissioner; quick majority party of the NYS Legislature, now dominant, passed and obtained the Governor's approval for the NYS Regional Poison Control Center Act and its enhanced hospital reimbursement funding of NYSDOH designated Regional Poison Control Center, legislation based on the context as 'cost savings', not especially for its public health value of prevention of injury; the Albany *ad hoc* community advocacy leaderships to the NYS Governor and Legislature, resulting in funding of NYS/federal discretionary US department of justice funding for CeaseFire local community programs. However, future forecasting permitted probable scenarios for actual events. (90) Make your own luck by using traits of attention, persistence and optimism (https://www.wsj.com/articles/to-be-successful-make-your-own-luck-1519921269?mod=searchresults&page=1&pos=1).

Les Fisher. Archivist Attic APHA ICEH Section 11/16/2016 Newsletter

Everything has a history - injury and violence prevention (IVP) is not an exception. Our founding American political history echoes up to the present like a mountain over our public polices, processes and outcomes.

"America is not liberal; ideologically, we are small government, capitalism, and social Darwinism. While that liberal US historical philosophy may 'bubble-up', serendipitously; we are, still, today, ideologically, a conservative-based nation". (www: MovieHistory.Us Hill Course, Delmar NY, (Session1),

And for all observers of that overlying historical conservative context, we needed more of founding father James Madison archetypical leadership of patience and working closely with both political allies and those he strongly opposed. Madison knew how to find, listen and make partnerships with moderates and extremes of the' loyal oppositions' of his day. Perhaps, historical lessons for the polarization on gun violence prevention … and most other politics, today? Founder Ben Franklin, served for politeness - another leadership competency from a founding father to imitate.

So, effective creative leadership to work with polarized conservative, liberal, technical, or political power, about IVP, especially actions affecting gun injury prevention, does not take place, nor return, quickly. Our historical IVP change agents' critical thinking was vertical and logical; but, more so, creative thinking for change, linked new ideas, horizontally, to do things, differently. And innovation requires not only an idea but its practical activation and compromises, as this story hints:

In the Boston harbor two lights were beginning to face each other.
The ship said: I am a cruiser and I request you change your position and course and go to the left.
I will not, was the response.
I am a cruiser and an admiral in the US navy; I demand you change your position and course.
I will not!
I demand immediate change in your course!
I am a five-star ship with rank.
I will not. I am a light house! (Based on: Proceedings of the US Navy Institute)

So, do look at our many U.S. and worldwide leadership historiographies for feasible gradient serendipitous transformations, with similar contexts, that effectively influenced our national and state data collection, evidence studies/research translation, prevention, treatment and rehabilitation of our many IVP and other public concerns Consider: 1) taking an American leadership history course and linking it to your historiographies or 2) skimming my Historiography -Leadership in Child Injury Prevention at: / http://www.medph.org/apha/injury-control-and-emergency-health-services). Historical outcome trends, thought, incorrectly as mostly a linear process, (y= mx + b), are actually a mix of cyclic (y=sine(x)), exponential (y =ce x) , and even more so, asymptotic (y= log (x) or S curves ! And, so, should be our framework forecasting.

And, maybe, in our visions of future histories, we need a few more recreations of James Madison's serendipity, especially for our future IVP "currency," not just on a 5T$ bill? Dialoging based not only on universal IVP but also on the particulars of gun rights by asking gun owners: "How do they see their role in gun suicide – the major gun death - prevention?" While

that innovative win -win collaboration is, for now, far from reality, there are a few new nascent IVP national and especially states' efforts. inherently framed on minimizing impacts of political angers and denials.

Let's still "dream the impossible" IVP dream and act how earlier historical leaders moved the IVP and other policy's evidence based "public well-being" mountains!

Personally, in my own public health career, when positive serendipitous innovation is "mused", I posit "Stepping to a different drummer's music". (Thoreau) – or humming" Fighting windmills, however measured or how far away". After Cervantes, Man of La Mancha's "Dream the Impossible Dream"-my career mantra!). or singing, "Moon River and Me ". These seem, somewhat, like universal American creative leadership values. And, so is James Madison's and Ben Franklin's values of serendipitous, interpersonal, compassionate, polite and empathetic leadership.

Les Fisher, MPH, Archivist, American Public Health Association, Injury and Emergency Health Service Section, Archivist and Historian,

Former, Assistant Director, Research and Policy Development, Public Health Management, NYS Department of Health,

Former Member City of Albany Gun Violence Prevention Task Force

Opinions are mine and not necessarily those of any group nor organization.

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Today, with COVID- 19 sequalae and impacts to IVP ,downsizing and budget challenged environments, we must learn, from historiographies of arts, not only from sciences, to focus on public health leadership contexts, framing and leveraging options of interpersonal skills and technical proficiencies to effectively formulate and integrate our injury and violence prevention goals:

New multidisciplinary collaborations can offer better public health efficiencies and effectiveness; jointly preventing air and water lead poisoning, air pollution, homicides Early focusing on spinoffs from Caviar's IVP sequala of suicides, homicides, child and adult poisonings, auto accidents, etc.

Public health education in history, human psychology, conceptual, management and policy skills, using veteran practitioner graduate school managers in residence'' lecturers, advisors, and panelists at national and state professional meetings may help also improve professional skills of

the IVP public health researcher. advocate and practitioner. (see below proposed syllabus) New York State ‘s IVP governmental, consumer and industrial leaders

And, “The issues that we debate today are not all new, neither are the solutions. Effective public health policy for child safety requires an 0standing of national and state practices and of history (91). National health and other state agencies may use similar reviews of previous published (and unpublished) work for acting on complex technical, interpersonal and policy inquiries on child health protection and safety practices (92

Which personalities, values and events will continue to improve “the thunder of history” of injury and violence prevention and control? How can the past contexts guide future forecasting?

We are all in the same boat, affected by each other’s rocking. http://bit.ly/same-boat.And using earlier wisdom, in combination with new training from management mind sets of “win—win” politics, coaching and nonhierarchical team relationships and with even newer leadership preferences, child injury preventive can maximize its public health and partner’s opportunities and successes on drugs, firearms or violence in the 21st century (93). We should recall the ancient wisdom in Leviticus 19which requires building fences on home roofs to prevent falls and to not place a tripping device in the path of the blind, certainly both relate to the need for comprehensive attention to al systems of child protection not just injuries — safe playgrounds may fix violence as well (79). and to those with nonsectarian views, we quote Socrates who said about effective child safety: If I could get to the highest plain in Athens, I would lift up my voice and say: What mean ye, my fellow citizens, that ye turn every stone to scrape wealth together, and take so little care of your children to whom ye must one day relinquish all?” Or do we still, as some ancient civilizations, promote “pedicide,” for one example suicide of young gun owners and users.

As the prophet Isaiah scolded the ancient Hebrews of his day, but also offered them consolation, as well, for the promise of moving the process of doing better, forward, so appropriate for the politics of gun safety rights, today, and the continued communal loss of child and adult lives and limbs by gun related suicide, homicide and non intentional injury in the USA, exceeding that of any other country combined*: “Your hands are full of blood” (Isaiah 1:15) “Learn to do well; Seek justice, relieve the oppressed, judge the fatherless, plead for the widow (Isaiah 1: 17). The princes are rebellious, the companions of thieves; everyone loves bribes, and follows after rewards; they judge not the fatherless, neither doth the cause of widow come unto them (Isaiah 1:23). And they shall bury their weapons and nations shall not lift up against nations, neither shall they learn war anymore. Justice, Justice you shall pursue! (Deut 11ff). Our free will to change is ours to pursue to fix our world.*

Part 5 Shaping the Millennium. From the History of Child - Home Injury in the United States, in public health journals, (1900 - 1975), to Policy Applications of Leadership Systems (with focus on health care)

Abstract

Researchers, practitioners, educators and legislators in public health injury prevention and control may have little formal training in management and policy leadership skills and proficiencies. Instead, the craft may only be learned on the job or through readings of

professional journals on a major health problem, its known or assumed etiology, and preventive practices. Especially with newer public health concerns, program plans and grant proposals are then planned, developed initiated, funded and assessed. Public health practices of assessment, policy development, assurances and management may not be structured into the process. Professional workers may also be unfamiliar with or not use competing models of leadership, ranging from human relations, innovation, rationale, and internal process models. Using several personally selected, archival articles from public health policy and leadership courses, mostly from the 1980's, the author offers a tapestry, only, of common weaknesses in application of injury prevention leadership, policy development and management models, and then suggests nascent leadership crafts for solutions, from the same archival literature on management, policy and leadership. This paper is meant to be just a tapestry, (at times from an underside view!), for possible further formal design and creative choosing the threads of several historical and seminal (1960's - 1980's) archives from health care reform policy management and from injury control literature, overlaid by several modern competing leadership values framework system supplements other more recent work. Each decade, new literature is published with limited historical system assessments.

Introduction

Prevention and control programs in federal, state, and local health agencies have grown rapidly over the last decades with extensively published program reports, studies and articles on the epidemiology, prevention and control of unreasonable risks; use, misuse, abuse; violence; diseases; injuries; disabilities; deaths; economic losses or other adverse sequelae (1—2). While empirical data are gathered, and reported, for such publications, an equal priority is to use leadership crafts of "professional value judgments", subjectively, to apply the new knowledge or for graduate school, history of injury control management and leadership courses to promote acceptance of alternatives approaches to help manage real world, applied scientific programs (3—6).

Adapted in part from the literature from The State University of New York, School of Public Health graduate courses in public health policy, on health care reform, management, leadership, in service courses on supervisory for New York State employees (5), and from the author's extensive work in child safety and from his collection (now at moved from the University of Colorado, SPH, Denver to the U of Washington or the Settle, VA), this paper identifies and expands upon a mid- management model of competing values framework, primarily for child safety managers; but also useful for other practitioners in preventive health. Many hard-political decisions are only briefly mentioned and might be part of another review. The second section offers several corresponding, solutions with an historical management/ leadership framework for prevention and protection from newer emerging safety risks to children and adolescents. The National Academy of Sciences in The Future of Public Health emphasizes that public health curricula contain management and leadership skills, not only technical and professional skills. Moreover, crosscutting public health practices of assessment, policy development and assurances remain under utilized (6).

Rational Assessment of Educational Needs: Barriers to Success

Goal Setting. Planning and Problem Solving

Improper handling of these management roles can lead practitioners to work on public health practices" harder, not smarter." Individuals with competencies of great enthusiasm and initiative may just" jump in" and" shoot from the hip" to save life arid limb without the use of clear goal—setting, planning or problem-solving strategies. For example, a newly hired health educator, to reduce a type of hand injury, may only prepare and distribute public information press releases and leaflets to local health agencies, without any attempt to determine if these are needed, used, nor effective for reducing hand injuries. Many taxpayers, who pay the public's bill, probably are entitled to more efficiency; earlier published experiences will guide current efforts (7-12).

Delegating

Many health care specialists trained to administer public health practice programs can become excellent advocates for health and safety (13—14). However, these leaders may not be equally trained in public health management and policy and may have difficulty in delegating authority or working cooperatively and in diverse group and team settings for reducing morbidity and mortality. These health professionals may have difficulty delegating because their past education and training may promote independent performance and the full responsibility for a patient in the medical setting is usually not delegated to others, at least not in classical medical training.

Because certain physicians and other professionals become managers without additional educational courses, teamwork and possibly productivity may suffer.

Howard Luft, in Economic Incentives and Clinical Decisions, points out that many physicians (and other disciplines) act as if diagnostic and treatment decisions were clear—cut and need not be discussed for consensus (14). They develop "standard operating rules" or "clinical policies" that dictate what should be done. They also ignore uncertainties and other possible options. Alain Enthoven in his book, Health Plan shows that the training of physicians as protectors of patients unwittingly can increase the cost of medical care. Health care providers may believe they are the sole decision makers for curing the sick patient at all costs (16).

