THE DAILY CLIPS

October 3, 2007

News, commentary, and opinion
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Author and CEO to speak as part of ECU College of Business series

Juan Enríquez is a leading authority on the economic and political impacts of life sciences.

The Daily Reflector

The College of Business at East Carolina University will feature best-selling author and businessman Juan Enríquez as its first speaker for the new Cunanans Leadership Speaker Series today at 3:30 p.m. at the Hilton Greenville. The presentation is free of charge and open to the public.

Enríquez is chairman and chief executive officer of Biotechonomy LLC, a life sciences research and investment firm based in Boston. He is widely recognized as a leading authority on the economic and political impacts of life sciences.

He also is an expert on the dynamics of the knowledge economy and the other social and political forces that are driving change in America and the world today.

Enríquez is the author of "As the Future Catches You," an analysis of the impact of genomics on business and society, as well as "The United States of America," which explores why, as technology advances, some countries are successful while others disappear.

"We are thrilled to bring some of our nation's most successful leaders to Greenville through the Cunanans Leadership Speaker Series," said Frederick Niswander, dean of the College of Business. "Insight from leaders such as Juan Enríquez will enrich, energize, and inform our students, faculty, and citizens alike."

In July, the College of Business announced the establishment of the Cunanans Leadership Speaker Series, made possible by a gift from Steve and Ellen Cunanans of Richboro, Pa. Matching funds were provided by the Johnson & Johnson Foundation.

The Cunanans Leadership speaker series is designed to bring distinguished leaders to Greenville, representing for-profit and nonprofit firms, entrepreneurial activities, government, and public affairs. Topics highlight leadership, professional development, ethics and the role of business in modern society.
Screenings for prostate cancer urged

A man dies from prostate cancer every 20 minutes. Currently, medicine's best options for men with prostate cancer exists when the disease is diagnosed early. This can be accomplished via screening and regular prostate exams.

Therefore, I congratulate the 175 men and their families who took advantage of the free prostate cancer screening at the Leo Jenkins Cancer Center on Sept. 29. I also congratulate the physicians' and staff of Eastern Urology, ECU and PCMH who volunteered their time and effort for this important cause.

More information about prostate cancer treatment and prevention can be found at the Radiation Oncology Web page on the East Carolina University site.

DR. RON R. ALLISON
director
Leo Jenkins Cancer Center
Brody School of Medicine at East Carolina University
Businesses aid cancer research

By Kathryn Kennedy
The Daily Reflector

Eating a bagel for breakfast may help fight against breast cancer. But only if you buy that bagel from Panera Bread.

The bakery-cafe at 516 Greenville Blvd. began baking its annual Pink Ribbon Bagel on Monday morning. A quarter will be donated to Pitt County Memorial Hospital’s Cancer Services for each ribbon-shaped, cherry-vanilla bagel sold during October.

The store kicked off efforts Tuesday morning with a ceremony and survivors’ breakfast, where Brody School of Medicine doctors provided information urging awareness and the importance of early detection. One hospital administrator also shared her own experiences fighting the disease.

Kathy Dutton, a registered nurse and the hospital’s vice president of emergency services, has been free of breast cancer for five years, news that brought the audience of approximately 25 pink-clad women to their feet.

“We need to band together and provide support for those who are currently going through this,” she said, before expressing her gratitude to God, her family, friends, and her “hospital family.”

“It wasn’t easy to continue going to work with a scarf or a hat, no eyebrows and no eyelashes, face puffy from chemotherapy, but they supported me.”

City Councilwoman Mildred Council read a proclamation from Mayor Don Parrott deeming October Breast Cancer Awareness Month and provided some revealing statistics.

An estimated 4,870 cases of invasive breast cancer will be documented in North Carolina in 2007, with 1,240 of those causing death, Council said.

Panera became involved with breast cancer fundraising three years ago, when one of the franchise owners developed the disease, said a company spokeswoman.

