THE INJURED CHILD

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(GREETINGS TO HOSTS, GUESTS)

THIS HAS BEEN AN EXTRAORDINARY THREE DAYS. IT'S BEEN TOTAL IMMERSION IN THE FIELD OF PEDIATRIC MEDICINE. AND I WONDER WHAT ON EARTH I CAN POSSIBLY CONTRIBUTE NOW, AT 4 O'CLOCK ON THE THIRD AND LAST DAY OF THIS EXCEPTIONAL COURSE ON THE INJURED CHILD.

I UNDERSTAND THAT THIS WAS TO HAVE BEEN A CONTINUING EDUCATION PROGRAM FOR ALL THE REGISTRANTS. BUT I HOPE DR. BROOKS CAN INCLUDE MY NAME ON THE ROSTER OF STUDENTS BECAUSE IT HAS BEEN A TREMENDOUS LEARNING EXPERIENCE FOR ME AS WELL.

THIS HAS ALSO BEEN A WONDERFUL TIME FOR REMINISCING ABOUT THE EARLY YEARS OF MY PARTICULAR SPECIALTY, PEDIATRIC SURGERY, AND FOR REMEMBERING ONCE AGAIN THE MAJOR ROLE PLAYED BY BOB GROSS IN THE DEVELOPMENT OF THAT SPECIALTY.

MY FRIENDSHIP WITH BOB GROSS BEGAN IN 1946, WHEN I WENT TO BOSTON CHILDREN'S HOSPITAL WITH INSTRUCTIONS TO LEARN WHAT I COULD AND TO RETURN TO PHILADELPHIA TO ESTABLISH THE COUNTRY'S SECOND TRAINING PROGRAM IN PEDIATRIC SURGERY. IT WAS AN EXCITING TIME FOR ME. BUT IT WAS ALSO ONE OF THE MOST DIFFICULT FOR BOB GROSS. THERE WAS NO

CERTAINTY THAT HE WOULD GET THE WILLIAM E. LADD CHAIR OR THE APPOINTMENT TO BE SURGEON-IN-CHIEF OF B.C.H. YET, IN SPITE OF THE EMOTIONAL TURMOIL HE MUST HAVE BEEN ENDURING, HE CONTINUED TO FORGE AHEAD ON INNOVATIVE CARDIOVASCULAR TECHNIQUES AND REAL BREAKTHROUGHS IN SURGERY.

SO I HAVE KNOWN BOB GROSS IN THE BEST OF TIMES AND IN THE WORST OF TIMES. WE'VE BEEN FRIENDS FROM THEN UNTIL NOW AND FREQUENTLY SHARED OUR HOPES AND ASPIRATIONS FOR THE SPECIALTY OF PEDIATRIC SURGERY, FOR THE DEVELOPMENT OF ITS QUALIFIYING BOARD AND THE JOURNAL OF PEDIATRIC SURGERY, AND MUCH MORE. SO I AM PROUD TO BE HERE AT THIS TIME AND IN HIS HONOR.

UNTIL 1981 I HAD SPENT MY WHOLE PROFESSIONAL LIFE AS A PEDIATRIC SURGEON. IT'S BEEN ONLY TWO YEARS THAT I TRADED MY O.R. GOWN FOR THE UNIFORM OF THE SURGEON GENERAL OF THE UNITED STATES. I DON'T REGRET DOING THAT -- BUT IT TAKES AN EVENT SUCH AS THIS TO REMIND ME JUST HOW QUICKLY MEDICINE CAN ABSORB NEW INFORMATION...NEW PEOPLE...AND NEW PROBLEMS. SO I HAVE LEARNED A GREAT DEAL SINCE EARLY THURSDAY MORNING. AND I WANT TO CONGRATULATE DRS. BROOKS AND HOELZER FOR PUTTING TOGETHER SUCH AN INFORMATIVE AND IMPORTANT PROGRAM AND FOR BEING ABLE TO BRING TO HOUSTON SUCH AN OUTSTANDING FACULTY.

WHEN I WAS PREPARING THESE REMARKS, I HAD BEFORE ME YOUR PROGRAM AND I WONDERED WHAT MY CONTRIBUTION MIGHT BE, IN THE LIGHT OF THE PAPERS THAT WILL HAVE BEEN READ BY THE TIME OF THIS LECTURE AND ALSO IN THE LIGHT OF MY OWN PARTICIPATION PROVIDING EXTEMPORANEOUS "SUMMATIONS" FOR THE PANEL PRESENTATIONS EACH DAY. SO I DECIDED THAT I WOULD DO AT THIS POINT WHAT I HAVE NOT BEEN ALLOWED TO DO SINCE THURSDAY MORNING. AND THAT IS, TALK ABOUT WHAT I WANT TO TALK ABOUT, REGARDING THE PROBLEMS THAT SURROUND THE INJURED CHILD. SO...HERE GOES.

FIRST, LET ME SAY THAT I TRULY VALUE THIS OPPORTUNITY TO SPEAK TO THIS COMMUNITY OF SURGEONS AND OTHER MEMBERS OF THE HEALTH TEAM ON THE SUBJECT OF "THE INJURED CHILD." YOU ARE AMONG THE MOST CONCERNED INDIVIDUALS REGARDING THIS PROBLEM, AND YOU ARE ALSO AMONG THE FEW GROUPS OF PEOPLE WHO CAN BRING ABOUT CHANGE -- WHO CAN STIMULATE AND CAUSE IMPROVEMENT TO TAKE PLACE -- FOR THE ULTIMATE BENEFIT OF CHILDREN WHO ARE VICTIMS OF TRAUMA.