Teamwork

Delegation also relates to interactions among public health practitioners to integrate diverse and specialized competencies:

Two cultures, the science, and the art of prevention, need not be engaged in separate revolutions(17). However, educators, practitioners, policymakers, and researchers may not ask for, appreciate, nor use each other's perspectives. Each has different themes and vocabularies. Kushner illustrates this weakness in suicide prevention. As the result of sociologists', psychoanalysts', psychiatrists', and neuropsychiatries' pursuit of causes during the last 70 years,the gap in preventive services has widened as each has denied explicitly the validity of the others' approaches and methods (18). We face this conflict in prevention services when avoidance of threatening ideas of others can be easier than to fully manage conflict and use an array of strategies to build on their strengths; such as enlisting and blending old and the new approaches. While diverse backgrounds and personalities may not always be cohesive, the

consequences of not accepting diverse backgrounds within and among public health and medical fields in management teams can lead to inefficient and ineffective preventive health services. In job cultures, difficult or supportive bosses and associates make or break the best technical approaches.

Monitoring and Critical Thinking

Louise B. Russell in" Is Prevention Better Than Cure?" illustrates the policy debate on vaccinations for smallpox and measles and drug therapy, for high blood pressure (19). Her thesis is that prevention is justifiable in its own right because the evidence is that these treatment-interventions rarely reduce overall medical expenses. Smallpox, measles, and drug therapy as long-standing institutionalized treatment programs, are rarely questioned on their effectiveness or efficiency. These programs must only be shown to be reasonably effective in addressing a given problem to be eligible for reimbursement funding, while newly developed and lower funded newer prevention programs must fully show that prevention works.

As with long—standing health programs (for example, in medical care, sanitation, nutrition, etc.) newer prevention programs may not show effectiveness, because of limited funding or technology, frequency of the health problem and short time periods for Intervention. Not only must attempts be made to show changes in morbidity and mortality associated with program interventions, but program surrogates such as risks, attitudes, and knowledge changes, must also be used in developing alternatives to assess, up front, the possible successes of alternative interventions (12).

Russell offers another solution about assessments. She stresses the need for a set of policy and managerial methods for evaluating the questions: what will this cost, and what effect will it have? The result is often described as cost per life saved. Traditional cost—benefit analysis, by contrast, is an attempt to evaluate everything in health benefits or dollars, which may be easier, but many people object to the idea that human lives can be represented by dollars. Such newer frameworks direct the scientist into those targets needing attention not based entirely on mortality or morbidity data but on feasibility and practicality for public health services.

Creativity and Innovative Leadership

Perhaps today, with limited resources for prevention, no role can be more substantial or necessary than creative thinking and leveraging change in public health leadership practices.

Creativity and the brokering of ideas are critical for developing prevention concepts for staffs, bosses, and legislative bodies. These skills are different from the critical skills used in assessments and analysis. Creative thinking often involves using information already known and finding new associations; at times it may appear illogical to an individual who strongly believes that all processes are objective and structured. On the other hand, the foundation of preventive health practices is the logic of the epidemiological research model or its application in demonstration programs to show negative health conditions can be improved. When such projects are completed in the absence of a major influx of new program support and permanent funding policies and organizational structures, the findings may not be used and the benefits cease. This lead, as Waller hinted, to eternally reincarnation of the Greek myth of Sisyphus, the figure doomed in Hades to roll, forever, a heavy stone uphill, only to roll down again.

And for creative thinking on the continuing changes required for risk communications to the public and other professionals:

How does the practitioner explain responsibility the different perceptions of hazards, risks and safety issues of toxic substances, diseases, drugs, and medical devices? How can industrial, voluntary, and governmental statesmen, involved in defining and preventing or controlling risks, best promote, together, public health? Where, in the literature, are effective interpersonal skills documented for promoting children's clothing flame retardant, automobiles with seat belts/air bags; lead-free housing or water which can help guide current risk communications. Another final example of a problem, especially for new prevention practitioners is the expectation that a new law or program can be created within a year. More than 10 to 20 years were required from an observation that a mold may stop bacteria growth on a Petri dish to penicillin's prescriptions, Applications of ideas to reduce burns by flame retardant, poisoning by safety closures, and motor vehicle injuries by protective compartments for occupants of motor vehicles, pasteurization of milk, chlorination of water or screening for lead poisoning or for birth defects required years. The growth curve for a new program requires many years to reach a fully operating condition, and it may be inappropriate to always use the same managerial or leadership style during development, planning, initiating, or assessing phases.

Part II: An in-service training syllabus for the Injury Control Researcher, Practitioner, Educator and Legislator: A Selected Archival Bookshelf on Injury Control and Health Care Reform - A Tapestry on Seminal Policy and Leadership Systems

> Part I of this MSS, RATIONAL ASSESSMENT OF EDUCATIONAL NEEDS: BARRIERS TO SUCCESS offered, from public policy archives, a theoretical tapestry of leadership systems. Part II, (below), HEALTH LEADERSHIP PRACTICE: TRAINING AND GRADUATE SCHOOL EDUCATIONAL SOLUTIONS IN PUBLIC, applies that archival base toward training on leadership solutions.

Training and Graduate School Educational Solutions in Health Leadership Practice Goal Setting, Planning, and Problem-Solving Leadership Crafts

As one example, one area:

What does the - policy literature suggest about graduate education for starting—up a project or for organizing steps to goal setting, problem solving or planning?

Moore, Behn, and Vaupel provide guidance about the probability that the decision to initiate the program (pI) may be greater than the cost to carry it out (pC) (25—26) which limited resources, what is the potential payoff for this or that public health activity? May and Allison describe" methods to address pre implementation problems and build consideration of implementation obstacles into the comparison of alternatives prescribed to decision—makers (27—28).An overall "primer" for policy analyses is provided by Stokey and Zeckhauser (29).

And after a policy decision is made on the worthiness of the project, what steps are routinely taught for goal setting and for problem solving? A leadership or management course offers such components.

Teamwork Leadership Crafts

“Teamwork” curricula might include exercises with small groups on decision—making, motivation, interpersonal communications, problem solving, Identifying, and using different managerial styles. To be successful, teams should be made up of, not of like, backgrounds, skills,and personalities, but diverse proficiencies. (https://youtu.be/pr9Xqf8oZDA)

A classical example of a” team building” exercise for a small program unit might be graduate students’ self-administration of a questionnaire on their leadership styles to determine balances for production vs. people issues. That self— analysis might help the inpatient supervisor, who begins to feel easily” rattled” by a slowly developing research project, recognize the need for time for a patient researcher to muddle through the planning stages, while he as a supervisor can focus on other issues that needs more immediate attention. The use of individual team member’s strengths in setting, initiating, and evaluating programs will build a better project.

Some case studies? How would you as a supervisor handle the over—ambitious for power oedipal employees who market a national event to their own name or who competitively” put down” others for their own advancement? Or the supervisor of two supervisors, one who is excessive in his/her people orientation management and the other in his/her production skills, both who continually are in conflict? What conflict or career management approaches and assertive boundaries are suitable, instead of avoidance or over—controlling management or leadership style.

Monitoring and Critical Thinking Leadership Crafts

A graduate course on management must include more than Gant Charts proficiencies to monitor the program’s progress, or routine spot checks progress of programs. The leader-manager must communicate constructively and clearly. But few professionals are taught the basics or a review of effective writing and speaking principles of selecting format, outlining, determining limits, organizing clearly and concisely. Bureaucratic cultural styles of communication need to be assessed so that individuals have an opportunity to constructively and positively discuss strengths present in writing, not only criticize weaknesses.

Creative Thinking and Innovative Leadership Crafts

Creative thinking helps institutionalize prevention programs. Behn suggests one approach: we can better sell our ideas by creatively considering in our requests on public health problems and solutions, the political inputs needed (e.g., losses of jobs, childhood morbidity, and income for hospital buildings) not just technical statements of numbers of disabilities and deaths per year (30)! As May recommended, we should craft our alternative ideas and assess potential errors guided by our understanding of what has worked elsewhere under possibly similar cultures and conditions (27).

And how should our program ideas be translated into long—standing institutionalized and funded programs?

McGinnis suggests we support new mandated preventive programs, currently funded from limited and restricted grants, from the larger ongoing insurance or other financed pools (31). In New York State, the poison prevention, and other preventive mandates are funded from Medicaid and other insurance dollars (21—25). As another creative example from the National

Highway Traffic Safety Act, (PL 89—564) new state and federal initiates can be linked to State matching funds or requirements so that states can receive and administer federal resources for preventive services rather than just apply for grants? Can professional fees be used? What other ways can we look at creating or using resources, differently?

Conclusions

Deniers of the evidence-based sciences takes place in every generation; more so today with social networking.(See : https://ethics.org.au/ethics-explainer-ad-hominem-fallacy/ .and Reductionist views won't stand the test of time

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An exaggerated prediction of not further expanding the current twin doctrines of etiology and epidemiology into courses on public health prevention and IVP evidence leadership with the collaborative efforts from the arts of economics, political, technical, and sociological drivers; could be recreations of Lost Discoveries, as Gulliver found in the mythological City of Lagado. There, evidence-based science deniers and revisionists, without value to public matters, engaged in potentially useless or dangerous projects (e.g., softening marble columns to make pillows or preventing the growth of wool on lambs!) (32-34). (BTW TRAVELS was a parody of King George.),

As public health preventive researchers, practitioners and advocates seek even greater critical excellence; our use, alone, of extensive epidemiologic disciplines may instead limit the potential for new practitioner's use of creative thinking.

As Haddon linked medicine with engineering (19), we must NOW link the science of epidemiology, medicine, and engineering to greater excellence in public/private integrated ecologic leaderships —not just working harder, but with smarter, innovative collaborative research, prevention, and advocacy. Our Journal articles should not only be descriptive and quantitative; but also report findings, recommendations and conclusions from crosscutting, ecological, holistic, and integrated research and prevention programs (11)

With the fluid health and economic impacts of increased air and water pollution, on COVID and the subsequent impact of suicides and homicides in the crowded low-income areas. it is essential to integrate public health IVP, .e. g. see: One Health Links People and Environment. Carolina Public Health, UNC School of Public Health.Fall2019.5:4, 14-15; or Guoqing Hu, Daniel Webster, Susan Baker. Hidden Homicide Increases in the USA, 1999-2005

COVID variants offer unique "challenges of change"; e.g., see: Typhoid Mary, (Leavitt, Judith Walzer. Typhoid Mary: Captive to the Public's Health. Boston: Beacon Press, 1996). Leavitt covers non-symptom carriers. (Source: Professor of History, Kendra Smith-Howard, State University of New York readings on the past "lessons" in the challenges of change, include e.g., appreciation of histories slow gradient, many times, non-linear progress.)

Also, note on www. the newer research IVP areas of communicability: See: Mary Duenwald: May 14, 2002 NYT article. Section F, page 68. and: Vianna N. and Polan A. Epidemiological Evidence for Transmission of Hodgkin's Disease. NEJM. 289. 499-502. 1973).

Histories of earlier public health issues and interventions may draw provocative contextual appreciations of earlier work and of COVIDs, today . and on IVP “Spinoffs” are” just upstream from COVID variants (See: Les Fisher. COMMENTARY. An Historian’s Future Attic Archives on Prevention Covid, Ecological Medicine and Public
Health Injury and Violence Prevention.
American Journal of Preventive Medicine and Public Health
2021 VOL 7, NO. 4, PAGE 197-199. and, Casie H. Morgan, Kristyn N. Jeffries, and David C. Schwebel): ACADEMIA Letters
Unintentional Pediatric Injury and the COVID-19 Pandemic: Data Trends and Prevention Strategies);

Consider these warnings:

- Bike and playground related injures increase now when kids are out of school,

- Safety of playgrounds from transmitting contact diseases, not only injuries.
- More toddlers at homes. Parent and grandparents/childcare know to call regional poison control center (RPCC) 1 800 222 1222? And also prevent, secondarily, a potentially preventable injurious pedestrian motor vehicle injury going shopping., to a hospital or doctor's office.
- At home homicides (urban low income by guns) and suicides (rural and suburbs by guns: Home interpersonal violence, many involving guns. See evidence based. www.cdc on ACE, and Cure Violence.
- Checking in for homebound friends and relatives needs
- Patio furniture and umbrellas’ lacerations when blown into glass doors.

- Chain saw cleanup injuries
- Charged cell phones and other sim appliances
- Falls off slippery ladders or roofs when removing debris
- During electrical failures, Carbon Monoxide deaths from use indoors of gasoline space heaters and barbeques for heating or cooking / handling downed power lines

See also and state authorities and https://www.cdc.gov/disasters/hurricanes/index.html

Advocacy in public health IVP history, using veteran consumer, industrial and governmental practitioner graduate school “IVP leaders in residence’’ targeted local meetings may help leadership skills in IVP public health researcher. advocates and practitioners. We mostly chat and hold conferences with ourselves, not other stakeholders?