She said the Greenville location hopes to surpass the $1,300 raised during last year’s campaign.

Ashley Furniture Home Store also is donating money in honor of Breast Cancer Awareness Month. Five percent of total sales from Friday through Sunday will go to the American Cancer Society.

“We decided to participate in this partnership because it gives the opportunity to raise money to help fight a disease that effects so many people,” said store licensee Tony Howell in a recent news release.

“The American Cancer Society is a reputable organization that has a solid history of helping fight cancer and providing services to cancer patients and their families.”

Additionally, mattress manufacturer Simmons will donate $50 for every Coble Hill Euro Pillow Top or Indigo SPT mattress sold at the Home Store through Sunday.

Pink Ribbon cards for a suggested $3 donation will be available all month.

Kathryn Kennedy can be contacted at kkenneedy@coxnc.com or 329-9566.

EVENTS

• V103.3 Live Broadcast: 6-9 a.m. at Pitt County Memorial Hospital’s Pine and Elm Rooms.

• Free Breast Cancer Screening: 4:30-6:30 p.m. Oct. 9 and Oct. 23 at Eastern Radiologists’ Breast Imaging Center, Arlington Boulevard.

Screenings are by appointment only. Call 847-6018.

• Evening Lecture: 6:30 p.m. Oct. 11 at Eastern Radiologists’ Breast Imaging Center. Dr. Bruce Schroeder, Eastern Radiologists Inc. Breast Imaging Center, and Dr. Nizar Habal, Carolina Breast and Oncologic Surgery, will talk about detecting and treating breast cancer. Dinner will be served. Call 847-6018 to register.

CANCER

Continued from A1

SHARON BEST, left, and her daughter, Alisha Burnett, sign up for a Mary Kay gift certificate during a kickoff event for Breast Cancer Awareness Month at Panera Bread on Tuesday.
Heart treatment favors white men

Studies: Women and black men overlooked

BY KRISTIN COLLINS
STAFF WRITER

White men with heart disease are far more likely to get a simple life-saving treatment than women or black men, two new studies from Duke University show.

The studies, published today in the Journal of the American Medical Association, found that men were up to three times more likely than women to get an implantable device that shocks a malfunctioning heart back into a normal rhythm, even though heart disease is the leading cause of death among women. Black men also lost out, getting the device about 25 percent less often than white men.

The device, called an implantable cardioverter defibrillator, can be installed with a minor surgery and is considered one of the best treatments available for people at risk of sudden cardiac arrest. The disease, in which the heart abruptly stops beating, kills a thousand Americans a day, according to federal statistics.

The Duke studies are the latest in a growing body of research showing that doctors treat women and minorities differently, even when their health problems are the same. Past research has shown that women and minorities get less aggressive treatment for cancer, HIV and other diseases.

SEE HEART, PAGE 10A

fewer preventive procedures and less advice about healthy behaviors. The disparities persist even when patients have similar financial situations or lifestyles.

"Unfortunately, there’s a recurring theme from all these kinds of studies," said Kevin Schulman, a Duke internist who worked on the heart studies. "It’s that you really have to take care of yourself, be aggressive, get a second opinion. The system’s not consistent."

In one of this week’s studies, researchers combed through the records of more than 256,000 Medicare patients between 1999 and 2005, all of whom appeared to be eligible for a defibrillator. Medicare covers most of the $30,000 to $40,000 cost of the devices.

They found that the devices, which have been in use for about a decade, were vastly underused. When they were implanted, men were most often the beneficiaries. For every 10 men who got a defibrillator, only three or four women did. Seven black men got the device for every 10 white men.

Even patients whose hearts had stopped in the past faced the same discrepancies in care.

In the second study, researchers studied use of the defibrillators among about 13,000 patients at 217 hospitals across the country between 2005 and 2007, a group that included some patients younger than Medicare recipients. They found that only 35 percent of those eligible for the device got one. Women were 50 percent less likely than men to receive them, and black men were 25 percent less likely than white men.

