THE DAILY CLIPS

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East Carolina University News Bureau
E-mail to durhamj@ecu.edu  Web site at http://www.news.ecu.edu
252-328-6481 FAX: 252-328-6300
Princeton history professor’s ECU address focuses on Civil War

Pulitzer Prize winner James McPherson delivered the history department’s annual Brewster Lecture to more than 300 Wednesday night.

By Jimmy Ryals
The Daily Reflector

Honest Abe and Tardy George.

In managing the Civil War, the Union’s commander-in-chief and its early general-in-chief diverged as sharply as their nicknames.

The enmity between President Abraham Lincoln and Gen. George McClellan was the topic Wednesday night for James McPherson, a leading Civil War scholar and history professor at Princeton University, who drew 300 people to Mendenhall Student Center for the East Carolina University history department’s annual Brewster Lecture.

Opening his comments, McPherson acknowledged some anxiety that he wouldn’t get a warm reception at ECU: a New Jerseyite lecturing North Carolinians about two of the most famous Union figures of the Civil War.

McPherson thought “since my topic was going to be about the rather dysfunctional relationship between the commander-in-chief of the Union armies and the general-in-chief of the Union army, that maybe my topic would be more welcome in these latitudes after all,” he said.

Lincoln was, in turns, “dull as a baboon,” “my strongest friend,” “the original gorilla” and an imbecile, McClellan wrote in letters to his wife during his time leading Union troops, McPherson said. McClellan commanded either the Army of the Potomac, the full Union Army or both from August 1861 to November 1862.

To Washington critics — more bitter enemies to McClellan than the Confederacy, McPherson said — and, eventually, Lincoln, the general gained a reputation for stalling. McClellan regularly overestimated enemy strength by 300 percent and held back his soldiers while waiting for Lincoln to approve unreasonably large troop surges.

On multiple occasions, Lincoln ordered McClellan’s armies to move on Confederate troops in Virginia. In January 1862, Lincoln went so far as to draft his own battle plan. Lincoln told McClellan aide “if General McClellan doesn’t want to use the army, he (Lincoln) would like to borrow it,” McPherson said.

McPherson’s “Battle Cry of Freedom” won the 1989 Pulitzer Prize for nonfiction. It is “the single most comprehensive, most important single-volume work that has been written” about the Civil War, ECU history professor David Long said. McPherson praised Long and Gerald Prokopowicz, head of the ECU history department, for their scholarship on Lincoln.

During a question-answer session after his formal comments, McPherson suggested that a fear of failure drove McClellan’s indecision. The general had lived a fairly charmed life: born to a wealthy doctor’s family, admitted to West Point at 16, second in his class on graduation and a rising military star before age 30.

“Because he had never experienced failure, he was obsessed by its possibility, either consciously or subconsciously,” McPherson said. “I think he did not want to take risks by attacking because if you take risks, there’s always the possibility of failure. It goes with the territory.”

Jimmy Ryals can be contacted at jryals@coxnc.com and 329-9568.
Fair offers seniors health information

The Daily Reflector

A health fair for area senior citizens brought a variety of agencies to the Aquatics and Fitness Center on Staton Road Wednesday morning.

East Carolina University students were among the groups providing services. At one booth, occupational therapy students tested the driving skills of participants. Lecturers discussed health topics and screenings for blood pressure, vision, diabetes and glaucoma were offered.

The Pitt County Health Department provided flu vaccinations for a fee. Fitness center staff later offered a line dancing demonstration to illustrate the variety of activities that offer exercise opportunities.
HOSPITAL BITES BACK AGAINST SUPERBUG

PCMH moves to universal testing for staph infections

By Jimmy Ryals
The Daily Reflector

As public concern over an antibiotic-resistant staph infection has risen in recent months, the strain's spread at Pitt County Memorial Hospital has been declining.

Methicillin-resistant Staphylococcus aureus, or MRSA, infections have fallen at the hospital since an aggressive new screening program began this past winter, hospital officials announced at a news conference Wednesday in the microbiology lab. MRSA pneumonia cases related to ventilator use have decreased by two-thirds in that time; cases tied to urinary tract infections are down 60 percent since February, officials said.

MRSA passed during surgery has dropped significantly, too, said Dr. Keith Ramsey, medical director of the hospital's infection control program. Ventilators, catheters and surgical suites are "superhighways" for MRSA transition, state epidemiologist Dr. Jeffrey Engel said.

