

# Restraint Systems for the Prevention Of Injury to Children in Automobile Accidents

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**Abstract:** Highway accidents are the leading cause of child deaths in the United States from the ages of 1–14 years—6,122 such deaths occurred in 1973.<sup>1</sup> In most instances deaths and permanent injuries occurred with the child as a passenger in an automobile. One approach toward alleviating this problem is the restraint of children in automobiles to reduce the likelihood of injury in a crash.

During 1970 through 1974, a series of studies were done in a large population of infants who attended a well child clinic at Madigan General Hospital, Tacoma, Washington to determine the types of child restraint systems used, and the effect of several different educational approaches to influence parents to use safe restraint systems for transport of their infants and young children in motor vehicles. Personal recommen-

dations by either a physician or a nurse at the four-week visit in the well child clinic increased parent compliance by twice that of other techniques by the eighth week of life. Ninety-six per cent (46/48) of the infants who were safely “packaged” at eight weeks of age, were still in relatively safe restraint systems at 9–12 months of age. The effect of various educational stimuli resulted in overall compliance rates at 9–12 months of 74%–88% compared with a pre-study rate of 38%. Compliance may be improved by parent education in the early postnatal period.

Multi-approach educational programs that involve the physician and/or nurse early in the life of an infant are effective in influencing parents to obtain and use safer restraint systems. (Am. J. Public Health 66:451–456, 1976)

“The chapter of accidents is the longest chapter in the book.”

John Wilkes (1727–1797)

## Introduction

Can a mother of a newborn baby lift 200 pounds? This is a question a physician might ask when discussing the need for safe automobile restraints. For in a head-on accident during the infant's first ride home from the hospital, with an impact of only 10 mph, this is the restraining force the mother must exert to hold the infant. At 30 mph, the infant can easily reach a peak weight of almost 600 pounds within 3 milliseconds. To put it another way, the mother would not be able to hold onto her infant, even if she was securely strapped in. She needs help to protect her infant from injury. The mother of a newborn usually does not realize that she needs help. Her mind is directed toward many other problems. Prevention of automobile accident injury is probably one of the last things on her list of priorities. The concerned health worker can provide her with the guidance she needs to obtain a restraint system that will decrease the chances of dis-

abling injury and death to this fragile new member of the family.

*Is there a significant risk?* In the last ten years over 15,000 children under the age of five years were killed in highway crashes (1,988 fatalities in 1973<sup>1</sup>). In most instances the young children and infants were not properly restrained at the time of the accident. In one study of 3,922 motor vehicle occupants from birth to age five years in motor vehicle accidents in Washington State during 1970, only 513 were in restraint systems (13.1 per cent).<sup>17</sup> The per cent of children restrained was less than one-half that of adults in motor vehicles (28.6 per cent). In the same study, motor vehicle occupants were significantly protected from disability and death when they were wearing seat belts or other restraining devices. Of 16 children, ages 0–5 years, killed in Washington State during 1970, not one was in a restraint. A cumulative 5-year review of the 1970 through 1974 seat belt statistics disclosed 19,061 motor vehicle occupants were under age five with only 2,880 restrained (15.1 per cent).<sup>18</sup> Not a single one of the 2,880 restrained young children was killed. However, 82 of 16,181 children who were not restrained were killed outright, or died as the results of injury (Ratio 1:197).

If present trends continue, the average U.S. citizen will have a 50 per cent chance of receiving a bed disabling injury and a 2 or 3 per cent chance of dying due to a motor vehicle accident.<sup>1</sup> The risks of both disability and death can be substantially reduced by the use of safe restraint systems.

*What were the restraint systems used by servicemen for their young infants in the State of Washington during 1970?* This question was answered in part by conducting a survey in September 1970 of 100 consecutive infants between the ages of 9

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to 12 months brought to the well child clinic at Madigan General Hospital for care. In this survey the parent was asked, "What restraint system do you most frequently use for your infant when you travel in your family car?" The responses are tabulated in Table 1, Group I. Sixty-two used either no restraint or restraint systems that were clearly unsafe; 38 used car seats of some type. Further inquiry disclosed that the car seats used varied from seats that hooked over the back of the rear automobile seat, to elaborate and expensive seats recommended by "experts". There was no consistent source to which the parents looked for advice. Ninety-eight of the 100 family automobiles had at least two seat belts. A minimum of two seat belts were required for registration of the automobile on the local military posts. However, there was no requirement for a child restraint system. Consequently, most young infants were not being transported safely.