The researchers who ran the studies said they were shocked by their findings.

"We’ve been trying to promote awareness that women die of heart disease," said Adrian Hernandez, a Duke cardiologist and lead researcher on the second study. "We were hoping that people would recognize this."

They say they don’t know the reasons for the stark differences across gender and race lines. There is no medical evidence suggesting that doctors should consider those factors when prescribing defibrillators. And in the Medicare study, all patients had the same insurance coverage — so cost was probably not a key factor, they said.

The researchers said it is possible that some patients refused the device against their doctor’s advice.
Doctors’ stereotyping

Experts say that the roots of this and many other medical disparities often lie within the relationship between patient and doctor. In many cases, the doctors are white men.

“They have stereotypes about minorities and about women and about old people and young people. We all do,” said Jay Kaufman, a UNC-Chapel Hill epidemiologist who studies health-care disparities. Kaufman was not involved in the defibrillator study. “It doesn’t mean that physicians are bad people. But physicians are the ones who have to write it down and have their judgments studied.”

Kaufman said doctors are often forced to make snap judgments because they have so little time with patients. That may lead some to assume, for example, that a black patient might not make the necessary lifestyle changes such as exercise or diet that are critical to a treatment’s success. Kaufman and others also said that some patients, especially women, might not be as aggressive as white men in seeking treatment for heart problems.

Several years ago, a survey by the American Heart Association found that many women did not consider heart disease a risk to them, even if it ran in their families.

“A lot of women just kind of ignore the symptoms, because they’re so busy taking care of everyone else in their lives,” said Sloan Garner, spokesperson for the Morrisville office of the American Heart Association. “They think heart disease is a man’s disease.”

Tesia Kinard, 42, of Durham, said she suffered through nine years of life-threatening congestive heart failure before her doctors at Duke implanted a defibrillator. Despite working as an assistant in a cardiologist’s office, she said she had never heard of the device until 2004, when her heart stopped while she was sitting in a doctor’s waiting room.

She was dead four minutes before emergency workers brought her back.

After that, Kinard said, there was never any doubt among her doctors at Duke that she needed a defibrillator. She said the device has saved her life at least once in the three years since it was installed.

Kinard says she has no complaints about her care, but she meets other female heart patients through a support group. She said they tell stories of being dismissed by doctors who blamed their symptoms on indigestion or anxiety.

“The word needs to be out there that we do suffer,” Kinard said. “We as women have to be our own advocates. Only we know what our symptoms are.”

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WOMEN AND BLACKS GET FEWER HEART DEVICES

Studies led by Duke University researchers found that women and blacks were far less likely than white men to receive implantable heart defibrillators to prevent sudden heart failure.

Percentage of people eligible to receive an implantable defibrillator who got one

<table>
<thead>
<tr>
<th></th>
<th>Black women</th>
<th>White women</th>
<th>Black men</th>
<th>White men</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>26.2%</td>
<td>29.8%</td>
<td>33.4%</td>
<td>43.6%</td>
</tr>
</tbody>
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Note: From a study of 13,034 patients at 277 hospitals.
Source: Journal of the American Medical Association

The News & Observer

WHO NEEDS ONE?

The defibrillator, an electrical device about the same size as a pacemaker, shocks an improperly beating heart back into normal rhythm. Medical guidelines recommend the device for patients:

- Who have had a previous cardiac arrest
- Who have chronic heart failure and severely diminished ability to pump blood out of the ventricles

CARDIAC ARREST

Cardiac arrest strikes immediately and without warning. Here are the signs:

- Sudden loss of responsiveness
- No normal breathing, even when when you tilt the victim’s head up and check for at least five seconds
- If you are alone with an adult who has the signs of cardiac arrest, call 911 and get an Automated External Defibrillator before you begin CPR

SOURCE: AMERICAN HEART ASSOCIATION

TOP KILLERS (2004)

654,092
heart disease

550,270
cancer

150,147
stroke
(cerebrovascular diseases)

123,864
chronic lower respiratory diseases

108,694
accidents
(unintentional injuries)

SOURCE: CENTERS FOR DISEASE CONTROL AND PREVENTION
The missing mission

Recent N&O reports announced two major events at UNC-Chapel Hill. Chancellor James Moeser is stepping down, and the university plans a major push to fund a new campus to be called Carolina North. Both were instructive in the priorities of our current higher education system. Neither mentioned education!

