Testimony to House Committee on Early Childhood and Family Support

Regarding House Bill 2643

Thank you for the opportunity to speak regarding House Bill 2643. I am here today testifying on behalf of the **Oregon Chapter of the American College of Surgeons**. The Chapter is in full support of the Bill in its current form, and I have no personal conflicts of interest to declare.

I would like to describe to you the emergency department when an injured child arrives as a trauma patient. First, everyone is a little more nervous – heart rates and blood pressures are high. It is loud- if the child is conscious, they are crying. Special protocols for equipment sizes must be followed and medications doses must be adjusted. It is harder to place IVs into their little veins, and difficult to obtain blood for lab work. Crying relatives might be outside, or the next patient over in the department might be a sibling or parent. The child might be the same age as your little girl.

I don't care how perfect your team runs, or how jaded your trauma surgeon is, pediatric trauma is hard. There are emotional, technical, and social considerations that are unlike anything I have experienced taking care of adults. So it shouldn't surprise you that a major interest of pediatric and trauma surgeons is Injury Prevention. Another interest of surgeons is using evidence to guide therapy.

House Bill 2643 provides an evidence-based solution, albeit partial, to the ongoing problem of children being injured at higher rates was not properly restrained in moving vehicles. Other speakers today have emphasized data, but I would like to take a moment to remind the committee that there were 3,817 childhood deaths from car crashes in 2014, and that the leading causes of death in children are all preventable. Rear facing infants have greater protection for their fragile neck and spine.

The American College of Surgeons supports strong passenger restraint legislation, including the bill presented here today.

A rear facing child seat is sometimes called the "orphan seat." In a moving vehicle, if a collision is made with another object, a rear facing infant is the most protected occupant of the vehicle. If the force is from the sides or the front of the vehicle, they are protected by the car seat, and if the force is from behind, they are protected by the vehicle seat. No other occupant in the car is so protected.

Please help eliminate unnecessary injuries among our most vulnerable citizens. Pass House Bill 2643, a measure supported broadly by the medical community of Oregon – including the Oregon Pediatric Society, I Oregon Medical Association, Oregon Chapter of the American College of Surgeons, and the Oregon Chapter of the American College of Emergency Physicians (OCEP).

Finally, I want to speak as a mother who has lived with this change. I have young children myself. My daughters, age 3 and 5, are both pretty tall for their age. My 5-year-old was an infant when the American Academy of Pediatricians originally released their recommendation to increase the rear facing age to two years old. I recall great debate among parents about this change. I would hear some of the following arguments:

- "I can't see my infant when they were rear facing, how will I know if they are safe?"
- "My toddler gets bored looking at the back seat all the time"
- "I think I know what's best for my child"

This committee, or other committees reviewing this Bill may hear these arguments. After review of the evidence, reviewing the recommendations of the AAP, National Highway Traffic Safety Administration, and Centers for Disease Control, I don't think any parental argument trumps the need to keep the child rear facing until age two.

Respectfully submitted,

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