This study and other published reports reveal that the majority of parents continue to neglect using restraints when transporting their children.<sup>3, 6, 9, 14, 19</sup> It is of particular concern that pediatricians and other primary care physicians do not exercise their influence as forcefully and persistently as they might to inform and persuade parents to protect their children from accidental injury. That pediatricians in private practice can be influential in persuading parents to install seat belts in automobiles, has been documented.<sup>2</sup> However, there are no published studies of pediatrician-directed educational programs which would indicate the degree of effectiveness of any specific approach to influence parents to obtain and use effective restraints for their children.

*What to recommend?* Information regarding what restraints to recommend, in 1970, came from review of several key articles.<sup>4, 5, 8, 9, 11, 12, 15, 19</sup> Initially only two items seemed worthy of recommendation: (1) The GM (General Motors) Infant Carrier for infants from birth to 9–12 months, or 20 lbs.; and (2) the Ford Tot-guard for infants and children from 20 lbs. to 40 lbs. In the fall of 1970, the total daily production of Ford Tot-guards for the entire U.S. was 18. These were available only through Ford dealers. However, the GM Infant Carrier was available in larger quantities (daily production 200), and arrangements could be made to sell them at a discount in our local Post Exchanges. Federal Motor Vehicle Safety Standards had been established for Harnesses (#209),<sup>11</sup> but standards for seats (#213) were not to be effective until April 1971.<sup>12, 13</sup> Also, there was then and continues to be severe criticism that Federal Motor Vehicle Safety Standard #213 was not stringent enough.

### Study Methods

We decided to concentrate on educational programs designed to help parents of young infants transport them more safely. The basis of our program was a static display located in the waiting room of our well child clinic which featured actual samples of a GM Infant Carrier, a Ford Tot-guard, and a standard car seat that had been recommended by the Physicians for Automotive Safety.<sup>17</sup> Since 1970 the GM Infant Carrier and the Ford Tot-guard have been consistently

rated safer than other devices sold in this country.<sup>3, 5, 6, 14</sup> Pamphlets, which gave parents specific instructions regarding restraint systems and told them where to obtain the restraints, were part of the display. The pamphlets also included information to help dispel commonly held fallacious beliefs, including: (1) Infants are safe when held in mother's arms<sup>10</sup>; (2) In case of an accident it is safer to be thrown clear<sup>16</sup>; (3) Travel in the city is safer than on the freeway<sup>7</sup>; and (4) Children should travel in the front seat so parents can watch them closer.<sup>7</sup>

The local Post Exchanges were stocked with GM Infant Carriers in anticipation of our campaign. To determine the effectiveness of this educational program, parents of 500 infants who came to our well child clinic at age four weeks were divided randomly into small groups of 12 to 20, stimulated in a variety of ways, and then reassembled into five groups of 100 each (Groups A-E). The effect of the stimulus was evaluated, at the eight week visit, by a questionnaire. As a way of maintaining interest among staff and to reduce bias, the results were not disclosed until after the study was completed.

Responses regarding the use of restraint systems were divided into two general groups: I. *Unsafe*, which included: no restraint, held by another passenger, seat belt, an infant seat or papoose seat system.\* II. *Safer*, included: a car bed lashed to the second seat by a seat belt, or a General Motors Infant Carrier. Both of the safer systems were mentioned in the pamphlet. However, preference for the GM Infant Carrier was emphasized both in the pamphlet and by clinic personnel. The stimuli given and the results are summarized in Table 2 and discussed below.

#### Results and Discussion

##### Questionnaire at 8 Week Visit (Table 2) (Number Studied in Each Group = 100)

**Group A**—Received no stimulus. At the eight week visit, 91 per cent of parents were transporting their infants unsafely. Most parents (57 per cent) relied on another passenger to hold the infant. Infant seats were used by 26, four used car seats, and one used a seat belt. Nine infants were transported most frequently in a safer manner—eight used car beds and one used a GM Infant Carrier that had been purchased from a local car dealer.

**Group B**—This group was exposed to a display in the clinic. No reference was made to the display by the clinic personnel. In fact, they *avoided* any mention of it. At the eight week visit, 88 were transporting unsafely, 11 were using car beds, and one a GM carrier. There was no significant difference between Groups A and B.

**Group C**—This group was exposed to the display, and, in addition, the secretary in the clinic placed a pamphlet in the hand of each parent when they checked in and asked them to read it. She did not discuss the contents unless asked. When asked, her answers tended to be short and factual. Five infants were in GM Infant Carriers at eight weeks, however,

\*There was general agreement by those physicians and nurses involved in the study that an infant or child restrained by a seat belt was in fact *safer* than a hand-held child or one who was unrestrained. However, for the purpose of this study, infants restrained with seat belts only were considered *unsafe*. Car seats are not recommended until the infant can sit without support.