FRANKLY, THAT IS LESS OF AN OBSERVATION AND MORE OF A CHALLENGE. THE EXTENT OF INJURY TO CHILDREN IS TRULY AWESOME IN THIS, THE MOST TECHNOLOGICALLY ADVANCED SOCIETY IN HISTORY. THE IRONY, OF COURSE, IS THAT THE ROOT CAUSES OF TRAUMA TO CHILDREN HAVEN'T CHANGED MUCH OVER THE YEARS. FOR EXAMPLE, ON THE BASIS OF FIGURES FROM CALENDAR

YEAR 1981, THE LATEST COMPLETE ONES WE HAVE, WE CAN SEE THAT THE MOTOR VEHICLE IS STILL ONE OF THE LEADING CAUSES OF INJURY TO CHILDREN. IN 1981, OVER A QUARTER OF A MILLION CHILDREN WERE ADMITTED TO EMERGENCY ROOMS FOR TREATMENT OF INJURIES INCURRED FROM SOME KIND OF ACCIDENT WITH A CAR OR TRUCK. TWO THIRDS OF THOSE CHILDREN WERE BETWEEN THE AGES OF 5 AND 14 AND A THIRD -- CLOSE TO 90,000 -- WERE UNDER THE AGE OF 4.

BUT, ACCORDING TO THE GOVERNMENT'S NATIONAL ELECTRONIC INJURY SURVEILLANCE SYSTEM, THE LEADING CAUSE OF INJURY TO AMERICANS IN 1981 WAS NOT THE MOTOR VEHICLE AT ALL. IT IS SOMETHING MUCH HUMBLER. THE LEADING CAUSE WAS STAIRS -- THOSE LITTLE ARCHITECTURAL AIDS THAT ARE SUPPOSED TO HELP US GET SAFELY FROM ONE LEVEL IN SPACE TO ANOTHER.

GENERALLY THEY DO. BUT IN 1981 THERE WERE 784,000 EMERGENCY ROOM ADMISSIONS FOR INJURIES INCURRED BY PEOPLE PRIMARILY GOING -- OR BEING CARRIED -- UP OR DOWN STEPS. OF THE THREE QUARTERS OF A MILLION INJURIES ASSOCIATED WITH STAIRS, ONE FOURTH OF THEM -- OR ABOUT 200,000 -- INVOLVED CHILDREN UNDER THE AGE OF 14.

THE NEXT LARGEST CATEGORY OF INJURIES INVOLVED THE USE OF BICYCLES. THERE WERE AN ESTIMATED HALF MILLION SUCH INJURIES IN 1981, OF WHICH ABOUT THE GREAT MAJORITY -- 378,000 -- INVOLVED CHILDREN UNDER THE AGE OF 14.

I WON'T GO ANY FURTHER WITH SUCH A LITANY. MANY OF YOU ARE ALREADY QUITE FAMILIAR WITH THESE KINDS OF STATISTICS. BUT I THINK THEY BEAR REPEATING. IT HAPPENS TO BE MY OPINION THAT OUR CONFERENCE THIS WEEK MAY WELL BE ONE OF THE FEW CONFERENCES THIS YEAR IN <u>ANY</u> AREA OF MEDICINE THAT WILL BE FOCUSING ON SO LARGE POPULATION OF VULNERABLE, VIRTUALLY DEFENSELESS PEOPLE WHO SUFFER SUCH A VARIETY OF LIFE-THREATENING INSULTS.

AND THAT IS WHY I BELIEVE THIS CONFERENCE ON "THE INJURED CHILD" CANNOT BE ONLY OUR OPPORTUNITY TO ASSEMBLE THE BEST OBSERVATIONS ON THIS SUBJECT. AND IT CANNOT BE REMEMBERED PRIMARILY AS A "SUMMATION OF SUMMATIONS." RATHER, THIS CONFERENCE, AS I MENTIONED A MOMENT AGO, SHOULD BE A GREAT PERSONAL AND PROFESSIONAL CHALLENGE TO EACH OF US.

AND THE FIRST CHALLENGE, BY THE WAY, IS RIGHT THERE IN THE TITLE. I WANT TO SPEND JUST A MOMENT TO TAKE A CLOSER LOOK AT THAT WORD "INJURED." IT USUALLY MEANS THAT THERE HAS BEEN SOME BLOW TO THE

HEAD, THE CHEST, OR TO THE EXTREMITIES...OR THERE ARE BURNS, CUTS, OR OTHER FORMS OF DISFIGUREMENT...OR THE CHILD HAS SUFFERED POISONING, STARVATION, OR SOME OTHER ACCIDENTAL OR DELIBERATE ASSAULT. THAT'S THE USUAL CLUSTER OF EXPLANATIONS FOR THE WORD "INJURED."

BUT CHILDREN SUSTAIN MANY KINDS OF INJURIES FOR WHICH MEDICINE CAN FUMBLE FOR AN ADEQUATE RESPONSE. AND SOMETIMES WE SIMPLY HAVE NO RESPONSE AT ALL. FOR EXAMPLE, THERE ARE THOUSANDS OF CHILDREN ON OUR STREETS TODAY FOR WHOM THE WORD "FAMILY" HAS LITTLE OR NO PERSONAL MEANING. THEY'VE BEEN DENIED THE KIND OF FAMILY LOVE AND CARE THAT THE REST OF US TAKE FOR GRANTED. THE ABSENCE OF A CARING FAMILY IS A CRUEL AND PROFOUND INJURY. AND I DON'T BELIEVE THERE IS ANYTHING -- EVEN IN SUCH A FINE HEALTH SCIENCE CENTER AS THIS -- THAT CAN REPAIR THAT PARTICULAR KIND OF HURT. NOTHING AT ALL.

OTHER CHILDREN HAVE BEEN PHYSICALLY AND SEXUALLY ABUSED IN THEIR OWN HOMES...THEY'VE BEEN PREYED UPON IN THEIR OWN NEIGHBORHOODS...BEEN EXPLOITED BY EVIL PEOPLE FOR EVIL ENDS. AND OUR SCHOOLS AND COMMUNITY ORGANIZATIONS MAY HAVE FAILED THEM JUST WHEN HELP WAS NEEDED THE MOST. THESE ARE NOT "INJURIES" AS THEY ARE UNDERSTOOD IN TRADITIONAL

PHYSICAL MEDICINE, BUT THEY ARE TRAUMATIC NEVERTHELESS. AND THEY ARE IMPORTANT, BECAUSE THEY DETERMINE WHETHER OR NOT A CHILD HAS THE WILL TO FIGHT THE PAIN OF PHYSICAL INJURY -- OR SIMPLY TO SURRENDER.