Consistent with the overall recommendations of the Public Health Faculty, Agency Forum (35) to make public health education more relevant and practical contents of a graduate school course education must continually be upgraded to teach leadership systems crafts. Such syllabi probably already exist or needs only to be reformed for joint health and other lay and professional

practitioners (5). These new educational advocacy and policy courses might eventually become part of new state and national, non-for-profit, and industrial funded IVP resource centers and institutes for the applied public health sciences.

Part 6

A Nascent Graduate School Teaching Curriculum inThe History of Injury Prevention Leadership

In prior issues of the ICEHS Newsletter, the Archivist promoted, described, analyzed, and conceptualized, from his injury control journal archives, some summary of our injury control leadership history. One application of those exercises, follows: The Injury Control Leadership Course of the Future: “The Past Presents the Future”. The course's focus is not so much on the “data bricks that don't make, by themselves, a house” but on the full leadership form and content of craft systems that translate the data into saving lives and limbs, and on personality’s impact history.

What would that course, (or its substantial segments), look like for graduate students or as an in service, say, in the Year 2025, if not before? I am sure I would not recognize my nascent work in- progress. Any interested teacher or practitioner might skim (below) and further brokering a funding source for development into a better focused course syllabus and description:

Then and Now - Research, Service and EducationLeadership for Public Health Injury Control.

A suggested example of a pilot course, from the author's own training, background, andexperiences over some 50 years, follows:

Course Description

Potential and future public health leaders may receive little formal training on practical leadership on the job (on public health managerial practices of: assessment, options development, assurances) involving many personalities with conflicting but complimentary leadership skills (of innovating, decision-making, goal-setting, problem-solving or the interpersonal skills of assertiveness, directing, facilitating, leveraging power, coaching, motivating, stress reduction, conflict and career management or creative thinking, monitoring and controlling).

For more than seventy years, state and national public health officials and agencies have led, with universities, pediatric and medical groups, media, and consumers, to enhance injury prevention and control. By the turn of the 2000 millennium, the public health perspectives and models for unintentional and violent injury prevention and control had influenced the thinking of the criminal justice and other disciplines. For example, public health-related models not only, non-intentional ("accidental ") injury, but also intentional (homicides and suicides) injury prevention and control have grown, though quite nascent, to support the criminal justice approaches for prevention of intentional (suicide and homicide) injury and deaths. However, much of how past challenges in injury prevention and control were handled has been forgotten.

This course assesses sentinel historical professional journal articles and reports focusing on historical leadership personalities, values and events in injury prevention practice that might continue to guide current and future innovative coalitions, especially during local, state, national and worldwide economic downturns. The course lecturer's leadership bookshelf publications link historical leadership timeline milestones, paradigms, archetypes on the dynamics of historical

successes and failures from the USA's prior applications to guide the present and potential future histories of injury prevention leadership.

This “in service” or graduate student will be able to illustrate at least five model applications of historical leadership crafts in injury control for today's challenges during limited funding resources. The final student research paper relates to his or her review and critique of published or potential contributions, from the course content and the student’s other courses or overall leadership experiences.

Course reference texts for the crosscutting leadership arts of injury prevention: Robert Quinn, Stephen Covey, Peter M. Senge, and Ronald Heiftz, are suggested but not required. Additional sentinel suggested archival readings include: Violence in America: A Public Health Approach. Mark L. Rosenberg and Mary Ann Fenley (eds.). Oxford University Press, 1991; and a prepared course reader, available at the university book store, of published journal archival reprinted articles and reports (1900-2000) which includes sentinel leadership archives from graduate school of public health leadership courses. The reader citations are divided for study before each lecture.

Major Goals and Objectives

1. To introduce students to primary and secondary sources of the history of injury and violence prevention leadership, to examine interpretations of it, and to discuss the relationship to the contemporary world and leadership affairs.
2. For students to understand some of the causes and consequences (including case studies) of the historical phenomena covered here.
3. For students to develop and enhance critical and innovative leadership thinking skills by frequent discussion of issues in class and by future forecasting, analytical writing and role plying assignments.
4. For students and professor – to enjoy class and learn from one another.

Course Outline

Lecture 1: Introduction, course goals, principles, review of history and conceptual theory of public health practice in injury prevention and control and course requirements. What are leadership crafts and skills? From Senge (the learning organization), Covey (principle centered leadership) to Heifetz (gradients of progress). Review of course outline. Lecture: Some injury data (CDC web); A descriptive timeline of injury control leadership watersheds (Part 1, Table 1 (above), a sample analytical paradigm of injury control history (Part 1, Table 3), Forecasting, Texts (optional assignment) and a look at historical conceptual frameworks in injury control leadership, normatively and empirically, in primary and secondary text sources.

Lecture 1: Review of syllabus. Assignment: Begin to look at NYT and WSJ newspaper articles for a Thursday session critical review (one page) class commentary or discussion on topics of injury prevention practice/leadership influenced by past, present, and forecasted histories.

Lecture 2: The ancients through the 1930s (Fisher L. Part 1 (see above text), PBS videos on safety history of non-uniform fire hydrants and non-crash compartment airplanes to auto sled safety) - Conceptual framework and approaches toward injury reduction: Emotive Strategies. Weaknesses and strengths. Discussion on primary and secondary sources.

Lecture 3: The 1940s - Transition from technician to administrator, manager, to leader. Review of models used: successes/failures.

Lecture 4: The 1950s - Human Factors School: Any applications for today's juvenile violence, crime, drug abuse? One-page critical reviews of newspaper articles using course concepts, class presentations. Outline of course final/paper due: topics to be handed out.

Lecture 5: The 1960s - Rationalism and control of applied research variables.

Lecture 6: The 1970s - Slide series (at: http://www.apha.org/membergroups/sections/aphasections/icehs/ecommunity/ Archivist's Bulletin Board): Leading in product safety-early warnings by public complaints examples, toward federal new legislative controls. Radio and Press Interviews and Programming, Leadership Leverages on New Alerts (Text: Parts 2-4 – above).

Lecture 7-8: The 1980s - From injury prevention regulations and laws to federal grants and contracts for programs.

Lecture 9- 10: Innovation and change for prevention in the 21st century- Creative Vs critical thinking and application: The Conflicting Values Approach.

Lecture 11: Midterm Critical Analysis Essay: Leadership in IC policy making, public communications, problem solving or decision-making studies for teamwork with other disciplines. Lessons in the history of federal and state development of laws. New York State Time Line on leverage leadership for Burns, Motor Vehicles, Poison Injury Prevention and Control). (Part 1. Table 2, above)

Lecture 12-13: Current professional literature: What's done to date (Student Reports) current work and student assessment of published articles? Changes in Gun related injury prevention. Student critique of the gun safety debate; on suicide prevention; (instructor's testimony before US Surgeon General) overall (lectures published work, e.g., 1999: Dissent. Public Health Practice Won't Work for Intentional Injury, Injury, March 1999, and book reviews on suicide prevention/guns) and of instructor commentaries in, Albany (NY) Times Union, for class "debate" and writing similar commentaries / advocacy to governmental, private, and volunteer agencies. Additional: Continued Group presentations or rebuttals of lecture's press commentaries (see Part 4 above), my mentoring for leadership on future projection scenarios for concussions, violence, social media, etc.; see my review at: http://www.**amazon**.com/**Teaching**-about-**Future**-Peter-Bishop/dp/0230363490 and archivist attic. Dec 2015.

Lecture 14: Career management forum: stress and conflict management; the art of leveraging and brokering in decade of limited funds; topics of interest and role playing (facilitated by lecture) - time permitting; bosses, coaches, mentors. Additional topics: review of drug abuse and violence prevention.

Textbooks and Readings:

Readings, (based upon Part 1-7 of this paper), will be will be adapted to students reported needs e.g. Assorted classical archives and contemporary journal articles reprints from researchers and practitioners- copies, available on white board or the university bookstore. Classical and current health care policy reviews from journal article summaries (Part 5, above) and from current New York Times and Wall Street Journal, to be read by students. These readings will be used in

various frameworks (including as part of three assignments to submit reviews/critiques and report in class and as a final research paper based upon the course contents).

Text Book Options: Consider those cited in Part 1 References (below) e.g. books by Andrea C. Gielen, David Sleet, et al.; Lynda S. Doll Sandra E. Bonzo, James A. Mercy, David Sleet, Karen Liller, David Hemenway, Rodger Cooter and Bill Luckin, John C. Burnham; Gallagher - among other related CDC, et al, histories of injury and violence prevention.

Teaching Approaches

1. Socratic lecture/questions
2. Role playing
3. Group critique of current short articles from newspapers, extensive resource files and reprints
4. Discussion of on-the-job experiences, problems, and concerns
5. Small group discussions
6. Harvard Business School forums

Credits: Course Requirements and Evaluation

Due by the last class lecture, an 8-12-page written project research report, on a specific topic of the student's interest with its thesis approved by the instructor for which an initial outline is submitted by lecture 4. Oral, in class reports, as scheduled. Three brief critical analyses / oral reports of current injury control happening as reported in the media. Quality of Student's Participation: Research Project Report (50%), Project Outline and critical analysis / oral reports (20%), Class Participation (30 %) = 100%.

The above syllabus / course outline above is illustrative and hypothetical only. To my knowledge no modern historical leadership arts for injury control systems are taught, to date, in any School of Public Health, except for some discussion of Dr. William Haddon’s work from the 1960’s to the 1970s and overall discipline proficiencies. The leadership past is prologue and presents the present and future; everything has a leadership history.

Three examples –ICEHS Newsletters, Archivist Attics- of classroom discussion questions orquizzes:

A. Nascent Discussion Questions for Use with My Proposed Course Syllabus in My Historiography on Child Injury Prevention Leadership. Les Fisher, Section Archivist

Our injury prevention history offers the past, new questions; it offers the present, empathy and understanding. My archivist attics in ICEHS Newsletters have articulated many of the tensions in our injury prevention leadership histories. Here’s my capstone commentary:

Below are nascent examples of: (1) Broad study questions for possible courses in schools of public health and (2) specific student exercises, for the time periods in my Millennium. Part 1. A Child Injury Prevention Leadership Historiography:

1. What are your general reactions to these historical leadership frameworks, patterns, evidence,and archetypes? Try a sample exercise, below:

Does our injury prevention history have some purpose or does it correspond to the way history takes place? How did two IVP leadership, (Part 1, Above) chosen time period differ? How were they the same, developmental or gradients?

Are all histories reconstructions? Is it not what people said or did, but how or why it's interpreted? Is human nature the constant? Have we paid a price, in modernity, by trumping the history of the empirical pure science of injury and violence prevention over the history of the many less scientific and transcended spirits of the leadership arts?

Obtain from ajph.org any cited archival article: What does the author argue, how does s/he know, why should we care, i.e. what does it matter?

For guiding gun injury and violence research, practice, or advocacy for prevention, today: Howdoes one or two cited leadership archetypes and historical time period examples, from the Biblical to the 1990-time period, move injury control progress; how did ineffectiveness in outcomes not change; from your assessment on that history, what new political or technical processes might be innovative, today, for gun violence prevention research, practice and/or advocacy?

Which primary or secondary source evidence, cited in any section of my work, is least reliable as scientific research? Make a two by two table of pros and cons, for both sources in your chosen section. Use your created rough table to provide support for your conclusions.

Why do you think Part 1 archetypical leadership focuses on the pre- founding of the ICEHS Section?

In Table 1, Timeline, which points do you feel are most historically significant, e.g. drivers of change or continuity, and why? What repeating patterns are evident in the table, which points most relate to the progress in your own professional autobiographic history? Based on the "Competing Values Framework" (Figure 2a-b) and my memoir, what outcomes was I most proud of- in my directing, monitoring, innovating, controlling, mentoring or other leadership archetype? Where in my paper might be a fallacy in historiography i.e. projecting present framing in safety technology on past history (Hint: See the "child safety ad", terminology on page 133 of my Historiography)

2. Here are some specific options for student writing exercises linked to my Historiography, Part 1:

On the Frontier

Note the 1830 wood block illustration on home schooling for accident prevention. Kids worked on the farm and later in the textile factories. What is your reaction to this visual's intention?