**TABLE 1—Survey of Restraint of Infants Ages 9 to 12 Months in Automobiles**

Group	Number Studied	Stimulus to Parents at Well Baby Visits					Restraint System Most Frequently Used (Nearest Whole Per Cent)										
		Display Age 4 Weeks	Display to Age 9-12 Months	Questionnaire Age 8 Weeks	Secretary Age 4 Weeks	Nurse Age 4 Weeks	Physician Age 4 Weeks	Unsafe					Safer				
								None	Held	Seat Belt	Infant Seat	Other	% Unsafe	Car Seat	Harness	GM Infant Carrier	% Safer
I	100	0	0	0	0	0	22	17	5	8	10	62	38	0	0	38	
II	100	+	+	0	0	0	1	11	9	0	0	21	78	1	0	79	
A	52	0	+	+	0	0	0	2	11	8	2	23	77	0	0	77	
B	54	+	+	+	0	0	0	20	2	5	0	27	72	0	2	74	
C	62	+	+	+	+	0	0	9	7	3	5	25	67	0	8	75	
D	59	+	+	+	0	0	0	10	3	3	2	19	74	0	7	81	
E	58	+	+	+	0	+	2	5	5	0	0	12	81	3	3	88	

Statistical Significance  
 (1) I vs II, A,B,C vs D,E  
 $p \leq .001$   
 (2) II,A,B,C vs D,E  
 $X^2 = 2.96$  with 1 d.f.  $.05 < p < .10$   
 (3) II vs A,B,C,D,E  
 $p = n.s.$

**TABLE 2—Restraint of Infants Age 8 Weeks in Passenger Automobiles**

Group	Number Studied	Stimulus to Parents					Restraint System Most Frequently Used (Nearest Whole Per Cent)											
		Neonatal	Pamphlet Nurse Physician Display	Age 4 Weeks—Well Child Clinic	Display	Secretary	Nurse	Physician	Unsafe					Safer				
									None	Held	Seat Belt	Infant Seat	Car Seat	Other	% Unsafe	Car Bed	GM Infant Carrier	% Safer
A	100	0	0	0	0	0	0	3	57	1	26	4	0	91	8	1	9	
B	100	0	+	0	0	0	0	2	53	5	24	3	1	88	11	1	12	
C	100	0	+	+	0	0	0	1	63	0	26	2	0	92	3	5	8	
D	100	0	+	+	0	0	0	3	47	2	26	0	0	78	7	15	22	
E	100	0	+	+	0	0	+	4	43	0	24	6	1	78	9	13	22	

Statistical analysis:  
 1) A, B, C, D, E.  $X^2 = 54$  with 1 d.f.  
 $p \leq .001$   
 2) Pooling the nurse and physician stimulation groups and testing against the other stimuli (A B C vs D E).  
 $X^2 = 15.9$  with 1 d.f.  
 $p \leq .001$

there was no significant difference between Groups A, B, and C in the number traveling more safely.

**Group D**—In this group, the parents saw the display and the clinic nurse spent one to two minutes encouraging them to take a pamphlet, read it, and obtain a GM Infant Carrier. At eight weeks, 15 parents did so. Combined with the seven infants transported most frequently in car beds, a total of 22 were traveling more safely.

**Group E**—In this group the parents saw the display and a physician spent one to five minutes encouraging them to read the pamphlet and to obtain a GM Infant Carrier. The results at the eight week visit were similar to Group D. Thirteen had Infant Carriers and nine used car beds.

From this study, it appeared that involvement by the nurse and/or the physician was *essential*, if parents were to be stimulated to obtain proper restraint systems for very young infants. However, most parents in all study groups were not convinced that holding the infant was really unsafe or that flimsy infant seats were insufficient. The physicians and nurses felt an injury to their egos when at the end of this study phase they learned how many parents had *not* responded to their recommendations. However, we continued to stimulate parents at the four week examination period with the display and verbal encouragement by the physicians and nurses on a less formal basis.