IT HAS ALWAYS BEEN MY FEELING THAT, ALTHOUGH WE CALL OURSELVES PROFESSIONALS, WE NEVERTHELESS PRACTICE AN INCOMPLETE FORM OF PEDIATRIC MEDICINE, IF WE CONFINE OURSELVES TO THAT DISCIPLINE. I BELIEVE MOST COLLEAGUES AGREE WITH THAT. BUT I DON'T THINK IT CAN BE RE-STATED TOO OFTEN. WE HAVE TO HEAR IT OFTEN -- AND BELIEVE IT ALWAYS.

WE NEED TO BE MINDFUL OF WHAT IS HAPPENING TO THE CHILDREN IN OUR COMMUNITY IN ALL ASPECTS OF THEIR LIVES. AND WHERE WE CAN, WE MUST BE COUNTED AMONG THEIR MOST ARDENT ADVOCATES FOR BETTER EDUCATION, BETTER FAMILY CARE, BETTER SOCIAL SERVICE, BETTER RECREATIONAL OPPORTUNITIES, AND BETTER PROTECTION AGAINST THE OCCASIONAL INSULTS OF A SOPHISTICATED BUT SOMETIMES INSENSITIVE SOCIETY.

WE HAVE NO POWER IN OUR KIND OF MEDICINE TO REPAIR THE HURT DONE TO A CHILD BY A FAMILY OR A COMMUNITY GONE WRONG. BUT WE MIGHT HAVE THE KNOWLEDGE AND THE ABILITY TO PREVENT THAT WRONG FROM EVER TAKING

PLACE. THIS IS PROBABLY ONE OF THE MOST IMPORTANT KINDS OF "PREVENTIVE MEDICINE" ANY COMMUNITY CAN PRACTICE FOR THE HEALTH OF ITS CHILDREN.

AT THIS POINT I WANT TO FOCUS IN ON TWO ASPECTS OF EMERGENCY SERVICE...ASPECTS THAT HAVE BEEN MENTIONED THIS WEEK IS SEVERAL PAPERS, BUT WHICH NEED OUR CONTINUED ATTENTION. THE FIRST ASPECT COVERS THE TIME AND THE CIRCUMSTANCES IN WHICH THE TRAUMA PATIENT IS FIRST ENCOUNTERED BY THE EMERGENCY MEDICAL TEAM. THE SECOND ASPECT COVERS THE PATIENT AFTER RELEASE FROM THE INSITITUTION, WHETHER FROM A HOSPITAL OR TRAUMA CENTER.

FIRST, I WANT TO ACKNOWLEDGE SOMETHING THAT HAS BEEN IMPLIED OVER AND OVER AGAIN IN THIS CONFERENCE BUT OUGHT TO SAID OUTRIGHT AND WITH GREAT CLARITY: <u>WE'VE MADE GREAT PROGRESS IN THIS COUNTRY IN DEVELOPING NOT ONLY THE CONCEPT OF EMERGENCY MEDICAL SERVICE SYSTEMS, BUT ALSO IN HAVING A LARGE NUMBER OF SUCH SYSTEMS IN PLACE AND WORKING.</u>

IN OUR ZEAL CONSTANTLY TO IMPROVE THE JOB WE DO, WE TEND TO OVERLOOK THE KIND OF STRONG BASE UPON WHICH WE WORK. THE AMERICAN PEOPLE SUPPORT EMERGENCY MEDICAL CARE WITH THEIR DOLLARS, THEIR VOTES, AND

THEIR TIME. THEY CONTRIBUTE TO THE PURCHASE OF NEW EQUIPMENT, SUCH AS AMBULANCES AND HELICOPTERS, NEW RESCUE SQUAD COMMUNICATIONS, AND THE RISING COSTS OF HIRING GOOD PEOPLE. THERE ARE VERY FEW FAMILIES IN THE UNITED STATES TODAY WHO HAVE NOT HAD A MEMBER'S LIFE SAVED -- OR WHO DON'T KNOW OF SUCH AN EVENT.

E.M.S. WORKS. AND THE COUNTRY KNOWS IT WORKS. SO WHEN WE LOOK CRITICALLY AT SOME ASPECTS OF EMERGENCY CARE -- SUCH AS THE CARE FOR CHILDREN, FOR EXAMPLE -- I THINK WE DO SO IN RESPONSE TO THE PUBLIC'S DESIRE TO IMPROVE WHAT THEY ALREADY CONSIDER TO BE A BLESSING. AND IT IS IN THAT SPIRIT THAT I WANT TO COMMENT ON THAT VERY IMPORTANT "PRE-HOSPITAL PHASE" OF EMERGENCY CARE.

I MENTIONED A MOMENT AGO THE LARGE NUMBERS OF CHILDREN WHO ARE INJURED AND ADMITTED TO EMERGENCY ROOMS FOR SOME KIND OF TREATMENT. THE MOST RECENT FIGURES I HAVE INDICATE THAT, OF THE 11 MILLION PERSONS TRANSPORTED BY EMERGENCY VEHICLES LAST YEAR, ABOUT 1 MILLION WERE CHILDREN UNDER THE AGE OF 14. THESE CHILDREN NEED SOME SPECIAL UNDERSTANDING -- THEY CAN'T BE TREATED AS "LITTLE ADULTS," AS THIS AUDIENCE KNOWS BETTER THAN MOST. YET, THE SPECIAL NEEDS OF INJURED CHILDREN ARE NOWHERE TO BE FOUND IN THE TRAINING GIVEN TO EMERGENCY MEDICAL PERSONNEL.