Moeser was lauded mostly for fundraising. The Carolina North Campus is described as an attempt to expand research facilities and "strengthening ties" with corporate partners. Obviously, these two goals are intertwined and likely have little to do with educating students. In fact, most "researchers" will not ever teach a student. The dollars being bandied about are staggering.

If a private university wants to spend its time, effort and money on such matters, so be it. When a public university, using public funds, loses sight of its primary mission, that of educating the young in its own state, it is disgusting.

Moeser led the charge to bring in more out-of-state students, and the Board of Trustees wants to impress corporate entities and rate high on the silly U.S. News & World Report's annual rating.

Maybe a history or English instructor could use a raise; after all, they do all the teaching!

Greg Gault
Raleigh
NCCU welcomes new master's field

Hospitality, tourism classes respond to market

BY ERIC FERRERI
STAFF WRITER

DURHAM – N.C. Central University will soon offer a new series of hospitality and tourism courses for graduate business students — a nod to a burgeoning market and the university’s desire to develop areas of specialty.

Approved last week by university trustees, a master’s in business administration program will offer a concentration in hospitality and services management, a broad field in serious growth mode.

Across the country, the industry expects to add 20 million jobs in the next decade, including 78,000 in North Carolina, and the university wants to place some of its MBA students in those high-paying jobs, said Beverly Bryant. She directs NCCU’s undergraduate hospitality and tourism administration program, a 10-year-old venture that has grown from 12 students in its first year to 180 now.

The growth is obvious, Bryant said: Just look at the continual development of hotels, restaurants and the like.

“People are always going to eat, people are always going to sleep, and they’re always going to take their families for entertainment,” she said, adding that the program might help improve an under-representation of minorities in hospitality and tourism management.

Although plenty of universities offer undergraduate hospitality programs, few do so through graduate business schools, Bryant said. Within the UNC system, NCCU is thought to be the first, she added.

The program will begin next fall, and Bryant expects about 25 students to enroll. Some will come from traditional undergraduate tourism programs, while others will be older students who have hit a ceiling within the industry and want to get into management.

It can be lucrative; a survey of available management jobs in hospitality and tourism this week in the Triangle found salaries ranging from $78,000 to $104,000, Bryant said.

For the university, the program does what new Chancellor Charlie Nelms wants: fills a need and offers the chance for NCCU to establish itself as a leader in a specialized market. One of Nelms’ first goals in taking over as NCCU’s leader is to find opportunities for the university to expand in areas where it already has a foothold or can offer a

SEE NCCU, PAGE 6B

NCCU
CONTINUED FROM PAGE 1B

service other institutions do not.

“I think it aligns nicely as one of the niche areas for this university,” Nelms said recently.

The success of the graduate program makes the graduate initiative viable, said Provost Beverly Washington Jones. She pointed to established relationships between the university and hospitality industry giants including Marriott hotels, Sodexo, Darden Restaurants, which provide internships and job opportunities for graduates.

“The program has been very well-planned with partnerships with industry,” Jones said. “It makes a lot of sense.”

Ted Conner, vice president for economic development for the Durham Chamber of Commerce, agreed.

“You look around at the number of hotels and the number of restaurants — it’s a situation of supply and demand,” he said. “It’s a huge industry and someone has to staff it.”