As another measure of effectiveness, we monitored the sales of the GM Infant Carrier in the local Post Exchanges for ten months following the end of the study. The sales of GM Carriers ranged from 35–54 per month, while the newborn nursery monthly admission rates ranged from 184–225. During the spring of 1972, along with a turnover in nursing and physician staff, the enthusiasm for the infant restraint program began to wane. Purposely we made no attempts to restore enthusiasm; the sales reports dropped rapidly to a low of three per month within four months, the GM Infant Carriers started gathering dust in the warehouses, and the Post Exchanges did not reorder. The visual display in the clinic remained unchanged, except for periodic updating of the pamphlets. It was even more apparent that the stimulus of a personal contact by a physician or nurse was required to maintain a compliance rate above 1 or 2 per cent for the GM Infant Carrier.

We were interested in knowing whether those that were transported unsafely at eight weeks continued to be unsafe at 9–12 months, and whether or not those who were safe at eight weeks continued to be safe. Therefore we sought to contact all 500 respondents to our 8-week questionnaire. We were able to contact from 52–62 from each original group of 100. The rest had left the area, or had been discharged from the service. Those remaining had visited the well child clinic at least five times during the intervening period. The loss to follow-up appeared to be random when based on the mode of restraint at the eight week visit. An additional (comparison) group of 100 mothers with infants 9–12 months of age (Table 1, Group II) was surveyed, to determine whether or not the questionnaire itself had influenced Groups A, B, C, D, and E.

### Questionnaire at Age 9–12 Months

The results are summarized in Table 1, with the five

study groups (A-E) compared to the pre-study group (I) and the comparison group (II).

All groups stimulated by repeated exposures to the display and updated pamphlets (Groups II, A, B, C, D, and E), transported their infants more safely than the pre-study group (I). The highest percentage (88 per cent) was in a group originally stimulated by a physician at the four week visit. However, the difference between the physician stimulated group and all others exposed to the display with or without other stimuli was not significant. During the 8–11 months preceding the second survey, casual recommendations were given by the physician and nurse during well child clinic visits which may have obscured the effectiveness of the display alone. Although several respondents mentioned in the comment section that the questionnaire had made them “think about” child restraints, there was no significant difference between the group that did not receive a questionnaire and the groups that did.

Anecdotal information from the comment section of the questionnaire indicated that many parents were helped by repetitious viewing of the display and stimulated to find suitable equipment. The decision to obtain a car seat was frequently made when the infant reached 7–8 months of age. Parents would often call the clinic and ask for recommendations. Parents tended to purchase car seats available in the Post Exchanges, because they were conveniently located and less expensive than in local department stores. Repeated contacts with local Post Exchanges by our Department ensured that only car seats that complied with Federal Regulation #213 were sold.

The most interesting observation from this follow-up survey was that most infants in safer restraints at eight weeks continued to be transported safely at 9–12 months (46/48) (Table 3). Only two parents regressed. One parent had received a GM Infant Carrier as a gift. When the ten month old infant had outgrown it, the mother held the child while the father drove. The other mother had used a car bed initially, and at twelve months, had the infant in a baby walker in the back of a recreational vehicle. Although most of the infants not safely restrained at eight weeks were in safer restraints at 9–12 months, 58/184 were not. The difference between the groups unsafe or safe at the eight week visit and at the 9–12 month follow-up survey is highly significant. It appeared that *the infant who starts safe stays safe*.

**TABLE 3—Follow-Up Survey of Infants Safely and Unsafely Restrained in Automobiles at Age 8 Weeks**

	Age 8 Weeks (Groups A—E)	Age 9–12 Months		
		Unsafe	Safer	% Safer
Unsafe	242	58	184	76
Safer	48	2	46	96

p = <0.01

## Epilogue

This observation renewed our sagging interest in re-establishing an educational program. We decided to start in the early neonatal period. In this program we planned to give each mother a pamphlet which would encourage purchase and use of GM Infant Carriers by the second day of the infant's life. The Army Health Nurse would reinforce the need for a safe restraint at the post partum class for mothers later on the second day or on the third day. On the date of discharge, the physician would ask the parent if she had read the pamphlet and offer to answer any questions. Before starting our second major educational program, we again surveyed 100 parents, at the eight week examination during November 1972 to determine whether or not they had a GM Infant Carrier. Only one did. This served to confirm our impression that any program initiated to educate parents to purchase safe automobile restraints for children must be continuous and consistent. By letting up on our original program, parents had been allowed to slip back into old habits.