WE DON'T KNOW TO WHAT AN EXTENT THIS LACK OF KNOWLEDGE HAS CONTRIBUTED TO THE LOSS OF SOME CHILDREN SO FAR. MY INSTINCTS TELL ME THAT IT HAS. AND I DOUBT THAT WE NEED TO CARRY OUT ANY EXHAUSTIVE, COSTLY, AND TIME-CONSUMING RESEARCH TO VERIFY SUCH AN OBVIOUS RESPONSE. INSTEAD, I WOULD HOPE THAT THE SURGEONS OF THIS COUNTRY -- WORKING ALONG WITH THE MANY OTHER PROFESSIONS AND DISCIPLINES CONCERNED WITH THE QUALITY OF BOTH EMERGENCY MEDICINE AND PEDIATRIC MEDICINE -- WOULD COME TOGETHER AND FOCUS ON THIS SPECIFIC AREA. I THINK THE TRAINING COULD BE ACCOMPLISHED QUITE HANDILY AND WOULD NOT POSE AN UNFAIR BURDEN UPON OUR EMERGENCY MEDICAL PERSONNEL. ON THE CONTRARY, I THINK SUCH PERSONNEL WOULD WELCOME THIS KIND OF ASSISTANCE.

OF COURSE, ONE MIGHT WELL ASK, "WHO ARE WE -- THE SURGEONS OF AMERICA -- THAT WE SHOULD CAST THE FIRST STONE?" YOU MAY RECALL THAT THE 1976 EDITION OF EARLY CARE OF THE INJURED PATIENT, PUBLISHED BY OUR OWN AMERICAN COLLEGE OF SURGEONS, HAD ONE CHAPTER OUT OF 24 DEVOTED TO THE COMMON INJURIES OF CHILDREN. BUT THE NEW 1982 EDITION, PRESUMABLY ENRICHED BY NEW INFORMATION AND UNDERSTANDING, HAS 25 CHAPTERS -- BUT NONE ON THE PROBLEMS OF INJURED CHILDREN. THE EARLIER 45-PAGE CHAPTER HAS BEEN REDUCED TO ABOUT THREE-QUARTERS OF A PAGE ON HOW TO HANDLE PEDIATRIC FRACTURES.

I THINK MORE OUGHT TO BE PUBLISHED ABOUT THE PROPER HANDLING OF INJURED CHILDREN -- AND I THINK IT ALL SHOULD START RIGHT HERE WITH US, WITH THE PEDIATRIC SURGEONS AND MEDICAL SPECIALISTS FOR WHOM THE INJURED CHILD IS OUR REASON FOR BEING IN PRACTICE IN THE FIRST PLACE.

ANOTHER AREA IN WHICH WE NEED MORE UNDERSTANDING AND TRAINING IS IN THE PROBLEMS POSED BY THE INJURED CHILD'S FAMILY. WHEN WE SPEAK OF THE "MANAGEMENT OF THE INJURED CHILD," WE SHOULD BE INCLUDING THE SPECIAL KINDS OF CARE THAT NEED TO BE OFFERED TO THE CHILD'S FAMILY AS WELL.

THE EMERGENCY TECHNICIANS SEE THE CHILD IN MEDICAL TERMS...ITS INJURIES ARE PHYSIOLOGICAL AND CAN BE ANATOMICALLY MAPPED AND ASSESSED ...AND THE COMMUNICATIONS QUICKLY TURN INTO A HIGHLY COMPRESSED MEDICAL SHORTHAND. ALL THAT IS GOOD. PLEASE DON'T MISUNDERSTAND ME. BUT ALL THAT IS NOT ENOUGH.

THERE HAS TO BE SOME BETTER WAY TO HANDLE THE HORROR AND THE SHOCK, THE FEAR OF IMPENDING LOSS, THE POSSIBLE FEELINGS OF GUILT, AND THE TERRIBLE CONFUSION FELT BY THE FAMILIES OF CHILDREN SUFFERING SERIOUS PHYSICAL INJURY.

GRANTED, THERE IS VERY LITTLE TIME FOR CONVERSATION ON THE SITE OF A SERIOUS ACCIDENT.

GRANTED, WE DON'T ALWAYS KNOW THE FULL EXTENT OF THE CHILD'S INJURIES AT THE FIRST ENCOUNTER.

AND GRANTED, THE PRIMARY NEEDS TO BE ANSWERED ARE THOSE OF THE CHILD, NOT OF PARENTS OR SIBLINGS, HOWEVER DISTRAUGHT THEY MAY BE.

BUT GRANTING ALL THAT, I STILL MAINTAIN THAT WE DO BOTH THE CHILD AND ITS FAMILY A GREAT DISSERVICE, THE LONGER WE PUSH ASIDE THIS ASPECT OF EMERGENCY PEDIATRIC SERVICE. I WOULD CALL UPON OUR COLLEAGUES IN THE SOCIAL SERVICES, IN PSYCHOLOGY, AND IN PASTORAL COUNSELING TO HELP US BETTER UNDERSTAND WHAT WE MIGHT BE ABLE TO DO -- AND ENCOURAGE US TO DO IT.

THERE IS A THIRD AND -- IF YOU CAN IMAGINE IT -- AN EVEN TOUCHIER ASPECT OF THIS "PRE-ADMISSION PHASE" OF EMERGENCY AND I WANT TO TACKLE IT HEAD-ON WITH YOU THIS AFTERNOON.

FOR MANY YEARS IT HAS BEEN ALMOST A RULE OF THUMB THAT YOU WANT TO WHISK THE INJURED PERSON TO THE MEDICAL FACILITY THAT IS CLOSEST TO THE SCENE OF THE ACCIDENT, KEEPING TRANSPORT TIME TO A MINIMUM. AT ONE TIME, NEARLY 10 YEARS AGO, THAT PROBABLY MADE GOOD SENSE, SINCE MOST FACILITIES HAD ABOUT THE SAME UNDERSTANDING OF EMERGENCY MEDICINE AND MOST, ALSO, HAD MADE ABOUT THE SAME MINIMUM COMMITMENT OF MONEY, STAFF, AND EQUIPMENT.

BUT TIMES HAVE CHANGED...WE KNOW A LOT MORE TODAY THAN WE DID 10 YEARS AGO...AND TODAY IT IS POSSIBLE TO IDENTIFY THOSE INSTITUTIONS THAT ARE COMMITTED TO QUALITY EMERGENCY MEDICINE AND THOSE THAT ARE NOT. THE DIFFERENCE IS CRITICAL -- I MIGHT EVEN ADD, THE DIFFERENCE CAN BE LIFE-SAVING.