"We're at war with a bad bug, and it's not just in our community," said Dr. Clyde Brooks, medical director of Pitt Professional Services and clinical operations. "It's a national war. It's actually a worldwide problem, this bug." MRSA has grabbed headlines recently with a series of deaths around the country. Two weeks ago, a pair of employees of the East Carolina University bookstore acquired MRSA but suffered no long-term health consequences.

Since February, Pitt Memorial has run MRSA tests on everyone admitted to the hospital. Roughly 8 percent

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of the 27,000 people screened were carrying MRSA bacteria, more than the 3 percent or 5 percent hospital officials had expected, according to a hospital news release.

Pitt Memorial is the only hospital in the state that universally tests patients for MRSA, according to the release. It's one of two in the nation using the practice.

Pitt Memorial President Steve Lawler applauded hospital employees and trustees for "pushing our organization to take a leadership role in identifying opportunities to make an impact on MRSA and help our patients enjoy health care in a safer environment."

Engel launched the hospital's first major staph screening effort in 2001. Then a Brody School of Medicine professor and head of infection control at the hospital, he started targeted testing for high-risk groups, primarily patients transferred from other facilities and nursing homes. High-risk screening continues at other hospitals owned by University Health Systems of Eastern Carolina.

MRSA has only grown as a serious health threat since Engel left for his job with the state Department of Health and Human Services, he said Tuesday. The strain emerging in recent years travels in locker rooms, jails and day care centers, rather than hospitals, the historic home of an older MRSA strain, Engel said. MRSA is responsible for most of the skin and soft-tissue problems treated in emergency rooms, he added.

"MRSA is no longer isolated to hospital-acquired infections," he said. "It is now a serious, communitywide problem."

Late last year, hospital leaders saw a spike in MRSA cases and decided to expand the testing regimen, Ramsey said. Since Feb. 1, the hospital has tested all patients admitted. Two weeks later, universal testing began for elective surgery patients. Patients can opt out of the test, but "virtually no one" has, Brooks said.

The test is "fairly simple," Ramsey said: a swab of the nostril, where humans typically carry the MRSA bacteria. Pitt Memorial Vice President for Quality Linda Hofler got the swab during the news conference. If the bacteria is present, the patient gets twice-daily doses of a nasal antibiotic for five days, Ramsey said. An antibacterial soap is also part of the treatment.

The idea is to root out MRSA before it enters the hospital, said Ramsey, who is also a professor of medicine at the Brody School of Medicine.

"We fully expect that with the changes we've made and as we tweak the program and understand how to do it better, we can reduce those infections even more. So again, the goal is to make it safer for folks to get care in the hospital," he said.

The PCMH testing system is a model for other hospitals, Marcy Harrison, vice president for performance improvement of VHA Central Atlantic, VHA works with 1,000 hospitals and health care systems around the country to improve quality, according to the PCMH news release.

"We really feel that the move that's been made here is a very bold statement of the vision of an organization and the leadership to accomplish it," she said.

Jimmy Ryals can be contacted at jryals@coxnc.com and 329-3588.
Racism is racism

In a column last month, I wrote about "Indoctrinate U," a recently released documentary exposing egregious university indoctrination of young people at prestigious and not-so-prestigious universities. I said the documentary only captured the tip of a disgusting iceberg.

The Philadelphia-based Foundation for Individual Rights in Education, a frontline organization in the battle against academic suppression of free speech and thought, released information about what's going on at the University of Delaware, and probably at other universities as well, that should send chills up the spines of parents of college-age students. The following excerpts are taken from the University of Delaware's Office of Residential Life Diversity Facilitation Training document. The full document is available at the FIRE Web site.

Students living in the university's housing, roughly 7,000, are taught: "A racist is one who is both privileged and socialized on the basis of race by a white supremacist (racist) system. The term applies to all white people (i.e., people of European descent) living in the United States, regardless of class, gender, religion, culture or sexuality. By this definition, people of color cannot be racists, because as peoples within the U.S. system, they do not have the power to back up their prejudices, hostilities or acts of discrimination. (This does not deny the existence of such prejudices, hostilities, acts of rage or discrimination.)"

This gem of wisdom suggests that by virtue of birth alone, not conduct, if you're white, you're a racist.