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As Carolina North moves ahead, here's a primer

UNC-Chapel Hill will hold a public information session on Carolina North on Thursday, the first community meeting since the board of trustees approved plans for the research campus Sept. 26.

Carolina North will be built two miles north of the main campus. The trustees' approval moves the project to the next phase, working with the town of Chapel Hill on permits and planning. Here is a look at the project and what some people are saying about it.

What is it?

Campus leaders say Carolina North will be a research, corporate and residential campus. Eventually it will house university research programs, startup businesses, a public school, housing, retail and recreation facilities.

The university has been holding public information sessions over the past few months. You can see the plans and read the comments at cn.unc.edu.

Where is it?

The site is nearly 1,000 acres, but plans call for developing only about 250 acres over 50 years. The initial development will be centered on what is now the Horace Williams Airport runway.

The development has been in the works for about 12 years. The university began looking at uses for the Horace Williams tract in the mid-1990s.

Why does UNC-CH want it?

The main campus is filling up. The university plans to move some operations that would collaborate with and support industry.

Carolina North also will be an incubator for public-private business partnerships that the university hopes will boost economic development and create jobs.

SEE NORTH, PAGE 6B

BY THE NUMBERS

1,000 ACRES: Approximate size of the Horace Williams tract
250 ACRES: Amount of land UNC-CH anticipates developing
729 ACRES: Size of existing UNC-CH central campus
5,000: Parking spaces UNC-CH wants at Carolina North
$220 MILLION: Estimated infrastructure costs (roads, utilities, etc.) for the 15-year phase
500,000 SQUARE FEET: Estimated amount of housing in the first phase
85,000 SQUARE FEET: Size of the Innovation Center, probably the first building to go up
**NORTH**
CONTINUED FROM PAGE 1B

**What's next?**

Construction on the likely first building, the 85,000-square-foot Innovation Center business incubator, could begin next year. It would be built by a private developer who would collect rent from tenants.

Other development would happen more slowly. The trustees approved 15- and 50-year plans for the campus.

The university says it might build a law school at Carolina North, as well as research space for the School of Public Health.

**What about the airport?**

Horace Williams Airport is home to the medical school's medical air operations. Doctors are fighting to keep the 70-year-old airport open and say it helps them serve rural areas. Medical flights account for less than one in four flights, records show. The rest are by private pilots.

The university plans to move the medical air operation to RDU. It says it will take 16 to 21 months to build a hangar there at a cost of $3 million.

**What people are saying**

'Carolina North is really about the university's third century. We will do, and need to do, some new and innovative things in the mission of the university. Carolina North gives us the space and the opportunity to do that.'

**JACK EVANS, CAROLINA NORTH EXECUTIVE DIRECTOR**

'One of the larger concerns about the whole project is they're going to have a whole lot of employees. Martin Luther King Boulevard is already very crowded. If they all drive to work, it'll become pretty intolerable. If we limit parking, it will encourage people to use public transit. And that will relieve some of the congestion, not to mention it will reduce the carbon footprint of the whole project.'

**CAM HILL, CHAPEL HILL TOWN COUNCIL MEMBER**

'I see it as a great opportunity for the town to have some high-tech research economic base that could support the people that actually live here.'

**JENNIFER ROGERS, CITY AND REGIONAL PLANNING STUDENT AT UNC-CH**

— Samuel Spies
CAREER MOVES

News about people who have been named or promoted to positions and news about business activities in North Carolina should be sent to Business News Desk, The News & Observer, 215 S. McDowell St., Raleigh, N.C. 27601 or e-mail amyrue@newsobserver.com

RBC Centura executive has bigger territory

Steve Jones has been named RBC Centura’s market president of the Carolinas and Virginia, expanding the territory he oversees.

Jones will assume his expanded role at the end of the month when Robin Lyle, market president for Western North Carolina and South Carolina, retires. That territory encompasses 85 bank branches and 600 employees.

Overall, Jones will oversee 206 branches and more than 1,500 employees. He will continue to be based in Raleigh.