I HAD A RATHER NEGATIVE COMMENT ABOUT THE AMERICAN COLLEGE OF SURGEONS BEFORE, REGARDING THE SHORT SHRIFT THEY GIVE TO CHILDREN IN THEIR LATEST TEXT ON THE CARE OF INJURED PATIENT. HOWEVER, I WANT TO CONGRATULATE THE COLLEGE AND ESPECIALLY ITS NATIONAL COMMITTEE ON TRAUMA FOR GOING AHEAD WITH THE "MAJOR TRAUMA OUTCOME STUDY." THERE ARE MANY FASCINATING SIDES TO THIS STUDY AND I HOPE TO MENTION SOME OF THEM. BUT ONE PIECE OF INFORMATION ALREADY HIGHLIGHTED BY THE STUDY OUGHT NOT TO BE IGNORED ANY LONGER.

DR. CHARLES FREY, VICE PRESIDENT FOR THE DEPARTMENT OF SURGERY AT THE UNIVERSITY OF CALIFORNIA, DAVIS CAMPUS, SCHOOL OF MEDICINE, IS CARRYING OUT THIS STUDY FOR THE NATIONAL COMMITTEE. HE'S WORKING HARD IT AT FOR A NUMBER OF REASONS, NOT THE LEAST OF WHICH IS THIS APPALLING STATISTIC: OF THE TOTAL NUMBER OF PATIENTS WITH MULTIPLE INJURIES WHO DIED LAST YEAR IN THE COURSE OF RECEIVING EMERGENCY CARE, FULLY 25 PERCENT OUGHT NOT TO HAVE DIED. IN OTHER WORDS, 1 OUT OF 4 PATIENTS WITH MULTIPLE INJURIES RECEIVE INADEQUATE TREATMENT; GIVEN THE NATURE OF THEIR INJURIES, THEY PROBABLY WOULD HAVE SURVIVED, HAD THEY BEEN TAKEN TO A FACILITY EQUIPPPED -- AND COMMITTED -- TO HANDLING THEM.

AT THE TIME OF THE PICKUP, THE EMERGENCY MEDICAL TEAM MAKES A DECISION AS TO THE FACILITY TO HEAD FOR WITH THEIR INJURED PATIENT. IN MANY CASES, THAT DECISION IS STILL BASED ON WHAT FACILITY IS CLOSEST. IN SUBURBAN AND URBAN AREAS, HOWEVER, WE ARE BEGINNING TO SEE AN INCREASE IN THE COMPETITION FOR EMERGENCY PATIENTS. HOSPITALS THAT ARE EXPERIENCING A DROPPING BED CENSUS, ARE LOOKING TO THEIR EMERGENCY ROOMS AS HELPING CORRECT THE DOWNWARD CURVE OF ADMISSIONS. BUT THOSE SAME HOSPITALS, COMING LATE TO AN INTEREST IN TRAUMA CARE AND COMING

FOR THE WRONG REASONS, ARE NOT MAKING THE NECESSARY COMMITMENT TO PROVIDE QUALITY EMERGENCY CARE. I WOULD SUSPECT WE WOULD FIND THAT IT IS IN THOSE HOSPITALS THAT THE UNNECESSARY DEATHS OCCUR. THE SUSPICION IS SO STRONG THAT WE WOULD BE TERRIBLY REMISS, IF WE DID NOT GIVE THE SITUATION A THOROUGH REVIEW.

THIS COMPETITION PHENOMENON IS NOW FURTHER COMPLICATING AND ENDANGERING THE LIVES OF INJURED CHILDREN. FOR SOME TIME, ALL OF US IN PEDIATRIC SURGERY HAVE PLEADED WITH HOSPITALS AND TRAUMA CENTERS TO PAY MORE ATTENTION TO THE SPECIAL NEEDS OF INJURED CHILDREN. A GREAT DEAL OF EFFORT HAS BEEN EXPENDED ON CERTAIN REGIONAL CHILDREN'S HOSPITALS SO THAT THEY ARE THE DESTINATIONS OF CHOICE FOR MOST EMERGENCY PEDIATRIC CASES. BUT THIS NEW ELEMENT OF COMPETITION FRANKLY GIVES ME AN UNEASY SENSE OF FOREBODING. THAT KIND OF ADMINISTRATIVE ACTION CAN QUICKLY UNDO SO MUCH EXCELLENT WORK ON THE MEDICAL SIDE -- THE KIND OF WORK SO CAREFULLY AND ELOQUENTLY DESCRIBED IN THE PAPERS GIVEN AT THIS CONFERENCE.

THE "MAJOR TRAUMA OUTCOME STUDY" HAS SOME 77 HOSPITALS AROUND THE COUNTRY SIGNED UP. SEVENTEEN ARE PEDIATRIC MEDICAL CENTERS. MANY OF

THEM ARE BEGINNING TO DELIVER PATIENT CARE DATA TO THE STUDY'S COMPUTER TEAM HEADQUARTERED IN WASHINGTON, D.C. EVENTUALLY THE STUDY SHOULD HAVE A DATA BASE THAT WILL CONTAIN THE NATURE OF THE TRAUMA, AN ANALYSIS OF ITS MANAGEMENT, AND THE OUTCOME FOR EACH OF 20,000 PATIENTS. THAT IS LARGER THAN A "STATISTICALLY VALID SAMPLE" HAS TO BE. I THINK THE INFORMATION COULD BE VERY SIGNIFICANT IN HELPING US SHAPE THE FUTURE COURSE OF TRAUMA CARE IN THIS COUNTRY.