If you're white and disagree with racial quotas, preferences and openly racist statements made by blacks to whites, and you call it reverse racism or reverse discrimination, here's the document's message for you: "Reverse racism: A term created and used by white people to deny their white privilege. Those in denial use the term reverse racism to refer to hostile behavior by people of color toward whites, and to affirmative action policies, which allegedly give 'preferential treatment' to people of color over whites. In the U.S., there is no such thing as 'reverse racism.'"

I agree with the last sentence. Racism is racism irrespective of color.

A white University of Delaware student might not have an ounce of ill will toward any race. According to the university's document, he's a racist anyway.

FIRE's outing of the University of Delaware's racist program elicited this official response from Vice President Michael Gilbert, "The central mission of the University, and of the program, is to cultivate both learning and the free exchange of ideas." (According to the FIRE web site, as a result of public exposure, and without condemning this racist program, on Nov. 2 President Patrick Harker ordered the mandatory re-education halted pending a review.)

It's a safe bet the university did not highlight this kind of learning experience to parents and students in its recruitment efforts. Nor were generous donors and alumni informed that they are racists by birth. I'd also guess that this kind of "education" was kept from the state legislators who use taxpayer money to fund the university.

Walter Williams is an economics professor at George Mason University, Fairfax, Va.
Easy test tells doctor if a patient smokes

By Eric Nagourney
New York Times News Service

If doctors want to know if their patients smoke, they can always just ask. But researchers say there may be a better way to determine a patient's smoking status — and at the same time provide a powerful incentive to quit.

Using a simple device that lets doctors know how much carbon monoxide is in the blood, doctors can often pick out the smokers, a new study says. And they can then tell the patients much of their blood at that moment is unable to carry oxygen.

One of the researchers, Dr. Sridhar P. Reddy of St. Clair Pulmonary and Critical Care in Michigan, said an alarm went off on the device in his office when it detected carbon monoxide over a certain level — and it did not go unnoticed by patients.

"It typically goes off at 10 percent," said Reddy, a pulmonologist. "They're wondering, why the bells and whistles?"

He tells them that a tenth of their blood is for all practical purposes not available to them.

The study was presented at a recent conference of the American College of Chest Physicians. The presentation was made by Reddy's son, Ashray, a high school student who began the study as a science project.

The advantage of using the device, a pulse co-oximeter, is that it is quick and noninvasive, the Reddys said. It clips onto the fingernail.

Smoking is not the only thing that causes high carbon monoxide levels. One patient, Reddy said, was found to have an exhaust leak in his pickup truck; another had a problem with his home heating system.

Whatever the cause, reducing patients' exposure to carbon monoxide can help them avoid heart and lung problems in the future.
Vital Signs

Health and fitness news and notes from The New York Times

Education level, dementia

People with more years of schooling appear to suffer the symptoms of dementia later than others who have it — but once it does come, it proceeds more quickly, researchers say.

The study found that for each additional year of formal education, the onset of memory loss was delayed by more than two months. The report, led by Charles B. Hall of the Albert Einstein College of Medicine in the Bronx, appeared in the Oct. 23 issue of Neurology.

The researchers based their findings on a study that began following the health of 488 people, ages 75 to 85, in the early 1980s. This study looked at 117 of them who had dementia.

The study suggests there may be a flip side to the benefits that education brings to the brain when it comes to memory loss. People with a lot of schooling are believed to develop what is known as cognitive reserve.

"Because education is associated with cognitive reserve," the study said, "more pathology must accumulate before cognitive decline accelerates."

But once the effects of dementia begin, they move more rapidly, because the condition is more advanced, the researchers said.

Music conductors’ eyes, ears alert

To concentrate on a difficult task that involves listening, people tend to unconsciously divert their attention from what they are seeing.

But music conductors, a new study reports, are not as apt to be distracted in this way.

Researchers used magnetic resonance imaging to compare how 20 conductors and 20 nonmusicians handled complex auditory tasks.

The researchers were from Wake Forest University Baptist Medical Center and the University of North Carolina at Greensboro. They were especially interested in learning whether their subjects would continue shifting resources as the demands of listening became more complex, said the lead author, Dr. W. David Hairston of Wake Forest.

The volunteers were placed in an MRI scanner and asked to listen to different notes over headphones while keeping their eyes open. As the notes were played closer and closer together, they were asked to say which they heard first.

In both groups, activity in the parts of the brain involved with seeing decreased, but as the task became more difficult, only the nonmusicians turned off more of their visual processing.