Growth of American Working-Class Safety

In his writings, Alexander Hamilton preferred a US nation of industrialists while Thomas Jefferson focused on the unique strength of America as a farming community and both saw the city squalor to young workers in the European work model. What was their experimental compromise for industrial working America (i.e. compare the American model with the squander they saw in urban Europe of children workers). What were the later worker safety interventions

and consequences? How does or does not Godfrey's work seem to portray that agrarian value? Today, is one's home still one's castle?

The Industrial Revolution and the Gilded Age

How did the mechanized factory change (pro and con) American health and safety? Defend or refute the following statement: The "Newsy" (Newsboys 1898 see www) strike won significant safety rights for these 12-18-year olds. (The play was great; it did not, of course, follow all the history.)

The Incorporation of America

What were/are the relationships among technology, mass production, mass use, safety, and the modern corporation? Based on Henry Ford's memoirs (search www), do you think automobile safety trumps profit? How did he link the wellbeing of his employees' increased wages and new mode of travel to his own profits?

The Progressive Era

The Progress Era, (1900-1914), the promise of citizen empowerment with professional scientific expertise (instead of just universal ward politics) to solve problems, was marked by expert studies, advocacy, legislation and enforced regulation. What was the paradox? How might the Progressive's consternation that pay- off- politics was not solving Musca Domestica (the housefly epidemic of typhoid, 1890 -circa 1910) "echoes up" to today's current injury and violence prevention challenges?

In the early Progressive Era, why were children's or wife's employment seen as an overriding non-social value? (Hint: It was not safety but economical value). What instead should children do instead of work i.e. what child recreational rights movement began, in 1906, partially related to child safety?

The Harding, Coolidge, Hoover ("Hamiltonian") presidencies were a return to liaise –fare and big business supports- what was one limited exception 'supporting' public safety?

Woman, Work and Scientific Management

Why was the turn- of- the- 19th century- American so concerned about efficiency? What is the Hawthorne (NY) Affect - how does it relate to modern injury control research?

The Wars

How did WW I and WW II stimulate early leadership toward prevention of public safety risks?

Look (www) at the images in the Sears Catalogue of the 1920's - the age of new consumer product demands – any warnings about risks of substantial injury?

How did technology, but also, innovation take place for Haddon?

What is one leadership lesson for Injury and Violence Prevention on the uncensored use of media in the Vietnam War? How can IP media trump IP politics, as media did in the Vet Nam, Tet offensive? If so, cite examples of IP sentinel media examples.

Post WWII

What are the ethical safety implications of modern military technologies?

How has post war technological and political values (e.g. freedom) changed mass consumer product risk and safety culture?

What's globally and seminally missing, in retrospect, using our modern views of injury control, in Godfrey's, Schlesinger's, et al injury prevention articles of the 1960's?

Youth uncertainty, alienation, and discontent, especially those of elders' and societal roles duringthe 1960's and 70's, remolded American ideas, values and activities- from issues of feminism, civil rights, the Viet Nam war, assassinations. What effect, if at all, argue on IVP progress?

Sample Final Questions (choose at least one):

1. In the belief that the study of the history of injury and violence prevention are of no value unless we can extract from it lessons for our own time, take one of the "time period" (below) leaders, movements or trends and argue that each represents exactly the leadership qualities that are needed in our IP world, today. Then turn around and argue that they are only earlier examples of and dangers to the arc of the IC movement, today. One or two good arguments will do. You may argue the positive side first and then the negative for each case, or vice versa, whatever works best for you; however, you must argue both sides for each of the following "time periods":

-Godfrey

-Harvard School of IP

-The Progressives

-The Industrial Revolution.

-The US Public Health Service or DHHS historical roles

- CPSC, CDC, or NHTSA

a. From course readings, show patterns of prevention agreement and disagreement from three-time periods. b. Briefly summarize the main content of the Godfrey article and the used cites and material. Evaluate their usefulness to the subject.

2. How will trajectory progress in injury and violence control continue? What and how are the next conceptual horizons for leadership? Figure 1 illustrated one past selected leadership timeline for injury prevention. What are three key additions to these historical landmarks from the last five years and then project for the next decades? Why these?

3. Describe the historical distinctions between slow incremental and radical break thorough in prevention and control. Describe the reliability and predictability of forecasting the future based on the past leadership in an historical social context.

4. One of the ways which the home or public environment shapes human history is through injury. A host of injuries are cited and assessed in my Historiography that altered social and political dynamics between industry, government, and the public. Do advantages of epidemiological research or interventions of evidence-based science always imply a political advantage? Why or why not?

5.Archivist's Attic - Crisis Leadership: Try a few forecasts; include a dark horse scenario:

6. Update Haddon's pioneering ecological thrust at https://injuryprevention.bmj.com/content/5/3/231.full by adapting the exercise in wring letters

at ICEHS Section Connect library, the historical archetype Figure 7 , at end of this book, write your own practical translational advocacy -talking points- targeted to a key commentary in AJPH or to a legislative staffer or a politician. Advocating the integration of innovative collaborations of public health, criminal justice mental health social work, consumer, industrial and other disciplines to define a problem and optional solutions. Explain why you chose your 2-page message

7. Critique this proposed letter -from above to your State media

One link in low income areas with greater COVID's, more lead in water, air toxins, violence and homicides,

Trump has shown little support for research and prevention of gun ownership suicides (the largest cause of gun suicides is in suburb and rural areas) and homicides (daily, mostly in poor urban neighborhoods). He also has cut back the EPA standards that limit lead in public water as well as the lead in urban soil, paint abatement and all toxins in air pollution.

These substantial risks presumptively also combine, interact, holistically, into the major residents of inner cities as pre and postnatal and childhood neurological damage to school learning cognitive skills, "criminogenic" political and social environments, increasing rates of incarcerations, and law enforcements' wars on drugs.

The priority is clear for newer financed innovative evidence-based collaborations of diverse disciplines' applied translative research and violence prevention engineering, education and legislation.

Moreover, the NRA and Congress had eliminated, for decades, CDC, and NIH funding of gun related, public health violence research and prevention. Programs like Cease Violence, work.

Tell our statesmen in Congress, industry. and public statesmen, that public health injury and violence prevention saves not only young minds and bodies- but decreases our federal, state, and local taxes, economic losses from unemployment hospital and doctor medical costs, personal losses, criminal justice services as well as families' physical mental care costs!

Moreover, as with the historical safety collaborative leadership movements of railroad and auto safety design of limiting child poisonings by the number of aspirin in the bottle, unsanitary meat packing: when bias, blame stops, the industrial economic profits begin with successful public "PR for leadership in "safety".

opinions are mine
Former member city of Albany task force on gun violence prevention

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Archivist/Historian, Injury Control and Emergency Health Services Section, American Public Health Association.
My new 2020
e book, A History of Child Injury Prevention Leadership is published at:https://www.medph.org/apha/category/membership-groups/history-of-sections/injury-control-and-emergency-health-service/

8. What would you agree, disagree, and advise changes in: The Challenge of Change How do leaders best handle crisis?

Leadership - seems, currently, we have the 'crisis of the day' in injury control and public health? Can crises, (budget cuts, downsizing of federal funds, poor markets for student graduate jobs to fears of terror or disasters, etc.), be prevented, controlled, or minimized in impacts? In olden days) of injury (accident) prevention and control, the victim usually would be blamed for his or her accidental carelessness and the major preventive response might be to conduct informational 'accident of the month' events. (Today, we seem to unproductively blame everyone else). William Haddon, Jr., the father of modern injury epidemiology, greatly changed, in 1962, that earlier focus. He adapted a new leadership conceptual framework matrix on the cause of injury as energy (mechanical, thermal, biological, chemical, electrical) gone wrong for injury vectors: motor vehicles, oven that burns, earthquakes, etc. related injuries. He overlaid that by a mixture of countermeasure interventions. Evidence of impact was always essential to him (see for example: June 2003 ICEHS Newsletter on his earliest days in New York State or see: Members Only and most injury control texts). How might we further update applications for leadership crisis in today's interacting injury people, technology, and organizational vectors? I'd like to share two excellent newer books on crisis leadership that I believe will be very valuable tools for injury control or allied students,

Practitioners, researchers, and advocates - as we move, even more so, into the postmodern Haddon era of the challenge of (crisis) change: Klann G. Crisis Leadership. (Center for Creative Leadership Press.2003) offers that Haddon type pre/during/post guidelines and examples primarily from the military, but applicable to any organization. Mitroff I. Crisis Leadership - Planning the Unthinkable. John Wiley & Sons, Inc., 2004, enhances the leadership competing and complementary values frameworks (see: Figures 2a-2d at Members Only) by applying Myers -Briggs (M-B) Personality Testing. Mitroff differentiates among normal accidents, abnormal accidents and natural disasters and then offers exercises with archetypes and figures or prevention, control, or amelioration of impact of risks by categorized "crises families" of risks. (It is not the old unproductive 'blame game'!) Mitroff contributes greatly, as Haddon did from engineering, by adapting from another discipline: Each of us interact with our unique psychological languages for which we may fail to communicate others' predominant tendencies to view life. "None are more important nor real than any other": Thinking (Things), Intuiting (Big Picture), Sensing (Details/Parts). Then, also from the great Swiss psychoanalyst, Carl Jung, Mitroff applies crisis leadership by readable illustrations and discussions of archetypes and paradigms in conflicts. Today's message for high quality impact system leadership, anywhere: we must focus on crisis leadership by thinking the absurd and unthinkable, by using no fault learning and by attempting compromise (or leverage) of conflicting values. Hi:) injury control and other allied graduate students! This fast-challenging rewarding world of change seems to be yours- more and more! Best in your crisis leadership! Try out a few of Mitroff's exercises in your future course on injury control leadership (see March 2003 Newsletter. A Nascent IC Leadership Curricula)

~Les Fisher

7.. How can these IVP leadership paradigms apply to larger public health and IVP trends?

Archivist Attic: Some Historiography in Injury Control Leadership for Limiting New Emerging

My October 2002, ICEHS Newsletter commentary, Rivers and Streams of Injury Control History, illustrated certain historical flows where our disciplines grew, other ended and still others branched off into to newer leadership system archetypes. Historiographical, each generation reflects its own stories and perceptions onto early history and this changes over time. In general, history greater than some 200 years ago was just the history of religion or kings and queens; with the Age of Enlightenment it was also the history of nations; one hundred years ago it portrayed mostly economics and demography, and fifty years ago everyday life, forty years ago social histories, most recently its mostly a matter of influence and power that makes history. Our injury field historical leadership also reflects these larger currents (see ICEHS members only, my MSS on injury control leadership systems metahistorical) (long term trends over many years with all its leadership challenges and the competing system values systems of power and influence leadership). Today's injury surveillance and control during newer emerging risks and injuries might only over focus on obtaining the most sophisticated evidence and representative based surveillance data before any preventive programming. And that paradigm both may become impractical and expensive for the “average" state or local injury control resources of researchers, practitioner, educators, and advocates. (Fisher L. Community Based Interventions – Less than Perfect. Injury Prevention 2004; 10:255.) Peter Senge, (Senge PM. The Fifth Discipline: The Art and Practice of the Learning Organization. New York: Currency Doubleday;1994,378-379.) the leadership theory pioneer, might suggest a better (one of many) archetype : "balancing system archetypes with any delays, (BSAD)" to help guide an injury control organization or individual adjusts its behavior in response to delayed feedback on the need for perfect data collection and follow up preventive actions. More particularly, Senge might suggest that when newer types of injuries emerge (e.g. injuries from auto back overs to adolescent self-strangulations, etc.) and good epi data is not available, not to wait entirely to create the good epi data ('suffering paralysis by waiting for great data analysis') from unavailable perfect surveillance and epidemiology. Instead, look outside the perfect box and begin "imperfect" injury prevention and control - which can lead to more resources for more perfect epi and programming.