THIS "MAJOR TRAUMA OUTCOME STUDY," BY THE WAY, IS NOT FEDERALLY FUNDED. IN FACT, THE PARTICIPATING HOSPITALS RECEIVE NO MONEY AT ALL. QUITE THE REVERSE, IT IS COSTING THEM MONEY TO TAKE PART AND I CONGRATULATE EVERY ONE OF THE 77 THAT HAS SIGNED ON. AND RIGHT HERE I WOULD LIKE TO GIVE RECOGNITION TO THE CO-HOST OF THIS LECTURESHIP, HERMANN HOSPITAL, FOR BEING AMONG THOSE 77, ALONG WITH HOUSTON'S BEN TAUB GENERAL HOSPITAL.

THIS KIND OF NATIONAL EFFORT IS NEEDED IN MANY AREAS OF TRAUMA CARE. WE STILL HAVE A LOT TO LEARN. WE MAY HAVE TO INVEST MORE THAN WE ANTICIPATE IN ORDER TO GAIN THAT NEW, LIFE-SAVING KNOWLEDGE. BUT I AM CERTAIN THAT SUCH AN INVESTMENT WILL REPAY ENORMOUS DIVIDENDS TO

OUR SOCIETY. IN ORDER TO HAVE THAT HAPPEN, WE ALL NEED TO BE AWARE OF WHAT OUR NATION'S RESEARCH AND SERVICE PRIORITIES ARE AND WE ALL NEED TO TAKE PART IN THE PROCESSES THAT WEIGHT THEM, JUDGE THEM, AND CHANGE THEM...IF THAT'S WHAT IS NEEDED.

I SUSPECT WE WILL EVENTUALLY RECEIVE SEVERAL IMPORTANT AIDS FROM THE COLLEGE OF SURGEONS' STUDY. AT THE VERY LEAST, WE MIGHT FINALLY GET A HANDLE ON SOME FAIRLY SIMPLE...STANDARD...YET RELIABLE WAY TO QUICKLY EVALUATE THE GRAVITY OF A PATIENT'S CONDITION AT THE TIME OF PICKUP.

DR. FREY AND THE COMMITTEE ON TRAUMA HAVE BEEN WORKING ON JUST SUCH AN "INJURY SEVERITY SCORE" WHICH SEEMS TO HOLD SOME PROMISE. THE GLASGOW COMA SCALE HAS BEEN USEFUL. THERE ARE ONE OR TWO OTHERS THAT HAVE BEEN USED OVER TIME, ALSO, SUCH AS THE "FINGERNAIL TEST" THAT DEMONSTRATES CAPILLARY REFILL. WE MUST BE CAREFUL, HOWEVER, THAT WE NOT PIN ALL OUR HOPES ON SUCH THINGS. THE BASIC INSTINCTS OF EMERGENCY PERSONNEL ARE ALL GEARED TO ACTION...TO DO SOMETHING...TO GET THE PATIENT QUICKLY TO A TREATMENT FACILITY...AND, TO BE QUITE CANDID, IF ANY OF US HAS THE POOR LUCK TO BECOME A PATIENT, I WOULD

BET THAT WE WOULD WANT THE SAME THING: WE'D WANT SOME ACTION, SOME MOVEMENT, SOME INDICATION AS SIMPLE AS A CHANGE OF SCENERY THAT WE'RE "BEING TAKEN CARE OF JUST AS QUICKLY AS POSSIBLE."

BUT HAVING NOTED THAT CAVEAT, I STILL BELIEVE THE DEVELOPMENT OF SOMETHING LIKE AN "INJURY SEVERITY SCORE" WOULD BE A VERY GOOD THING.

WE ALSO NEED A GREAT DEAL MORE ATTENTION PAID TO HOW WE ORGANIZE THE DIAGNOSTIC AND TREATMENT PERSONNEL WHO TAKE OVER FROM THE EMERGENCY MEDICAL TECHNICIANS. A GOOD MODEL SEEMS TO BE THE MULTI-DISCIPLINARY ORGANIZATION OF BURN CENTER TEAMS. I WOULD CONSIDER IT A MAJOR STEP FORWARD, IF EVERY TRAUMA CENTER WAS INDEED ORGANIZED ON A MULTI-DISCIPLINARY TEAM BASIS, WITH A GENERAL SURGEON IN CHARGE -- NOT A SURGEON <u>GENERAL</u> BUT A GENERAL <u>SURGEON</u> -- SOMEONE WHO HAS THE HEALTH OF THE WHOLE CHILD AS HIS OR HER MAJOR RESPONSIBILITY AND CAN ASSESS WHAT OUGHT TO BE DONE -- AND HOW WELL THINGS ARE DONE -- BASED ON THE CHILD'S OVERALL WELL-BEING.

I HAVE NO INTENTION OF DISPARAGING THE SURGICAL SPECIALTIES. FAR FROM IT. NEVERTHELESS, CHILDREN DON'T LIVE ACCORDING TO VERTICAL MEDICAL SPECIALTIES...THEY ARE GENERALLY NOT INJURED ONLY BY SPECIALTY

AREA...AND WE KNOW THEY DO NOT RECOVER ON A SPECIALTY-BY-SPECIALTY BASIS. HENCE, I WOULD ENCOURAGE THE DEVELOPMENT OF THE TEAM APPROACH, WITH PRIMARY RESPONSIBILITY RESTING IN THE HANDS OF A GENERALIST.

BUT I DON'T WANT TO DWELL ON THESE MATTERS, SINCE THEY ARE PART OF THE IN-HOSPITAL PHASE. INSTEAD, I WANT TO MOVE ON AND FOCUS SOME ATTENTION ON THE PROBLEMS OF THE POST-HOSPITAL PHASE OF CARE FOR THE INJURED CHILD.

FIRST, LET ME SAY THAT WE HAVE THE PROBLEM OF HOSPITAL COMPETITION IN THIS PROBLEM, ALSO. THERE IS THE TEMPTATION FOR A HOSPITAL WITH LOW BED CENSUS -- PARTICULARLY A HOSPITAL IN AN OVER-BEDDED SUBURBAN OR URBAN SETTING -- TO HANG ON TO INJURY PATIENTS FOR A LITTLE MORE TIME THAN MIGHT BE EXPECTED IN THE NORMAL ROUTINE OF CARE. THAT TEMPTATION MUST BE ERASED. I DON'T WANT TO SAY ANYTHING ELSE ON THIS MATTER, BUT I DO FEEL IT NECESSARY TO AT LEAST ACKNOWLEDGE THAT THIS KIND OF THING CAN OCCUR AND THAT WE MUST EXERCISE OUR PROFESSIONAL RESPONSIBILITY TO SEE THAT IT DOESN'T.