The promotion continues Jones’ ascent at RBC Centura. In February, he became president of the bank’s Eastern North Carolina and Virginia market.

“Since joining RBC Centura in 2000, Steve has proven to be a great leader, and we know that he will continue to be an important asset as our business grows,” said in a prepared statement from Drew Putt, RBC Centura’s president.

Jones, 39, is a native of Fayetteville and graduate of East Carolina University.
THE INFORMED PATIENT
By LAURA LANDRO

A Dangerous Gap in Trauma Care

Systems to Transfer Patients
To Best-Equipped Hospitals
Fall Short in Most States
October 3, 2007; Page D1

Catapulted off his motor scooter after hitting a deer in Big Lake, Minn., last month, 74-year-old Robert Johnson was bleeding internally from a ruptured kidney and spleen and had multiple broken bones when he was brought by ambulance to the emergency room at Monticello-Big Lake Hospital.

Staffers at the small community facility quickly arranged for Mr. Johnson, a pastor, to be transported via helicopter to North Memorial Medical Center, a designated Level I trauma center that serves Minneapolis and areas to its northwest. There, specialists with high-tech imaging equipment inserted a tiny filter in one of Mr. Johnson's veins to prevent potentially deadly complications from the bleeding, and another device to prevent his kidneys from leaking fluid into his body.

"I should have been dead after what happened to me," Mr. Johnson says. "The local hospital just didn't have the facilities to take care of my injuries, but I was lucky that there is a web of protection in Minnesota."

Many patients in the U.S. who are severely injured aren't so lucky. Trauma from injuries including accidents, falls and violence is the leading cause of death for Americans under the age of 44, claiming more than 140,000 lives and permanently disabling 80,000 people annually. But only one in four lives in an area served by a coordinated system to transfer patients to designated trauma centers from less-equipped hospitals, according to the American College of Surgeons, which sets standards for trauma care. And only eight state trauma systems met nationally recommended preparedness levels in a study by the federal government after the Sept. 11, 2001, terrorist attacks. While some progress has been made, many states remain woefully unprepared, trauma experts say.

Efforts are under way to develop a national trauma system to ensure referral of severe injuries to qualified...

http://online.wsj.com/article_email/article_print/SB119137095495147098-IMyQiAxMDE3OTAxMzM... 10/3/200
centers, but funding is tight. In the meantime, it's often up to patients and families to be prepared and know what level of trauma care their local hospital can provide before an accident happens -- or what arrangements the hospital has to transfer patients if necessary. Patients can check out the American College of Surgeons Web site, which has a list of verified trauma centers and the level of care they provide (www.facs.org/trauma/verified.html).

At highest risk are those in rural areas, where nearly 60% of trauma deaths occur even though such areas account for only 20% of the population. But some big cities such as Washington and heavily populated states such as California are still struggling to put all the pieces of a failsafe trauma system together. Since 1990, the federal government has provided only about $34.1 million to help develop statewide trauma systems. A law passed in the spring authorized an additional $12 million for all 50 states. Some states have passed or are considering their own legislation to create formal trauma systems.

While the biggest threat, of course, is a mass casualty like a natural disaster or terrorist attack, hundreds of thousands of victims suffer injuries each year that can quickly turn into life-threatening events, from car crashes and gunshot wounds to falls or a child's injuries on a football field. Studies show that patients who suffer traumatic injury are 25% more likely to survive if they are treated at a verified trauma center.

But emergency departments are plagued with overcrowding and long waits, which make it harder to determine quickly which patients are in need of transfer. And while many community hospitals may have experienced surgeons on staff, often there is no on-call system to make them available 24/7.

"While patients can pick and choose where to go for elective procedures, if you are in a car accident or fall off a ladder, you are at the mercy of the system -- or the lack of a system," says A. Brent Eastman, chief medical officer of Scripps Health, a nonprofit health system based in San Diego, and an American College of Surgeons trauma expert.