Four chosen historiographical examples, from my own experiences, of the interrelationship injury surveillance and control archetypical systems follow for consideration for prevention limiting other emerging reported early warnings of newer injuries:

1. Oven Roasting Bags: Here’s how the same system archetype from hospital ED's and consumer telephone injury reporting stopped exploding and injurious plastic oven roasting bags, circa 1972, long before any sophisticated NEISS (which I helped develop at the state level) or Federal DOT injury surveillance systems. The national CBS-TV and two articles in NY Times led to my meetings with plastic roasting bag (used to cook food) manufacturers who cooperatively voluntarily reformulated the roasting bags, nationally, so that zero injury were later reported. (Fisher, L. "Risks Associated with Roasting Bags and Other Consumer Products", Editorial, American Journal of Public Health. December 1973.) 2. Zulu War Guns In 1965, I had used the same leadership archetype at the Philadelphia City Health Department for limiting

childhood trachea injury from a plastic toy pea (dart) shooter, distributed nationally in cereal boxes, for which the child's inhaled plastic dart was not visible on X-ray across the city. And kids began to also use needles as makeshift shooters. The Philly nationally-based toy manufacture, with Kellogg's cooperation, ceased distribution of thousands after we publicly asked for more reports of cases and demonstrated at the manufacturer's headquarters the risk and injury pattern. The company president told us at our meeting that was no problem; then after being asked to try to shoot a plastic dart, he began to choke! Consumer Reports carried the injury control success story. (Steer Kids Away from this Toy Zulu gun. Consumer Reports. 33:572 Nov.1968 and Final Report of National Commission on Product Safety, April 1970); see also Newsletters, Nov 2002) 3. Toys Circa 1972, the National Study Commission on Product Safety held hearings on injurious toys in the marketplace. The industry promised to remove them; our survey using consumer activist volunteers showed these toys still for sale and our report was shared with the Commission and the State Attorney General. The AG under the state's general business law (GBL) - no need for any new state legislation nor new laws - held hearings (also the GBL was applied in 1969 for safety glass regulations in homes and in early 1970's for children's sleep wear flammability regulations, from cases we collected from press clippings and ED phone and record reports to NYSDOH Year's later MASS. AG did the same for gun safety regulations.) In circa 1978, a consumer called that a cloth pin shaped rattle had almost stuck in a baby's mouth. The field investigation and our petition under Section 15 sent to the federal CPSC led to an amended the federal toy small parts regs. (A similar petition on unstable tipping refuse bin led to national standards; leaking chemicals in teething rings led to a FDA voluntary industrial recall; mobile homes safety standards were upgraded when fire hazards (e.g one exit only) were shared with State Building Codes Council - Fisher, L., "Communications and Home Product Safety", Association of American Food and Drug Officials Annual Conference, Portland, Oregon, June 22, 1977, Association of Food and Drug Officials Quarterly Journal. January 1978.Fisher, L., Van Buren, J., et al. "Product Safety -Monroe County, NY IS Involved", Journal of Environmental Health. November December 1977.Mattison, B., Fisher, L., et al "Monoxide Slight Hazard in Mobile Homes: Fire Dangers High", Journal of Environmental Health. July/August 1972.) 4. Poison Prevention and Control One last example - It was cost savings not public health nor injury concerns that interested NYS legislative leaders in 1986. It took many tries to get the NYS Regional PCC Act and its cost-savings funding of 4M$ annually of Medicaid funds to the hospitals with poison control centers until the bill sponsor gave the bill to the majority leadership party. The full bill and its funding promptly moved and was signed by the Governor. I mention all this personal history as I believe it is generally efficacious for many of today's modern injury surveillance and prevention challenges on newer injury risks especially when new epi surveillance data are incomplete. How prior early warning challenges were handled, may guide continued current leadership in epi research and injury prevention practices under limited resources - and in fact help obtain those new resources - while limiting a newer growing substantial injury. For more details on these and other early warning alerts leading to national and state injury prevention, see: Fisher MS at members only. (The opinions above are mine alone) LFisher copyrighted 2006

Credits:

Thanks to State of NY at Albany (SUNY-ALB) History Professor David Hochfelder, who during his AHIS 276 Technology and Society in America course lecture developed a variation of the above syllabus course outline questions and midterm examination, Spring Semester, January 31, 2011, and to SUNY-ALB History Professor, Kendra-Smith Howard who during her History 329,

Environmental History, Winter 2013, History 314 Course on The Progressive Generations, Spring 2014, and her History 101, American Social and Political History, 1865-2014,Fall Semester 2014, especially her lecture on Musca Domestica, (Sept 29, 2014) and History 277,Culture, History of Food in the United States, Fall 2015 course lectures which I adapted for our injury and violence prevention disciplines. For Professor Hochfelder's primary course related text on technology, see related chapters in: Gary Cross and Rick Szostak, Technology and American Society: A History. 2nd Edition Prentice Hall; to Professor Tim Snyder, Yale University Professor of History for his critical historiographical methods analyses of his book, Bloodlands, at The State University of NY- Albany, March 30, 2011; to Rabbi Robert Fine for his final assignment. The History of Judaism in Antiquity. Temple Israel. Albany NY, winter 2010; and, again. to Professor Smith-Howard, SUNY- And also thanks to SUNY-ALB History Professor Arthur Brenner who during AJST 357, Western European Jewry in Modern Times, Spring Semester 2015 on concepts of historical assessments. All the above history courses I have audited.

B. An Historical Resource for the 2014 New Orleans APHA ICEHS Section Annual Meeting: The 1936 New Orleans APHA Primary and Secondary Sources Historical Documents. Landmarks in Our Field. A Tool for Injury Control Presentations, Publications, MSS Reviewers and Teachers in Graduate School Courses.

A seminal thrust of a primary source document for key later planning and development for our field of injury and violence prevention began at the New Orleans 'October 23, 1936, Annual APHA Vital Statistics Section Meetings. New York State Health Department Commissioner, Edward Godfey, subsequently APHA President, posited his thesis statement that health departments study of" accidents" required an epidemiological approach:

"Few, if any health officers or health departments are displaying any interest in prevention of injury and death from accidents. They are content that statistics shall be tabulated and published, leaving prevention entirely to other agencies or the will of God. … It is the field of home and public accidents however, that I believe the health department has the greatest responsibility and opportunity." (1)

Godfrey cited evidence that injury deaths were beginning to exceed deaths from the major communicable diseases, and a 1938 APHA Resolution requested Congressional funding support for accident prevention and mentored his idea (2, 3).

Our publications may routinely only cite histories from just a few years back; certainly, many web pages exclude much earlier key primary and secondary historical sources:

Primary source reading documents such as Godfrey's, above, offer us, today, a first-hand prism into our history, especially as we stand on his shoulders and earlier leaders' shoulders at the 2014 APHA Section Meetings. These primary sources can guide our own applications of our histories in our own articles, presentations and in our reviews of MSS for publication!

What questions should we ask about the primary source documents we cite or use in our research, preventive practice, teaching and advocacy?

Below, in quotes from history professor Smith-Howard's, State University of New York at Albany,

History 314, Course: Progressive Generation (which I audited Winter semester 2013-14) adapted from Patrick Rael, Reading, Writing and Researching for History: A Guide for College Students

(Brunswick, ME: Bowdoin College, 2004); and Zachary Schrag, How to Read a Primary Source (Arlington, VA: George Mason University, 2007):

"Analyzing primary sources requires asking lots of questions… to guide your reading and using of primary sources:

Author & Intent:

- Who is the author and what is her or his place in society? What could or might it be, based on the text, and why? Provide an example from the text that suggests this position.
- Why did the author prepare the document? What problem was he/she attempting to address or resolve?
- Does this argument have a thesis? What – in a sentence – is that thesis?

Style & Audience:

- What is the intended audience of the text? How might this influence its rhetorical strategy? Cite specific examples.
- What kind of evidence (personal observations, metaphors, narratives, evidence) does the author use to make his/her argument?

Context:

- In what year (within 10) do you think this document was created, and what clues in the document led you to that conclusion? What features, other than its publication date, mark it as a document from its time?
- How do the ideas and values in the source differ from the ideas and values of our age? Offer two specific examples. How might the difference between our values and the values of the author influence the way we understand the text? Explain how such a difference in values might lead us to understand it in a way contemporary would not have. Offer at least one specific example.

Unexpected/Omissions:

- What strikes you as weird, surprising, or quirky about this text? What lessons about this person, place, or period does it reveal that would be difficult to surmise without interpreting this source?
- Does the author leave anything out? What does the source try to hide, skim over quickly or obscure in a footnote?

Patterns & Connections:

- How might this source support one of the arguments found in secondary sources we've read? Choose a paragraph anywhere in a secondary source we've read, state where this text (or image, film, or object) might be an appropriate footnote (cite page and paragraph), and explain why.
- Choose another of the readings, and compare the two, answering these questions:
    - What patterns or ideas are repeated throughout the readings?
    - What major differences appear in them?"

In historical documents, secondary sources readings are most common in our Journal reviews. These sources must also be looked at critically. For example, try a few questions, from your skimming of your favorite secondary documents or those cited in my Historiography - Child Injury Prevention:

- What were the causes? What were the consequences?
- Where's the beginning, middle and end of the author's interpretation?
- Who are the key players?
- What's the methodology/approach? Case Study? Comparison? Response to another?
- Besides the narrative, how does the analysis structure the evidence presented?
- What kind of sources does the author use? To illustrate or demonstrate what?
- How does the author deploy these sources?
- What does each kind of source illumine? What does it obscure?
- Does the author seem attentive to the limitations of the source? How/why can you tell?
- Does the author manipulate the source to serve his/her own argument?
- Is the source relevant to the author's major claim?"

…….

1. Godfrey E. Role of health departments in the prevention of accidents. Am J Public Health. 1937; 27:152 - 155.
2. Year Book. Amer J Public Health.1938;28:34-35. (see also Godfrey's advocacies on noise conditions and accidents and on his presentations at national meetings, respectively, in: Amer J Pub Health. Year Book Part III.28(2);160-161 (Feb1938); Year Book 1938-39; Part 1. 29 (Feb 1939); and also 29 (Aug 1939). (For the last two citations, the pages were not found but search phrases 'Godfrey and accidents' found at www.ajph.org, on 8/16/07)
3. Editorial: The health officer and the accident problem. Am J Pub Health. Dec 1937; 27:1289-1290.

C. Analyzing Injury or Violence Prevention Archival Photographs, Cartoons and Films as Historical Documents-A Graduate School Course Tool

Photographs, cartoons, films, and other images are also important cultural productions that historians use as primary sources. They can be strong political advocacy tools and can serve as a flash point or accelerator for violence and injury prevention and control. Some of my collection of watershed archival images was presented at national meetings.

Questions to Consider (below) when looking at cartoons and images: Sample (1) FDA Magazine Cover: Consumer Product Safety or Sample (2) Apparent Car Seat Ad:

Thanks to Professor David Hochfelder, SUNY-ALB, History Department, for the handout text, (in quotes below), for his students enrolled in AHIS 276: Technology and Society in America, Spring 2011, which I audited:

"Photography was invented and commercialized around 1850 and film in the 1890s, so these sources capture much of the history of the past 150 years. Particularly for the 20th century, much of our history is recorded visually rather than written down. Historians and political cartoonists use images in similar ways to other primary sources, as evidence to support their arguments and to illustrate specific points in their narratives.

There are three major sets of questions to consider when analyzing a photograph, cartoon,journal figure or film as a historical document.

1. Content. What information can you obtain from it? What does the photo, cartoon or film include? What does it exclude; where might that be found? How does it portray characters and setting?

2. Production. Who made it and for what purpose? How might personal, political, or professional backgrounds of photographer, director, actors, etc. have influenced the content? What was the moral or message of the image or film?

3. Reception. How did audiences respond to it? Who were the intended audiences? Was the image or film effective at conveying its moral or message? What effect, if any, did it have on the pace or direction of events at the time it was made? Now?

Types of Analysis. Historians analyze or use images and films for at least three purposes:

1. As Evidence of Historical Fact. Candid photos and films, such as newspaper photos, newsreels, and films taken by participants often convey useful historical evidence- these can also be used to advocate for progress in injury prevention, consumer product safety. (See: Photographs of Abraham Lincoln, for example, show how he aged during his years in office. Newsreels of Franklin Roosevelt show how he dealt with his polio-induced paralysis. The Super 8 film taken by Abraham Zapruder yielded significant evidence for investigators of John F. Kennedy's assassination.

2. As Evidence for Social and Cultural History. Photos, films, and TV shows are important sources to understand social relationships and cultural values. These images offer unique windows into social markers like race, class, gender, regional difference, education, etc., and

cultural assumptions about those markers. For example: Selling comfortable cars but showing lack of technical progress on the safety for infant or other riders. For example: Television shows like *Ozzie and Harriet* and *The Honeymooners* give very different views of family life, class, and gender roles in the 1950s.