BUT WE ALSO NEED TO MAKE SURE THAT PATIENTS ARE DISCHARGED INTO A HOME-CARE SITUATION THAT WORKS. AND THAT TAKES SOME THOUGHT AND ORGANIZATION, ALSO.

LET ME SAY THAT I HAVE HAD TO WORK THROUGH MY OWN THINKING ON THIS MATTER TWICE BEFORE, IN THE SPACE OF LESS THAN THREE MONTHS. IN MID-DECEMBER I BROUGHT TOGETHER A NUMBER OF NATIONALLY RECOGNIZED EXPERTS IN A "SURGEON GENERAL'S CONFERENCE ON CHILDREN WITH HANDICAPS AND THEIR FAMILIES." IT WAS A VERY EXCITING AND REWARDING EXPERIENCE. I'VE BROUGHT ALONG A STACK OF COPIES OF THE REPORT OF THAT CONFERENCE BECAUSE I BELIEVE MANY OF THE SUBJECTS WE DISCUSSED BACK IN DECEMBER BEAR DIRECTLY ON THE KINDS OF SUBJECTS WE'RE TALKING ABOUT TODAY, ESPECIALLY IN THIS MATTER OF HOME CARE.

AGAIN, JUST THREE WEEKS AGO, I ADDRESSED THE SEVENTH CLINICAL CONGRESS OF THE AMERICAN SOCIETY OF PARENTERAL AND ENTERAL NUTRITION AND THERE, AGAIN, THE ISSUE OF HOME CARE CONSUMED A GREAT DEAL OF TIME AND INTEREST. THE ISSUE IS COMPLICATED BY SEVERAL FACTORS THAT NEED TO BE SORTED OUT FOR EXAMINATION. LET ME TAKE SEVERAL OF THEM IN ORDER.

FIRST, WE NEED TO ACCEPT THAT FACT THAT PEOPLE HAVE A GENERALLY LOW LEVEL OF FAMILIARITY WITH THE KINDS OF SUPPORT SERVICES THAT ARE -- OR ARE NOT -- AVAILABLE OUT IN THEIR COMMUNITY. PEOPLE LIKE US -- SURGEONS, PHYSICIANS, NURSES, AND TECHNICIANS WHO WORK IN HOSPITALS OR

TRAUMA CENTERS -- ARE USUALLY FAMILIAR WITH MOST OF THE COMMUNITY SERVICES NETWORK AND VERY OFTEN WE ASSUME THAT EVERYONE ELSE HAS THE SAME INFORMATION. BUT MOST PEOPLE DO NOT.

THEY MAY, ON OCCASION, HAVE USED ONE OR ANOTHER SOCIAL SERVICE OR HEALTH AGENCY OR THEY MAY EVEN HAVE REGULARLY CONTRIBUTED TO CERTAIN ORGANIZATIONS CONCERNED WITH A PARTICULAR DISEASE OR DISABILITY. BUT WHEN FACED WITH THE IMMEDIATE NEED TO GET INFORMATION, APPLY FOR HELP, REQUEST CERTAIN RESOURCES, MAKE CONNECTIONS, MAKE DECISIONS -- MUCH OF THEIR PAST EXPERIENCE AND KNOWLEDGE BECOMES SOMEHOW DISJUNCTIVE. THEY CAN EASILY BECOME OVERWHELMED BY THE OFTEN BYZANTINE COMPLEXITY OF OUR SOCIAL SERVICE DELIVERY SYSTEM. TIRED AND CONFUSED, THEY GIVE UP TRYING TO GET HELP.

IN MY PREVIOUS ROLE AS A PEDIATRIC SURGEON, I FREQUENTLY WORKED SIDE-BY-SIDE WITH PARENTS, NEGOTIATING HELP FROM A WIDE NETWORK OF PRIVATE, PUBLIC, FREE, AND FEE-FOR-SERVICE PROVIDERS. BUT IT IS NOT A SURGEON'S ROLE. FRANKLY, SURGEONS ARE REALLY NOT VERY GOOD AT IT NOR ARE MOST PHYSICIANS, I AM SORRY TO SAY. AT BEST THEY MAY ONLY HAVE A SENSE THAT THERE IS SOME HELP OUT THERE. THE TRUTH OF THE MATTER IF

THAT MOST COMMUNITIES ARE VERY RICH IN GRASS-ROOTS SERVICE AGENCIES OF EVERY KIND. THERE MAY BE SOME OVERLAP AND THERE MAY BE SOME GAPS. AND SOMETIMES IT CAN BE QUITE DIFFICULT TO LAY OUT ALL THE SERVICES AND THEIR RELATIONSHIPS ON A NEAT CHART. BUT HELP OF SOME KIND IS USUALLY AVAILABLE...IT IS USUALLY CAPABLE HELP...AND IT IS ALMOST ALWAYS DISPENSED WITH A GENEROSITY OF SPIRIT AND COMPASSION.

OUR FIRST TASK, THEN, IN THIS POST-HOSPITAL PHASE OF EMERGENCY CARE, IS TO MAKE SURE THAT OUR PATIENTS AND THEIR FAMILIES ARE TOGETHER AGAIN AT HOME AS SOON AS POSSIBLE AND THAT THEY HAVE HELP AVAILABLE TO THEM TO MAKE THIS HOME-CARE PHASE WORK.

