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A regional solution


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U.S. needs the political will, adequate funding to cover gaps in trauma care

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While speaking at a U.S. congressional meeting a few years ago about the state of emergency care in America, I was asked to describe my ideal vision of how trauma care should be delivered in our country.

My reply: If I throw a dart at a large map of America while blindfolded, wherever the dart lands there should be a system in place to ensure the expeditious transfer of patients to the appropriate level of care commensurate with their injuries.

My response was born from equal parts logic and compassion. Empirical studies have shown trauma systems provide the highest-quality care to injured patients, reflected by significant reductions in preventable death rates after their deployment. And as the leading cause of death among those 45 and younger in America, trauma is a major public health issue that destroys families and rips at the very fabric of our future.

Despite the benefits they've delivered both here and abroad, trauma systems remain something of an enigma today. Trauma care is often misconstrued as dealing strictly with the most critically injured patients, but their reach is far broader. The inclusive trauma system encompasses mild, moderate and major injuries and includes all qualified healthcare providers and facilities in a region, from community hospitals to Level 1 trauma centers. An inclusive trauma system also provides many services beyond acute care, including education, rehabilitation and research.

The patchwork quilt of inclusive trauma systems now scattered across America has achieved considerable success, but much work remains. Trauma care in the U.S. is currently so fragmented, overwhelmed and underfunded that the survival and recovery of those who suffer major trauma often depends on where they

happen to be when they are injured. I expressed these conclusions in a recent edition of the *Journal of the American College of Surgeons*, which published the transcript of the Scudder Oration on Trauma that I delivered at the 2009 ACS Clinical Congress. *(Editor's note: The Scudder Oration is the group's annual speech on trauma.)*

In preparing my Scudder Oration, I assembled three distinct U.S. maps to illustrate the state of trauma care in America. The first shows U.S. death rates because of trauma per 100,000 population down to the county level, marking the first time these data from the Centers for Disease Control and Prevention have been published. The second map, from the University of Pennsylvania, shows travel times to the nearest trauma center and the third, from the ACS Health Policy Research Institute, shows a geographic distribution of surgeons.

When I overlaid these maps, the results were indisputable: A combination of a shortage and poor distribution of surgeons and gaps in regional trauma systems has stymied access to timely, appropriate trauma care in many areas of the country. The result is unacceptably high death rates, especially across wide swaths of rural America. To gain a further sense of how our country is faring on the front lines of trauma, I conducted a survey of all 50 state chairmen of the ACS' Committee on Trauma. I asked each state chairman two questions: Does your state have a plan in place for a statewide trauma system? And is there enabling legislation in place to support such a system?

Again, the results were telling: 19 states reported having no statewide trauma system. And of the 31 states that did report having a statewide trauma system, most indicated that funding to sustain these systems is in jeopardy. Without funding, statewide trauma systems are unsustainable.

Trauma-care providers in America's private sector have much to learn from our counterparts in the U.S. military. The highly developed Joint Theater Trauma System serving troops in Afghanistan represents an ideal trauma model, elements of which should be incorporated here in America. In this system, the injured are rapidly transported from combat zones to sophisticated care in field hospitals, combat support hospitals, the Landstuhl Regional Medical Center in Germany and eventually to the continental U.S. Transport in C-17 aircraft with intensive-care capabilities plays a vital role in this process.

Also, sophisticated videoconference technology links military care providers along the full continuum of care, so doctors in far-flung areas can discuss and learn from patient cases from start to finish. I had the privilege of experiencing this system of care firsthand as part of a senior visiting surgeon combat casualty program in Landstuhl, sponsored by the ACS and the American Association for the Surgery of Trauma.

It's encouraging that the Patient Protection and Affordable Care Act addresses

needed improvements to trauma care in the U.S. However, it's disappointing that funding to make these improvements has not yet been appropriated. All of those involved in America's healthcare delivery system must advocate for trauma systems in regions where fully developed systems are lacking.

Trauma is a major public health issue for which we have a cure—the inclusive trauma system—but we need the financial support and political will to bring them to many areas of our country, especially rural America. The ACS has developed a proven model for regional trauma systems, which has been deployed successfully nationally and internationally.

Given our nation's worsening shortage of hospitals, physicians, nurses and healthcare professionals, the creation of regional inclusive trauma systems will literally mean the difference between life and death.

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