"Americans think if they call 911 that everything is going to be taken care of, but there has to be a trauma system in place to ensure that you are taken to a center that can provide the level of care commensurate to the degree of your injury," Dr. Eastman says.

While local and state authorities designate trauma facilities, the American College of Surgeons verifies their level of expertise: Level I centers are the most highly equipped, with a full range of specialists and equipment such as CT scans available 24 hours a day, as well as trauma research and education programs. Level II centers provide trauma care but aren't required to do research or have a surgical residency program. Further down the chain are Level III centers, which don't have all the specialists but can perform emergency resuscitation, surgery and intensive care of most trauma patients, and have transfer agreements with higher-level centers. Finally, Level IV centers can stabilize and treat severely injured patients in remote areas where no alternative care is available.

Michael Rotondo, who heads the American College of Surgeons group that consults on trauma-system development, suggests that consumers who aren't located near a Level I or II trauma center should ask if their local hospital has staffers trained in the Advanced Trauma Life Support Course, which is used to train
emergency workers around the world. And they should ask whether the hospital has a transfer arrangement with a trauma center, especially since ambulances often take patients directly to the nearest hospital or to hospitals specified by local ordinance.

State health-department Web sites usually have information on trauma care; if there is no formal trauma system in place, Dr. Rotondo urges residents to lobby local and state officials to create one, no matter how rural or remote the community.

Trauma systems coordinate care in a specified geographic region with air-transport arrangements and written transfer agreements between hospitals that cut through red tape. In San Diego, for example, which created a trauma system two decades ago, the mortality rate from preventable deaths has dropped to just 1% from 22%. Triage experts working by phone can quickly help determine if a patient is severely injured. They can then guide emergency responders -- including firefighters, emergency medical technicians and ambulance drivers -- to the nearest trauma center instead of just the nearest emergency room.

A recent beneficiary of the San Diego system was Bubba Blackwell, a stunt rider who suffered massive injuries in a crash when he attempted to jump over 22 cars with his motorcycle at an event in nearby Del Mar in July 2001. With a shattered pelvis, broken vertebrae and ribs, punctured lungs and a severe head injury, he was immediately taken by helicopter to the Scripps Memorial Hospital in La Jolla -- rather than another facility not designated as a trauma center. There an MRI revealed a subdural hematoma. "Not only did I recover, but everything still works," says Mr. Blackwell, who credits the trauma center with saving his life.

Some large trauma centers work closely with hospitals in their region to create their own de facto system. The Department of Surgery at the Brody School of Medicine at East Carolina University worked with University Health Systems of Eastern Carolina over the past five years to develop the Pitt County Memorial trauma center in Greenville, N.C. The center hired experts in surgical critical care, paying specialists extra to be on-call 24 hours, and bought new high-tech equipment. And it set up transfer arrangements and collaborative agreements with 19 other regional hospitals.

Over five years, according to Dr. Rotondo, head of Brody's surgery department and chief of trauma at Pitt County Memorial, the death rate in severely injured adult patients fell from 22.4% to 16.4%, and fell in injured children from 27% to less than 10%, saving more than 200 lives. The cost -- $15 million or about $70,000 per patient -- is a bargain, he says.

Minnesota, meanwhile, is attempting to improve its system and has provided 80 grants of up to $5,000 to hospitals for equipment or training. Larger trauma centers like North Memorial, where Mr. Johnson was treated, also help train physicians and nurses in nearby hospitals to better recognize the less-obvious trauma cases and quickly transfer patients they can't handle.

"The more they know, the quicker they can make the decision to move patients up the chain of care," says Kevin Croston, surgical director of trauma at North Memorial and chairman of the state trauma committee. "If someone walks into a rural hospital with an ax in their head, it shouldn't take three hours to make the decision that he needs a neurosurgeon."

• Email informedpatient@wsj.com

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