A <u>SECOND</u> TASK IS IN REALITY A CAREFUL QUALIFICATION OF THE FIRST. I AM NOT "WAFFLING"...I AM QUALIFYING. IN THE PROCESS OF DISCHARGING OUR INJURED CHILDREN TO THE CARE OF THEIR FAMILIES, WE MUST NOT UNWITTINGLY "ORPHAN" THEM FROM THE MEDICAL CARE SYSTEM. WE NEED TO INSURE SOME METHOD OF STAYING IN TOUCH, SO THAT WE HAVE SOME BASIS OF KNOWING HOW WELL WE'RE DOING. UNFORTUNATELY, THE AVAILABLE MORTALITY DATA WILL TELL US HOW POORLY WE'RE DOING. AND AN AUTOPSY REPORT -- MATCHED AGAINST THE RECORD OF THE MANAGEMENT OF THE DECEASED PATIENT -- WILL TELL US GREAT DEAL ABOUT THE EFFECTIVENESS OF OUR IN-PATIENT CARE.

BUT A SIMPLE, ROUTINE, BUT CONSISTENT METHOD OF FOLLOW-UP OF PATIENTS WHO GO HOME WILL PROVIDE US WITH THE OTHER KIND OF RECORD -- THE ONE THAT REVEALS HOW WELL WE'RE DOING AND THE KINDS OF THINGS WE OUGHT TO KEEP ON DOING. AS OUR DISCHARGE SYSTEM NOW STANDS, WE TEND TO LOSE A GREAT DEAL OF VALUABLE MEDICAL INFORMATION FROM OUR "ORPHANS," THE CHILDREN WHO'VE DONE WELL AND HAVE BEEN SENT HOME.

THE THIRD AND LAST TASK IN THIS POST-HOSPITAL PHASE INVOLVES THE USE OF THE NEW TECHNOLOGIES THAT MAKE HOME CARE POSSIBLE. THE TECHNOLOGY FOR HOME CARE MUST REPRESENT A CONSIDERABLE COST SAVING OVER IN-PATIENT CARE, WITH NO LOSS OF EFFECTIVENESS. IN OTHER WORDS, WE MUST NOT COMPROMISE THE EFFECTIVENESS OF OUR MEDICAL CARE IN THE NAME OF ECONOMY. THAT IS A TRAP THAT CAN BE FATAL BOTH TO OUR PATIENTS AND TO THE PRACTICE OF GOOD MEDICINE.

BUT SUCH AN ARGUMENT CANNOT BE USED AS A SHIELD BEHIND WHICH WE OVER-DESIGN AND INFLATE THE TECHNOLOGY OF HOME CARE. I MAKE THIS POINT BECAUSE A NUMBER OF PHYSICIANS FOR WHOM I HAVE GREAT RESPECT HAVE ALREADY RAISED THIS ISSUE WITH ME. HOME HEALTH CARE IS A NEW AND POTENTIALLY LUCRATIVE FIELD FOR THE IMAGINATIVE AND AGGRESSIVE ENTREPRENEUR. THE GOVERNMENT AND OTHER THIRD-PARTY PAYORS ARE ALL

INTERESTED IN HOME HEALTH CARE AS HAVING THE POTENTIAL OF BEING A LOW-COST, MEDICALLY EFFECTIVE WAY TO DELIVER MEDICAL SERVICE TO A PATIENT. BUT THAT POTENTIAL CAN QUICKLY DISAPPEAR, UNDER THE PRESSURE OF CERTAIN FORCES IN THE PRIVATE SECTOR THAT WOULD REPLACE THE HIGH INCOMES ONCE FREELY AVAILABLE FROM TRADITIONAL HOSPITALIZATION WITH A NEW SCHEDULE OF INFLATED FEES AND REIMBURSEMENTS FROM HOME-CARE TECHNOLOGY.

I'VE TOUCHED ON A NUMBER OF ISSUES THIS AFTERNOON THAT I FEEL NEED OUR CONSTANT ATTENTION. WE NEED TO DO A BETTER JOB PREPARING OUR EMERGENCY MEDICAL PERSONNEL TO HANDLE INJURED CHILDREN AND TO MAKE THE BEST POSSIBLE ASSESSMENTS AND JUDGMENTS AT THE MOMENT OF PICKUP. AND WE NEED TO FOCUS MORE OF OUR ATTENTION AT THE PROBLEMS TO BE FACED BY THE CHILDREN AND THEIR FAMILIES FOLLOWING DISCHARGE FROM OUR HOSPITALS AND TRAUMA CENTERS.

AND THESE ARE JUST A FEW OF THE ISSUES THAT MAKE THIS ENTIRE FIELD SUCH A RICH FIELD FOR RESEARCH AND SERVICE. IT HAS LONG BEEN MY CONTENTION THAT WE OUGHT TO MOBILIZE OUR PROFESSIONS AND THE PUBLIC TO ATTACK THE PROBLEMS OF TRAUMA -- PARTICULAR TRAUMA TO CHILDREN -- IN THE SAME WAY WE ATTACKED THE INFECTIOUS DISEASES OF CHILDHOOD. THANKS

TO AN EXTRAORDINARY, RECENT HISTORY OF VACCINE DEVELOPMENT AND MASS CHILD IMMUNIZATIONS, WE ARE SEEING RECORD LOW NUMBERS OF MANY OF THE MOST COMMON CHILDHOOD DISEASES. POLIO HAS VIRTUALLY DISAPPEARED AND WE ARE ON THE BRINK OF ANNOUNCING THE END OF INDIGENOUS MEASLES IN THE UNITED STATES.

THESE GREAT ACCOMPLISHMENTS IN CHILD HEALTH ARE THE RESULT OF THE COLLECTIVE PROFESSIONAL AND PUBLIC WILL. AND WE MAY WELL NEED THE SAME KIND OF TOTAL NATIONAL COMMITMENT TO TRAUMA, IF WE HOPE TO SEE ANY REAL DECLINE IN THE MORTALITY AND MORBIDITY FIGURES ASSOCIATED WITH THE INJURIES OF CHILDREN.

CERTAINLY THE EXAMPLE OF DR. ROBERT E. GROSS AND THE ATTENTION BEING SHOWN BY EVERYONE AT THIS CONFERENCE CAN ONLY HELP TO CAPTURE THE NATION'S INTEREST. I, FOR ONE, AM HONORED TO HAVE BEEN ASKED TO TAKE PART AND I THANK YOU AGAIN FOR YOUR INVITATION.

THANK YOU.

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