3. As Representations of History. Films that portray historical events provide insight into contemporary thought about those events. Bear in mind that any film portraying a past event is subjective and biased in some way. For example, the films *Birth of a Nation*, *Gone with the Wind*, and *Glory* portray the Civil War differently because they were made at different times and to convey different messages. Taken together, they show how our views about slavery and the Civil War have changed during the 20th century. The two illustrations show that historical portrayal."

Historically, injury and violence prevention frameworks changed (e.g. see my Leadership in Child Injury Prevention, Historiography, web cite above, Table 3).

So, when using archival or current leadership imaging for injury and violence prevention, in your classrooms or on social media for advocacy with facts, evidence, social and cultural history or representatives of history - do consider the above! As the ole adage goes: An image is indeed worth a thousand words.

Part 7 Figures 7 a and b': Epilogue and Summary: One Historical Leadership Archetype is an adaptation of Haddon's Historical Framework (In: Fisher L. Childhood injuries - Causes, preventive theories, and case studies. an overview on the role of the sanitarian and other health professionals. *Journal of Environmental Health* 1988; 2:123-6.):

The "cause" (see Figure7a, right side) is the mix of agent, environmental and host factors kinetic (thermal, radiation, electric, mechanical, biological) energy gone wrong (the lightning in the middle of the triangle). The Zen prevention, mitigation, and rehabilitation Zen mix (interacting and independent circles) are advocacy (not to our colleagues or the public; but, targeted to policy makers, legislation/regulation (most regulations are excellent voluntary industrial standards) and engineering (passive IVP impacts risks more effectively than just public information and education). What are the other protective factors for IVP?

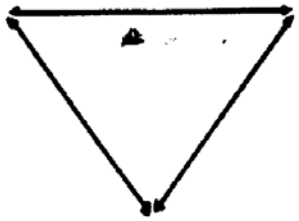
Offer your own reformulated, fluidity archetype illustrating the real-world dynamics of jointly integrating public health and other disciplines for preventing, and mitigation of different descriptive morbidities Explain why you chose that model. Has that been done well, partially, historically? What about liberty and freedom that impacts risks on injury and violence prevention? (Hint search Baker's et al, on Freedom; et al. I found a few articles.)

New York State Department of Health
Conceptual Model Components
Injury Control Program Dynamics

(Energy Release)

Agent Markers

Selected tracers of injury related agents (e.g., child auto restraints, drain cleaners, playgrounds, toys)



Impact on Host

Environmental Management Processes

Parameters in Injury Control Program Processes, e.g.:

1) Developing
2) Planning
3) Organizing
4) Initiating
5) Evaluating

Within economic, social, political, psychological and physical values, activities and interactions.

Examples of Impacts on Host

(1) Conducting public and professional seminars, legislative initiatives e.g., through advisory groups.
(2) Professional and public educational diagnosis; community consortia for program processes.
(3) Diverse methods for same results, e.g., community matching of resources.
(4) Pre-post testing of knowledge.
(5) Pre-post telephone surveys of attitudes.
(6) Pre-post observation of household and marketplace behavior/risks in proper selection, installation, use and storage of products.
(7) Government discount purchasing of safer products for distribution/installation; linkage of prevention component to ongoing medical care services.
(8) Federal National Electronic Injury Surveillance System or other reporting systems to monitor pre-, post-, and comparative population injury risks, morbidity and mortality; reductions in incidents of new substantial risks reported, increased informational calls to hotlines, e.g., regional poison control centers.

Process Markers for Tracing Favorable Educational Enforcement/Engineering Strategies:

	Outputs		Outcomes	
	Activities	Adequacy	Efficiency	Effectiveness
• Sensitivity/Awareness/ Knowledge	(1)	(2)	(3)	(4)
• Attitudes	(5)			
• Behavior				(6)
• Environmental Risks			(7)	(8)
• Anecdotes/Complaints				(8)
• Hospital Emergency Dept. Visits				(8)
• Hospitalization				(8)

←Sophistication/ Feasibility→

←Feasibility / Sophistication→

Based on Simon 1966 Schulberg 1969 Haddon 1980 Fisher 1981 1982 1986 Wilson 1985

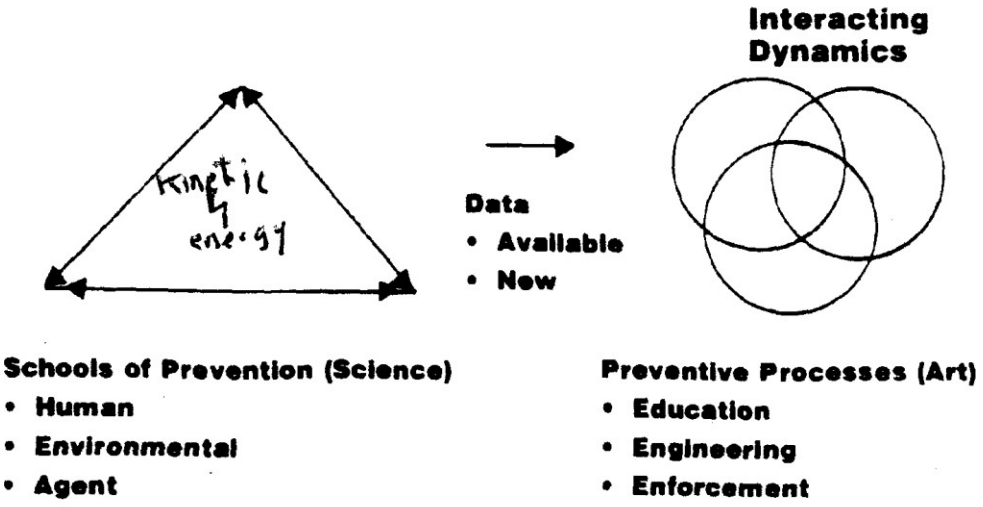


Figure 1: The Injury Causation/Prevention System

2/1/12 | Guide for any condition being studied: translational research, as well, px, dx, rx.
Fig 50s JAH 1988 LF., Speeches NYS CPB, 1970's

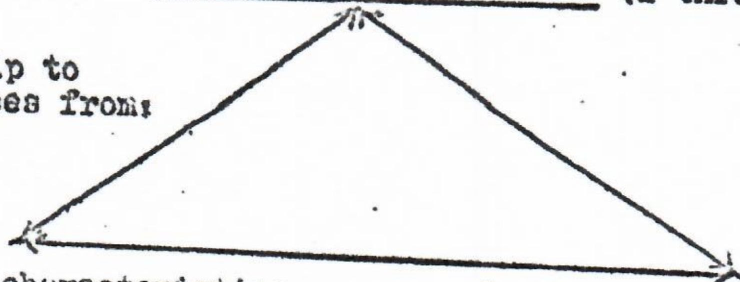
Rachel Sull
FERT
See Next page
I Found it! (2)

...ch of the following...

1. Statement of Problem
2. Facts and opinions
3. Alternative solutions
4. Best solution
5. Stategy

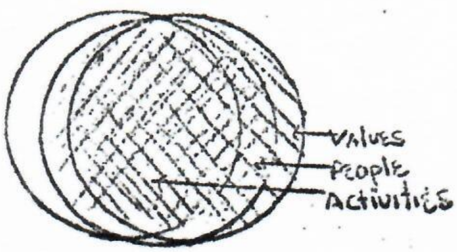
CONDITION BEING STUDIED (1 thru 5 above)

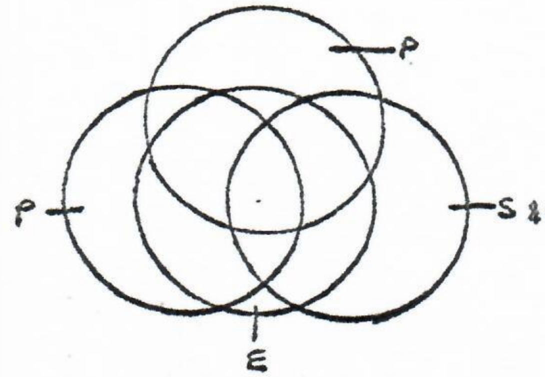
in relationship to
major influences from:



1. Interacting characteristics of individuals, formal and informal groups, agencies inside and outside of the decision makers own organization

2. Interacting environmental conditions





a, Examples of values
- ~~(1) Efficiency~~
- (2) Firmness - Flexiblitiy
- (3) Conformance- Deviance
- (4) Initiative- Sluggishness
- (5) Habits of cooperation

b, Examples of activities
- ~~(1) Past experiences~~
- (2) Training and Ed.
- (3) level of program desired or possible

c, Examples of individuals, ~~groups, agencies (organizations)~~
- ~~(1) The Decision Maker~~
- (2) His formal and informal groups
- (3) His organization
- (4) The individuals he deals with in the decision process who are outside his organization
- (5) This individuals groups and formal organization

a, Examples of interacting environmental conditions
- (1) Political
- (2) Social and Cultural
- (3) Economic
- (4) Physical

...

FIG. 2 Application of the Epidemiological Model to the Role of the Executive as a Decision Maker

Major Sources:
Course GS 622F Fels Institute
Simon, H. et al, Public Administration (New York: Alfred Knopf), 55-129 especially.

Section II : Models Application See Figure Last pages

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I was not entirely satisfied with this. But, I start running out of time to do extensive research on the problem since coursework is left to readings, lectures + extensive assignments besides papers.

Les

Carmen,

Perhaps may be of some practical application for us.

Les

(In any event the latest info + studies are placed in this paper)

Good

COPY

THE CONSTRUCTION OF A MODEL OF THE DECISION MAKING ROLE OF THE EXECUTIVE

(See last page & Figure 1-5)

In partial fulfillment of the course requirements for Fels* Institute Course GS 627, Fall Semester 1967 (Wharton Grad. School)

MGA

Les Fisher

November 30, 1967

(Collection of 7-8 papers)

Please Return

INTRODUCTION

Section I of this paper deals with the construction of a model of the decision making role of the executive. The particular model that is constructed is a combination of public health and general administrative theory. The public health contribution attempts to make the model more emperical and the administrative theory contribution attempts to give the model a general application in most decision making roles of an organization.

Section II is concerned with relating the model to actual executives and their agencies via the presentations of Fels Institute Course GA 627, Administrative Practices in State and Local Government.

In both sections there has been no attempt to describe the various strategies of decision making (e.g. game theory, operations research). The scope of this paper is limited to a more conceptualized approach to the role of the decision maker.

SECTION I: CONSTRUCTION OF THE MODEL

A. The Epidemiological Model

Epidemiology is the study of disease behavior and health characteristics as manifested by groups of people.[1] In a behavioristic sense, the role of the epidemiologist is to make decisions about disease recognition and appraisal pertaining to aggregations of individuals.

On the whole, the method employed in this discipline is the scientific method of (1) defining the nature and significance of the problem, (2) critically appraising the existing information on the subject to seperate facts from hypothesises and to find gaps in knowledge, (3) formulating hypothesises based upon an this critical evaluation, (4) testing the hypothesis, (5) making a conclusion (decision) based upon these hypothesises and applying it stategically.[2]

The model that the epidemiologist uses in decision making is shown in Fig. 1. He concerns himself with a condition (e.g. state of health such as disease, accidents; response to a health program, adequacy of a program, etc.) and studies the quantitative and qualitative influences from the characteristics of the group and of the habitat. He also realizes that no one conner of the triangle exists without some interaction between the other corners of the triangle. Any condition is multicauseal -

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1. John Gordon, "Epidemiology: The Diagnostic Discipline of Public Health", Roy. San. Inst. J., 74, (July 1954),445-454.

2. "Modern Concepts of Epidemiology", J. Chronic Dis.,2 (Nov.1955) 593-596.

this is shown by the arrows on the triangle sides.

By using the model, he is usually able to prevent diagnose, or control a heäähh problem.

There are many other uses for the epidemiological model in the field of public health: [3.]

(1) To determine the effects of host-agent-environment relationships

(2) To describe the epidemiology of a disease or classes of diseases

(3) To measure risk

(4) To study the occurance of disease on health with time as a variable

(5) To aid in the detection of presymptomatic and latent disease

(6) To assist in making administrative decisions in medicine and Operational research

The last use in administrative medicine, is the major link to the field of general administrative decision making. The assumption is made that the epidemiological model may be used effectively in other disciplines than public health and in most organizational decision making processes.