Concurrently with the survey in the well child clinic we started our educational program in the nursery. One hundred parents stimulated in the nursery during November 1972 were asked at the four week examination whether or not they had an Infant Carrier. Eleven had and the rest did not. However, despite the observation that only 11 per cent had responded to this program, the Post Exchange had been swamped with orders and had sold out within four weeks from the launching of our new study. Also, contact with local GM dealers disclosed that sales were averaging 10 per week with some backlogs of orders compared to essentially no sales in the early fall of 1972. The resurgence in sales of GM Infant Carriers at the local Post Exchanges and automotive dealers, as the result of our educational program, in December and January 1973, preceded a nationwide advertising campaign by General Motors which was imitated five months later, in April, 1973.

This Group of 100 was not followed for compliance beyond age 8 weeks, but at 8 weeks of age 16 were using a GM Infant Carrier and three had them on order. Also, a significant number had shifted the previously held infants to flimsy infant seats (a practice to be condemned). Many used infant seats because they recognized that holding the infant was *not safe*. The increased use of infant seats was a partial response to our recommendations made during the neonatal period. A small sampling of ten who used infant seats disclosed that three thought they were adequate, four considered them all right for ordinary travel but did not think they would be safe in a crash, and three bought them because a GM Infant Seat was not available in the Post Exchange when they went to make a purchase.

One excuse used by parents repeatedly for not obtaining a GM Carrier was the cost. However, placing this reason in its proper perspective, the cost (about \$16.00) is equal to one or two tanks of gas. Put another way, the cost is less than 6¢ per day for its useful life of at least nine months.

Studies were not continued beyond the age of one year. However, if our hypothesis is correct—that an infant in a safe restraint early in life remains in a safety restraint into

early childhood—then our efforts toward motivating parents to seek a restraint early in life might be considered analogous to “immunizing” early to prevent a serious disease.

Thus far it seems apparent that a physician-nurse directed educational program for parents can be an important influence in guiding them toward safe restraint systems for use in the family automobile. Physician-nurse interest, combined with the presence of a visual display of appropriate restraints in the well child clinic, was a motivating stimulus to parents at each visit to the clinic, which influenced many parents to obtain and use safer restraints for their young infants.

The data reported were based primarily on parents response to questions. The actual behavior and the consistency of the transport of infants in a safe manner was not measured. However, to transport safely, safe restraints must be available. These studies reflect, most likely, a measure of parental intent to protect their infants and young children.

It remains to be proven that the infant who takes his first ride home from the hospital in a safe restraint, will, with the further guidance of his parents, progress into a lifetime continuum of safe restraints as a result of habit. However, the consistent use of suitable restraints for young infants and children will contribute toward a significant reduction in childhood injury and death on our nation's highways.

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### **Calendar for Policy Development Process 1976**

The following calendar has been established for processing position papers and resolutions of the American Public Health Association this year. These procedures are designed to ensure careful technical review by expert committees and to provide an opportunity for any member of the Association to comment on each policy paper at the Annual Meeting in Miami Beach, October 17-21, 1976, prior to final action by the Governing Council. Proposed resolutions and position papers should be sent to APHA, Division of Program Services (or section liaisons) 1015 18th Street, NW, Washington, D.C. 20036 by June 1, 1976.

- June 1 Deadline for position papers and resolutions to be received at APHA headquarters.
- June 1-28 The four reference committees (Personal Health Services; Environment; Manpower & Training; Social Factors) will review each proposed policy statement.
- June 28-29 Joint Policy Committee (JPC) meets in Washington, D.C. to make recommendations on each proposed policy statement.
- July 9 All proposed policy statements are returned to authors with review comments and recommendations of JPC.
- July 30 Deadline for all revised policy statements to be returned to APHA headquarters.
- September 10 Proposed policy statements sent to affiliated officers and members of Governing Council; copies sent to APHA members in *The Nation's Health*.
- October 18 Public Hearings during Annual Meeting. Submission deadline of 2:00 pm for "late breaking events." Only those policy statements which address issues arising between June and the Annual Meeting will be considered as "late breaking." Anyone wishing to submit a late-breaking resolution should contact the Chairperson of either the Action Board or the Program Development Board before 1:00 pm for referral to the appropriate hearing.
- October 19 Joint Policy Committee (JPC) meets during Annual Meeting to develop final recommendations for presentation to the Governing Council the next day.
- October 20 Governing Council votes on policy.

Proposed resolutions and position papers, plus name of the submitter and the recommendations of the JPC, will be published in the Agenda Book of the Governing Council. The September issue of *The Nation's Health* have the full text of each proposed policy statement; printed copies will also be available in the registration area at the Annual Meeting in Miami Beach. Resolutions and position papers adopted by the Governing Council will be published in this Journal as soon as possible following the Annual Meeting.