Part of the explanation may lie in the need for conductors to make extensive use of both their eyes and ears, “to read the score and to keep track of who’s playing what,” Hairston said.
UNC tuition increases will be more moderate

State budget, new caps limit damage

BY APRIL BETHEA
THE CHARLOTTE OBSERVER

Tuition increases should take a smaller chunk from the accounts of many UNC system undergraduates and their parents, thanks to a fatter budget from state lawmakers.

Four schools, including UNC-Chapel Hill, can't request any tuition increase for in-state undergraduates under a new policy the UNC system's Board of Governors approved last year.

That policy limited tuition increases to 6.5 percent each year but promised to lower the cap if the system received better-than-average funding from the state. The caps don't apply to out-of-state or graduate students, though campuses must justify any proposed increases.

UNC system President Erskine Bowles pushed for the new policy, saying the schools have a responsibility to keep tuition low and state leaders have a responsibility to adequately finance public universities.

One provision of the policy states that the tuition caps for each campus would drop if the schools received more than a 6 percent increase in state funding. For example, an increase of 7 percent would drop a school's tuition cap to 5.5 percent.

Fee increases, excluding those for debt service, still face a 6.5 percent cap.

More from the state

As a whole, the UNC system received a 10.7 percent increase in state money for this school year, said Rob Nelson, vice president of finance.

The size of the increases varied by campus. UNC-Charlotte received 7.5 percent more in money per full-time-equivalent student, dropping its tuition cap to 5 percent. UNC-Chapel Hill's increase was 12 percent, leaving it no room to raise tuition for its in-state undergrads.

N.C. State University is one of five schools able to propose a 6.5 percent increase.

However, NCSU leaders expect to submit a smaller proposal to the Board of Governors. Under a proposal going before NCSU trustees next week, tuition would rise by $100 to about $3,380 next school year for in-state undergraduates.

Out-of-state undergrads would face a $200 tuition increase under the proposal, while there would be no increase for graduate students, school leaders said.

UNC-Charlotte trustees are expected to vote on that school's tuition proposal next month. All proposals are due to the system office by Christmas, and trustees will vote on plans in February.

2008-09 TUITION CAPS

Better-than-average state funding means UNC campuses are facing new caps for their tuition proposals for in-state undergraduate students. Here is what those students are paying this year and what the school's cap is for the 2008-09 school year:

<table>
<thead>
<tr>
<th>School</th>
<th>'07-'08</th>
<th>'08-'09</th>
</tr>
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<tbody>
<tr>
<td>Appalachian State</td>
<td>$2,221</td>
<td>2.6%</td>
</tr>
<tr>
<td>East Carolina</td>
<td>$2,431</td>
<td>6.5%</td>
</tr>
<tr>
<td>Elizabeth City State</td>
<td>$1,587</td>
<td>6.5%</td>
</tr>
<tr>
<td>Fayetteville State</td>
<td>$1,826</td>
<td>6.5%</td>
</tr>
<tr>
<td>N.C. A&amp;T</td>
<td>$1,994</td>
<td>2%</td>
</tr>
<tr>
<td>N.C. Central</td>
<td>$2,216</td>
<td>0</td>
</tr>
<tr>
<td>N.C. School of the Arts</td>
<td>$3,224</td>
<td>0</td>
</tr>
<tr>
<td>N.C. State</td>
<td>$3,760</td>
<td>6.5%</td>
</tr>
<tr>
<td>UNC-Asheville</td>
<td>$2,307</td>
<td>1.4%</td>
</tr>
<tr>
<td>UNC-Chapel Hill</td>
<td>$3,705</td>
<td>0</td>
</tr>
<tr>
<td>UNC-Charlotte</td>
<td>$2,461</td>
<td>5%</td>
</tr>
<tr>
<td>UNC-Greensboro</td>
<td>$2,458</td>
<td>2.2%</td>
</tr>
<tr>
<td>UNC-Pembroke</td>
<td>$1,949</td>
<td>6.5%</td>
</tr>
<tr>
<td>UNC-Wilmington</td>
<td>$2,413</td>
<td>3.9%</td>
</tr>
<tr>
<td>Western Carolina</td>
<td>$2,028</td>
<td>4.6%</td>
</tr>
<tr>
<td>Winston-Salem State</td>
<td>$1,701</td>
<td>0</td>
</tr>
</tbody>
</table>

SOURCE: UNC-SYSTEM
Johnson runs with a purpose

ECU senior setting team records, eyeing C-USA title

BY RON WOODWARD
CORRESPONDENT

GREENVILLE — Chris Johnson is ripping through opposing defenses just as he is East Carolina's record book this fall.