It will, however, first be necessary to modify Fig. 1 to fit a more general application.

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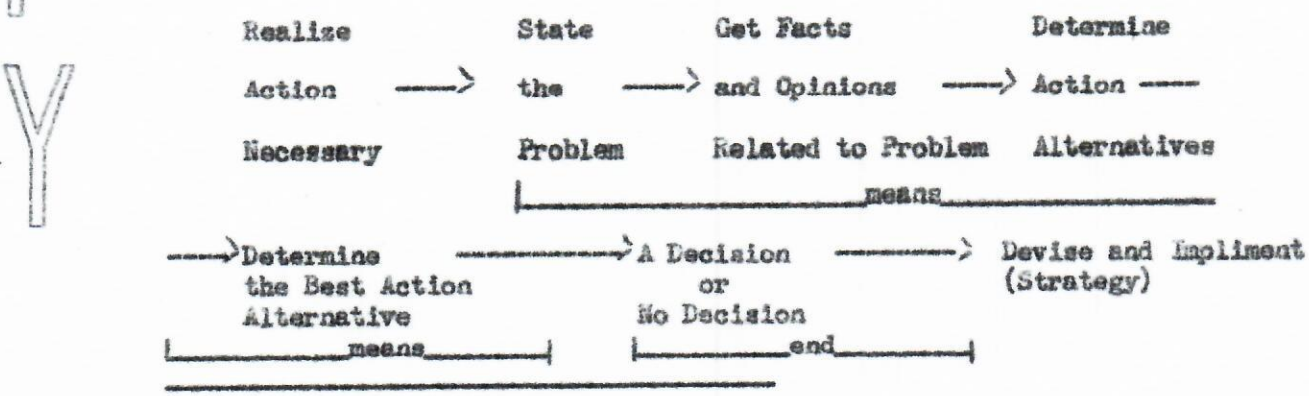
3. George Saiger, "Ten Uses of Epidemiology", Canad. Med. Assoc. J.85, (Oct. 1961) 992-995.

B. Organizational Decision Making Models

Before relating the epidemiological model to the role of the decision maker, some basic characteristics of decision making will be reviewed. What is a decision?

A decision is a conscious or unconscious selection of actions possible.[4] This statement suggests that (1) the decision maker realizes a decision is necessary, (2) he chooses from available action alternatives possible, and (3) if he makes a logical decision he has referred to some past experience.

Stated in a different way, a decision maker uses certain means to obtain a decision (the ends in this process).[5] From the above assumptions, the role of the logical decision maker consists of the following variables in order to obtain a suitable action:[6]



4. Herbert Simon, Administrative Behavior, (N.Y., N.Y. 1957) 4.

5. Chester Barard, The Functions of the Executive, (Boston, Mass, 1938)

6. Modified from J.P.McDonald, The Administrative Decision Making Process in the Philadelphia (MCA Thesis, Fels Institute 1964)

This role summarized is (1) identification and clarification, of the problem, (2) discovery of alternatives, and (3) analysis.[7.]

But this is more a process than a role. A role has dynamic implication - what is above, is static. There are many peasons for a more dynamic role:[8.,9.]

(1) The decision maker does not operate in a vacuum; he is surrounded by program and organizational influences which affect his decision
(2) In addition, the decision maker can not divorce himself from his own values and opinions during the decision making process
(3) Finally, the decision maker does not make a decision in a static world. He is constantly fighting back and forth between his extemnal environments (physical, social, political, economic, cultural) and his goals -- both of which are constantly changing.

Thus the role of the decision maker is also to be aware of the values and interactions of himself his organization; other individuals, groups and organizations; and the external environment as they relate to a specific decision.

These components are the same as the epidemiological model of Section I. This is the triangle of inter-relationships between the characteristics of the group (or individuals, groups, organizations) the e

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7. Leonard J. Kazmier, Principles of Management, (N.Y., N.Y. 1964) 42 - 46

8. Simon,SHerbert, et al, Public Administration (New York,Alfred Knopf)55

9. Barnard, loc cite

characteristics of the habitat (the total external environment) and finally the condition being studied (here, the variables of the decision making process).

A brief description of the components of the model of the role of the executive as a decision maker follows. Fig. 2 shows this model.

1. Interacting characteristics of individuals, formal and informal groups, agencies inside and outside of the decision maker's own organization.[10]

Any individual has a unique set of values gained from past interactions with others. The executive is no exception. His values affect everything he does to some degree. His objectivity, initiative, conformance and other personal characteristics and his training affect his ability to make a decision as well as the decision itself.

The values, interactions and activities of his own agency also influence his decision. For example, if his agency does not traditionally deal with another agency then decisions that relate to other agency will probably have conservative tones. As another example, if the decision maker's organization is non-innovative, decisions will probably show limited communications, group processes, and rigid formalization.

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10. Thompson, Victor A., "Bureaucracy and Innovation", Admin. Sc. Quaterly, 10 (June 1965) 1-20

Analogies hold for any other personal, agency or groups involved in or affected by a decision of the executive. Section II shows examples from the GA 627 course.

In defining the problem: determing facts and opinions, alternative solutions and strategy of the decision making role, the executive must also attempt to realize (as best he can) the "tinting" by the human elements. This can be a "clinker" to the entire decision making process especially if the decision maker (with his own) values) Has someone (with extremely different values) carry out the decision. What seems obvious, feasible and desireable to the decision maker may seen quite otherwise to those who are affected by the decision.

In summary, the role of the executive in decision making is not only recognition of the logical process of a decision but also the understanding of the values. Interactions and activities of all those human elements involved in the decision. This is no mean task but should be attempted by some priority system.

2. <u>The interacting environmental conditions</u>

The executive must also allow the flow of information into his decision from the outside environments: the social, political, economic, and physical environments. Of course, it may be hard to distinguish which environment the executive is looking at since in reality they are all inter-related. The important thing is that he attempts to look broadly outside his organization for the influences of his decision from and on the external environment.

If the executive is directly in one of these environments (such as an executive)of a citizen's group being in the social environment) the amount of influences from that particular environment will probably be greater than from the other environments.

There are many examples of these external environmental influences.

From the political areaa are the lobbies, interest groups and the influences of the judiciary. Similarly professional societies help to establish goals and standards for the executive in making his decisions.

The cultural-social environment of the community - its mores - must also be accounted for. Decisions with out these elements are likely to result in attacks from the community.

What follows are examples of these catagories of influences.

SECTION II: THE MODEL'S APPLICATION

The model just described admittedly is a complex one and probably requires a "super-human" mind to bring out all the inter acting factors. Nevertheless, I feel confident that it is applicable to any executive in his decision making role is possible. Realizing that he cannot possibly integrate all catagories he must choose priorities to the best he can. Proof of this last statement may be possible if extensive information were readily available on many executives as decision makers.

This is not possible. However, the model can be related to the different executives of GA 627. These presentations will provide the data base for the mode above, in lieu of comprehensive exhausted studies of decisions executives make.

Most of the executives who participated in the GA 627 course either directly or indirectly showed that the decision maker is influenced by other individuals, values and activities. The effectiveness of his decision is highly related to the executive taking these values and activities into account during the decision making process.

For example, during the November 16 presentations, Mr. Manuel Kaufman, First Deputy Commissioner, Philadelphia Department of Public Welfare, stressed that coordination with the State depends upon personalities , not structure nor organizational relationships. Thus, effective decisions involving coordination between state-city welfare agencies are inferred

to rely heavily upon understanding the values and previous experiences of the other executive involved in the decision. (Perhaps the lack of accord in decisions made during the presence of the federal government representative were due to a lack of understanding of values and activities of the city and state?)

Mr. Stanley Brody, Regional Director, Southeastern Pennsylvania Department of Welfare supported the above idea when he stated that the role of the regional directoriin welfare is to know people and to use his position to manipulate and build-up relationships with other individuals (who he may have to deal with) - to develop a mutual trust (so that decisions might be made?). He mentioned later that the individual is what the job is. Similarly the background, values and activities of decision maker and other individuals involved in the process is what the decision actually is.

At a November 2, 1967 presentations Dr. Irvin Karam, School District Supervisor noted that the decision maker in a school district must relate to the mandate being served. A decision for a new program in the school curriculum is determined by dealing with the mass media and obtaining consensus with the community. This strategy helps bring out facts and opinions of the community or schoold executive.

Social organizations such as the P.T.A. enter into the decision making process. The decision maker, Mr. Karam, must consider how best to sell the ideal of a new physical facility (Action Alternative). The political

system of interest groups and consensus making is readily apparent. The executive must determine the effects of his decision on each of these catagories.

Decisions in the Department of Licenses and Inspections will be discussed next.

On October 12, 1967, Mr. Nelson, Chief of Administrative Services and Licenses Issuance Section described the checks and balances of decisions in his organization, such as the Board of Licenses and Review. On the other hand, the decision to issue a license is based upon his values and the framework of thepolitical (legal) system. We must also depend upon other agencies to provide facts (and opinions) surrounding the issuance of a specific license. For example, the decision to issue a restaurant license depends upon the Health Department.

His Commissioner, Mr. Gordan Cavanaugh, during the October 19,1967 showed that he interacts closer with the various environmental conditions than his section chief. Decisions that he makes or those affecting him are influenced by the decisions of the federal government, (e.g. H.U.D.). He also is concerned with the socialization of people as a major concern, the total cost of programs and the total physical housing environment.

Mr. Clifford L. Jones, Secretary, Pennsylvania Department of Commerce on September 7, 1867 discussed his responsibility for making decisions regarding economic development in the Commonwealth. The major value of organization is that the State agency is only a stepping stone. It relies

heavily upon private cooperation from non-profit promotional groups. (This is an interaction with the social and political systems about it). Its planning board of laymen and professional staff make economic decisions for schools and hospitals; the Science and Economic Advisory Board depend upon expertise in the field of science and technology for decisions in these areas.

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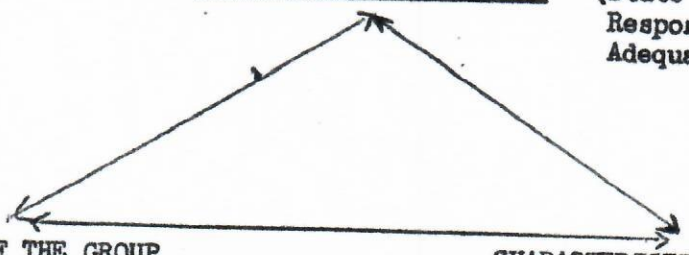
CONDITION BEING STUDIED (State of Health. Response to Health Program Adequacy of Program, etc.)



CHARACTERISTICS OF THE GROUP

1. Composition of the Group

A. Biological Characteristics
   i) Age Distribution
   ii) Sex Distribution
   iii) Race Distribution

B. Social Structure
   i) Occupation
   ii) Education
   iii) Residential Area
   iv) Social Stratification
   v) Religion
   vi) Marital Status

2. Cultural Characteristics (Including Material Products)
   i) Values, Attitudes, Framework of Knowledge
   ii) Customary Practices (e.g. Diet, Smoking, Alcohol, Disposal of Excreta, Use of Health Services, etc.)
   iii) Material Products and Equipment (e.g. Income, Housing, Water Supplies, Transportation, etc.)

3. Other States of Health and Physiological Attributes

CHARACTERISTICS OF THE HABITAT

1. Physical
   i) Temperature, Humidity, Light, Seasonal Change
   ii) Geological Structure, Water and Soil Composition
   iii) Geographic Topography, Altitude
   iv) Atmospheric Pollution, Radiation, Smog

2. Biological
   i) Micro-Organisms
   ii) Vegetation
   iii) Animal Life

3. Human - The Larger Groups Which Interact with the Study Groups

FIG. 1 Interrelationships in the Environment

Source: (Department of Epidemiology, University of North Carolina)

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It is with deep regret that we report that Dr. Ayub Ommaya passed away on July 10. (2008) Ayub had a large role in the creation of the National Center for Injury Prevention and Control at CDC. He treated a family member of Congressman Bill Lehman's and they became friends. Their discussions about the need for injury prevention research together with efforts by Mike Finkelstein of the National Highway Traffic Safety Administration (NHTSA), led to the 1985 Institute of Medicine report, Injury in America. As Chief Medical Advisor for NHTSA, Ayub oversaw the report which, with Congressional support, was the linchpin for the initial funding to create the injury control program at CDC that later became the National Center for Injury Prevention and Control. He served on the Secretary's Advisory Committee for Injury Prevention and Control for many years.
View the July 14 Washington Post obituary: http://www.washingtonpost.com/wp-dyn/content/article/2008/07/13/AR2008071301791.html.