Johnson recorded a school-record 408 all-purpose yards in the Pirates' 56-40 victory over Memphis on Saturday. His fourth touchdown of the game, a 50-yard run in the final quarter, moved him past Carlester Crumpler and into first place on ECU's career touchdowns list with 38.

"I don't think I've ever seen a guy consistently do what he did, in so many facets of the game, for four quarters," ECU offensive coordinator Todd Fitch said of Johnson's performance. "He's playing with great confidence, he's working hard and he's doing all the little things we're asking him to do. ... That [individual performance] was probably the best I've ever seen."

Johnson's success is a big reason the Pirates are in position to capture the Conference USA title. With two games to go, ECU controls its fate in the East Division and would host the league championship game on Dec. 1.

Johnson's 301 rushing yards against Memphis ranks as the second-best rushing performance in ECU history. The Pirates' single-game rushing record is held by Scott Harkey, who rushed for an unforgettable 351 yards against archrival N.C. State in November 1996.

SEE ECU, PAGE 5C

ECU

CONTINUED FROM PAGE 1C

"On the first drive, I had a nice run around the left side for a score, and I could tell the offensive line was ready to play," said Johnson, who leads the nation in all-purpose yards at 218.9 per game. "After that, I had a feeling that I could have a good game, but I never thought I would get 301 rushing yards."

Johnson led the Pirates in all-purpose yards in each of his first three seasons, but he was constantly moved between running back and wide receiver.

This season, however, Johnson has started every game at running back and became ECU's main weapon on offense.

"You always want to be a consistent running team and he's obviously getting the ball a lot in the running game," Fitch said. "We try to spread the ball around, but he's certainly our focal point."

After a 1-3 start to the season, the surging rushing attack has guided ECU to five wins in its past six games.

Johnson has averaged 148.4 rushing yards and scored nine touchdowns in ECU's five-game conference winning streak.

"The offensive line has been progressing real well this season," Johnson said. "Now, I feel I have a really good offensive line and can show everybody around the country what I can really do."

As the Pirates head to Marshall this weekend, Johnson is eyeing a 1,000-yard rushing season. After the 301-yard performance against Memphis, which was the fourth-highest total in the NCAA this season, the 5-foot-11, 195-pounder has 973 rushing yards.

"My first three seasons here I couldn't do it and to be on the way to 1,000 yards this season feels real good," Johnson said. "It feels like all the hard work is paying off."

Johnson, who is the NCAA's active career leader in all-purpose yards (6,202) and kickoff return yards (2,536), also leads ECU's kickoff return unit, which ranks first in C-USA and No. 8 in the nation.

The Pirates' speedy playmaker is just 23 yards away from becoming C-USA's all-time leader in kickoff return yards.

With the loss of many leaders from last year's offense, Johnson has stepped up in many ways for the Pirates this year.

"He's come to work every day this fall, from two-a-days to right now today, he's been the hardest working guy that we have," Fitch said. "And when you have your best player doing that, it's a great thing because it sets the tempo for all of the younger guys."
Pitt Memorial program shows stubborn infections, some of them deadly, can be reduced.

BY JEAN P. FISHER
STAFF WRITER

Under pressure to curb antibiotic-resistant staph infections, which kill 19,000 people a year across the nation, one North Carolina hospital is pioneering a system that tests every patient to identify carriers of the superbug.

The effort by Pitt County Memorial Hospital in Greenville has slashed infection rates by more than 60 percent and demonstrated that the bacteria may be more prevalent than scientists suspected.

The bug in question is methicillin-resistant Staphylococcus aureus, or MRSA, which is thought to be carried by as many as 5 percent of people, and doesn't cause harm unless it enters a cut or wound. Nearly 90,000 people develop serious MRSA infections nationally, more than 80 percent in hospitals, according to the U.S. Centers for Disease Control and Prevention.

In Washington on Tuesday, the director of the centers called MRSA “the cockroach of bacteria” and called on Congress to help develop a vaccine to fight it, Cox News Service reported. With no vaccine and few new antibiotics available, Julie Gerberding said the CDC is vigorously pushing prevention messages. American hospitals have been slow to seek out and contain MRSA carriers.

Pitt County Memorial is one of just six hospitals in the United States that tests all admitted patients for MRSA, hospital officials said.