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The American History of Poison Prevention and Control National Poison Prevention Week: March 21-27, ICEHS Newsletter 2004-page 7ff.Leslie Fisher Copyrighted 2004

The history of poison prevention and control in the US is one of the most successful chapters in child injury prevention leadership. Most recognized by the public is National Prevention Week, Congress designated as the third week in March, each year. However, few injury control professionals appreciate the gradient leveraging of educating political leaders, safety engineering design, and regulations, over many decades, that led to evidenced-based reductions in childhood toxic substances ingestions. The latest outcome is Congressional funding of regional poison control centers.

What are the leadership lessons learned or to be learned as in the 21st century continue to tackle long standing and new emerging injury risks and morbidities, from gun related suicides to terrorism, on the shoulders of our earlier injury control pioneers?

I have reconstructed that leadership history using primary documents with end notes. Please also refer, for supplemental information and resources, ICEHS Newsletter) and Shaping the Millennium. The people, events and ideas that influenced the course of child and home safety in the United States, as reported in public health journals (1900-1975) (Members Only-all at www.icehs.org)

1) Precursors for USA Poison Prevention and Control

The National Academy of Pediatrics in 1950 appointed a Committee on Accident Prevention to explore the problem so as to reduce, if possible, the toll of the leading cause of death, injury, to children. A survey chaired by Dr. George Wheatley, with Metropolitan Life, showed a large percent of these injuries related to accidental poisonings and many were handled by pediatricians and other physicians who did not have up to date information on emergency care and treatment. In 1953, the first poison control center, established in Chicago under Dr. Edward Press, led to a proliferation of similar Centers nationwide, but with duplicating efforts nationwide, especially in

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compiling emergency information. By 1957, professional books on emergency advice and treatment of the poison victim were in print. And the US Food and Drug Administration's (FDA's) National Clearing House, had leveraged by an APHA Committee's recommendation to the US Surgeon General for the Public Health Service, as the designated agency, to support the Centers' work.

2) The South Carolina Project - 1961

In 1961, a pilot sentinel study, sponsored by the US Public Health Service, the State of South Carolina, and the County of Charleston, investigated various educational methods and techniquesby which accidental ingestions of toxic substances by children might be reduced. For three years,the community was exposed to extensive radio and television programs, group discussions among church groups, garden clubs, civic organizations, nursing, pharmacy, and medical associations, and classroom projects among the kindergarten and grade school students and their parent-teacher organizations. The net result over the three-year period was 29% decline in hospitalization of children under the age of 5 years as reported by area poison control centers. Several other communities across the country developed programs patterned after the one in Charleston.

3) National Poison Prevention Week - 1950 to today Still another significant childhood poison prevention initiative was the passage of Public Law 87-319 which requested the President to designate annually the third week in March as National Poison Prevention Week (NPPW) "... to aid in encouraging the American people to learn of the dangers of accidental poisoning and to take such preventive measures as are warranted by the seriousness of the danger." In 1950, Homer George, a pharmacist from Cape Girardeau, Missouri, convinced his mayor to proclaim a Poison Prevention Week in his community. George then followed this up with the Governor of Missouri and subsequently then prevailed on his congressman to introduce national legislation.

The introduction of state and national Poison Prevention Week (PPW) provides community organizations an opportunity to initiate poison prevention programs or highlight ongoing ones. While PPW was beneficial in developing and fostering community interest, in itself had relatively little impact on the total picture of poisonings. Today, National Poison Prevention Week facilitates the bringing together of the poison prevention coalition and the resulting preventive processes during the year. Educational and promotional resources, including local proclamations, are designed for Poison Prevention Week and year-round.

4) Regulatory Efforts toward the Consumer Product (Vector) of the Potential Injurious Chemical Energy Agent

In the early 1970s, underlying his concern about the number of aspirins (especially those involving flavored aspirin) the Commissioner of the FDA met with producers of aspirin, representatives of poison control centers, and public health officials. One of the results of the conference was a voluntary agreement on the part of the manufacturers to restrict to a lower toxicity dose the number of children's aspirin in a single container to 36 one and one-quarter grain tablets. This approach would do little to affect the frequency of ingestions but hopefully would have an effect on their severity should a child swallow the aspirin.

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5) Vector/Agent, Environment, and Host Controls System Wide Preventive Practices

Another decision of the FDA conference laid the groundwork for a far-reaching change in US consumers' experience with the packaging of household products. The FDA’s industry chairperson appointed a subcommittee to look into the state of the art for child-resistant packaging which one manufacturer of children's aspirin was already using, on a voluntary basis. The manufacturer offered to make available whatever data the firm had which might be useful to the Subcommittee. As part of this new approach to the prevention of poisonings, two

independent studies were undertaken. One showed that child-resistant packaging was more effective to prevent poisonings than the standard screw caps. The other showed while that a vigorous education program to prevent childhood poisonings for 10 years had no effect, but that the initiation of child-resistant closures on all prescription tablets and capsules significantly reduced ingestions. Backed by this and related information showing that childhood ingestions could be reduced through the use of child-resistant packaging and that regulations for just cautionary labeling or warnings on household toxic substances were inadequate, as concurrently documented by state health departments and poison control centers, Congress enacted the Poison Prevention Packaging Act. 6) Monroe County - New York State Health Department Demonstration Project - 1976-79

The Monroe County Poison Prevention Project used these findings that informational and educational programs can make a dent in some poisonings but that community-based education, environmental and regulatory efforts to control the substance itself were also required in comprehensive use of poison prevention countermeasures.

Using an extensive review of the prior poison prevention initiatives nationwide and extensive hospital assessment of countywide poisonings, the project, funded by Blue Shield Insurance, CPSC, Health Research Inc contracts, showed empirical positive changes in poisoning reports to the PCC, to local hospital emergency departments, to household and retail risk behaviors marker household toxic substances. The project showed some $25 saved for each 1$ spent. The projects' successful outcomes and promises led in 1966 to the NYS Legislature amending and the Governor signing a NYS regional poison control center act to fund (about $3 million/year, Medicaid) State designated regional poison control centers, establishing standards, an advisory council. The NYS majority political party had received the bill from the minority party sponsorship and recognized the cost containment value of poison prevention and control.

7) More Recent National Leadership Actions

In small part using the NYS work, the US Congress began to explore that national poison control centers were about to close due to cuts in funding. Hearings and studies by CDC/BMCH, DHEW have funded regional centers nationwide.

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Source: Professor of History, Kendra Smith-Howard, State University of New York Health in her Fall 2011 graduate student course" History of Public Health in the United States", lectured on the above course reading among other books (I was privileged to audit). Histories of typhoid, et al, public health historical studies, draw provocative parallels to COVID-19, today. Leavitt covers non-symptom carriers and all readings on the past challenges of change, e.g. slow gradient historical progress toward public health prevention especially IVP: More on the communicable diseases' history is beyond my present study:

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Shah, Nayan. *Contagious Divides: Epidemics and Race in San Francisco's Chinatown.* Berkeley: University of California, 2001.

Tomes, Nancy. *The Gospel of Germs: Men, Women, and the Microbe in Everyday Life.* Cambridge: Harvard, 1999.

Warren, Christian. *Brush with Death: A Social History of Lead Paint*. Baltimore: Johns Hopkins, 2000.

Additionally, SUNY-ALB Professor David Hochfelder's Fall 2011 course, The Gilded Age, 1865-1896) suggested to me the many differences and parallel landscapes and tensions for today's economic and political downturns; and SUNY-ALB Professor Kendra Smith-Howard's Spring 2014 course, Progressive Generations offered extensive background on the safety (e.g. child labor, playgrounds) and larger Progressive reforms. Her lectures also guided analyzing, researching and using primary and secondary source documents. (See especially her end-course resource: Gordon, Linda. (New York University). If the Progressives were Advising Us Today, Should We Listen. *Gilded Age and Progressive Era. 1:2 (April 2002).*

Do not go where the path may lead, go instead where is there is no path and leave a trail. (Thoreau)

Don’t cry when it all ends. Laugh that you were doing it - at all!

Version management page:

Name	Date	Notes
Nathaniel Pinkes	9/5/2021	
Nathaniel Pinkes	10/10/21	

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Historiological Lessons Ignored in Public Health. A Focus on Injury and Violence Prevention

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This paper is dedicated in honor of the J IP Retired Chief Editor, Dr. Rob McClure 's. years of distinguished service to IP and IVP and to our other historical IVP pioneer leaders

At times, IVP (Injury and Violence Prevention), et al, mentors, educators, researchers, practitioners and advocates, are unaware of complex interacting historiographical contextual drivers: Ethical, physical, biological, economic, psychological, sociological that must be integrated in applying decision-making matrices and forecasting potential evidence-based scenarios (1,2).

Instead, it's not unusual to read a IVP journal article that cites only short background historical sentences that excludes analyses of holistic historiographical contexts; but, instead some analogs, many with just are unintended false dichotomies and polemic (3)

Here is one, familiar , of many IVP case studies of contextual effective drivers and scenarios: *Leadership in Child and Home IVP*, case (4): The context of the 1950's of the developing US poison control centers' (source:1960's PHS training courses) data increasing public and physician calls on prevention and emergency care Some politicians and manufacturers perceived the PCC system as a growing business control menace and a failure. However, timely, gradient collaborative leadership heuristics among pediatricians, business, government, media, parents confronted that false dichotomy.

Historiographies can sometimes offer lessons from leadership paradigms; but, mostly empathy for IVP leaders' mutual struggles for Public Health IVP and other public health evidence-based-sciences and arts.

In group collaborative planning and development dynamics, we all have experienced the lack of early mailing of brief written and timed topic meeting agendas The first meeting is most important as a welcome mixer with self-introductions, participants' election of leadership chair, vice chair, and secretary for minutes .the mandates; sharing examples of what other leaders

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nationwide have done well in process and outcomes; later potentially available program funding sources, actions and other expected dynamics--- what can go wrong. and will). Advisory groups can also appear as pawns to limit more unfunded agency mandates or to help develop more gradient political advocacy- even inviting a key legislative leader to recommend program names and IN VIVO supporting ideas

Commented [f1]:

An expert facilitator greatly can offer group deliberations with silent. Adelphi group decision making techniques, and asap guide group objectives by definition: clear, specific, doable, concrete, time lined and who will do, if not clearly directed by the sponsoring organization.

So, get out more into public health IVP leadership (like Pasteur, Godfrey, Fleming, Salk, Wheatley, Moynihan, Haddon, Baker, Greensher, Mofsenson, Rosenberg, Mc Clure and many ,many others who coached and mentored) and more away from the computer lab of those days to advocate to media, government, business, government, and not only talking, just to ourselves, our non-collaborative disciplines' ideas or critiques.

Today, walk the walk, together, with your prophetic angry against yesterday's, todays' and even futures' forecasting of one-sided, nonsensical and false historical contexts/polemics on gun violence prevention, Covid immunization, drug addiction, women's rights, and climate change.

1 https://www.amazon.com/Teaching-about-Future-Peter-Bishop/dp/0230363490 Bishop and Haines. Teaching about the Future. Paulgrave McMillen NY NY 2012 (see my comments on helping teach IVP futures to university students

2. Arnold JU. The Art of Decision Making. 7 Steps to Achieve More Effective Results. John Arnold Exec/Trak Inc. 1978.

3. https://www.google.com/search?q=false+dichotomy+how+to+react+to+it&gs_ivs=1#tts=0

4 Fisher L. E-book: A history of Child IVP Leadership The APHA History Project 9/5/2021.:

https://www.aphahistoryproject.org/category/membership-groups/history-of-sections/injury-control-and-emergency-health-service/ Search IVP PH exceptional collaborative outcome models e.g. poison prevention week; polemics, prevention in health care, a nascent IVP historiographic, leadership course curriculum with student exercises: All with cites of primary and secondary resource documents, and other IVP archives many at APHA. ICEHS MEMBER CONNECT LIBARY.'

The opinions are mine and not necessarily those of any organization.

I am retired