In February, hospital staff began taking nasal swabs from every patient. Carriers of the bacteria are placed under “contact isolation.” Hospital staff and visitors...
STAPH
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...don fresh gloves and paper gowns each time they enter the patient's room. Such precautions stop only after carriers are de-bugged with antibiotic ointment and soaps.

Since the effort began, infections associated with ventilators have plummeted 67 percent, Pitt County Memorial infection control specialists said Wednesday during a news briefing. Urinary tract infections caused by MRSA fell 60 percent.

"You can imagine an MRSA-free hospital," said Dr. Keith Ramsey, the hospital's medical director. "That's the end of the rainbow, and that's our goal."

Ramsey said hospital officials expected to find that no more than 5 percent of patients carried MRSA, based on the latest national research. They were surprised to find that 8 percent of the more than 27,000 patients tested since February were carriers.

Testing people to identify carriers is a proven way to reduce MRSA infections, which are considered the most active and dangerous in hospitals today. "Active surveillance" has helped hospitals in Canada limit MRSA to less than 10 percent of infections, and Scandinavian countries such as Denmark have used such testing to virtually eliminate the bug from their healthcare facilities.

American hospitals have known about MRSA since the late 1960s but have become especially concerned about it in recent years because of the rapid emergence of a new strain that is easily picked up in the community and strikes healthy people. That's the strain that made headlines in recent weeks after it caused the death of a Virginia teen.

Patients infected with the community-acquired bug, which causes more serious illness than MRSA strains traditionally found in healthcare facilities, bring it into hospitals through the emergency room. From there, it can spread.

"The community-acquired strain is now a major threat to hospitals," said Dr. Jeffrey Engel, North Carolina's state epidemiologist. "It can be very easily transmitted to patients, usually on the hands of health care workers."

The test Pitt County Memorial has used to detect the bug is simple. A swab from inside the patient's nose is taken, and samples are sent to the hospital's laboratory. The hospital invested in technology that delivers results within hours rather than the two to three days it takes using conventional laboratory tests.

Such expenses are likely to inhibit other hospitals from adopting the program. In addition to laboratory costs, hospitals must spend thousands more on protective gear such as gowns and gloves. Pitt County Memorial, the flagship of University Health Systems, a private nonprofit health system affiliated with East Carolina University's Brody School of Medicine, has invested about $1 million in its MRSA testing program, according to president Steve Lawler.

Other hospitals

At Wake Forest Baptist University Medical Center in Winston-Salem, a smaller, targeted program to detect MRSA costs about $250,000 a year. It has focused efforts on testing patients in intensive care units and other high-risk patient groups. That program has cut MRSA infections by more than half, said Dr. Christopher Ohl, an infectious disease specialist there.

Wake Forest expects to begin a universal surveillance program starting next year, Ohl said.

In the Triangle, the Duke University Health System, which includes facilities in Raleigh and Durham, is the only one that actively seeks out MRSA carriers, testing patients in most of its ICUs, oncology ward and neonatal nursery. UNC Hospitals in Chapel Hill and Rex Hospital in Raleigh, which is part of the UNC system, are both pursuing targeted surveillance programs for MRSA. And WakeMed Health & Hospitals in Wake County will start a trial program doing targeted surveillance next year.

jean.fisher@newsobserver.com or (919) 829-4753
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
Emergency responders in Kentucky rush an injured patient to transport after a car crash.

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 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 $341 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

<table>
<thead>
<tr>
<th>Trauma Center</th>
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<tbody>
<tr>
<td>Here are some facts about trauma, which is the leading cause of death for people 44 years of age and younger:</td>
</tr>
<tr>
<td>■ Motor-vehicle crashes are the largest cause of injury deaths in the U.S. In 2006, approximately 450,000 Americans suffered a disabling motor-vehicle crash-related injury.</td>
</tr>
<tr>
<td>■ Falls are the second highest cause of injuries, accounting for 27.2% of hospital trauma admissions.</td>
</tr>
<tr>
<td>■ Fires and burns are the fourth leading cause of unintentional injury deaths. In 2006, an estimated 21,200 individuals were treated in emergency rooms for burn-related injuries.</td>
</tr>
<tr>
<td>■ Intentional causes (e.g. homicide, suicide, abuse and assault) account for about 14% of trauma-related patient admissions.</td>
</tr>
</tbody>
</table>

Source: the American College of Surgeons