D.O.A.

Above right: Dr. Tom Gallaher, a 27-year-old first-year resident, gets a moment of rest during the morning shift in the Baylor trauma ward. Gallaher "takes call" in the trauma ward every third night. At Baylor, doctors trade working on emergency shift for other hospital rights. Below right: At Parkland, a two-year-old boy is brought in with second- and third-degree burns after being scalded in a bathtub. He was one of two children with life-threatening trauma injuries that Parkland treated this night. That is not surprising, as trauma is the leading killer of infants and children. The little boy with the burns is still hospitalized, but now is listed in good condition.

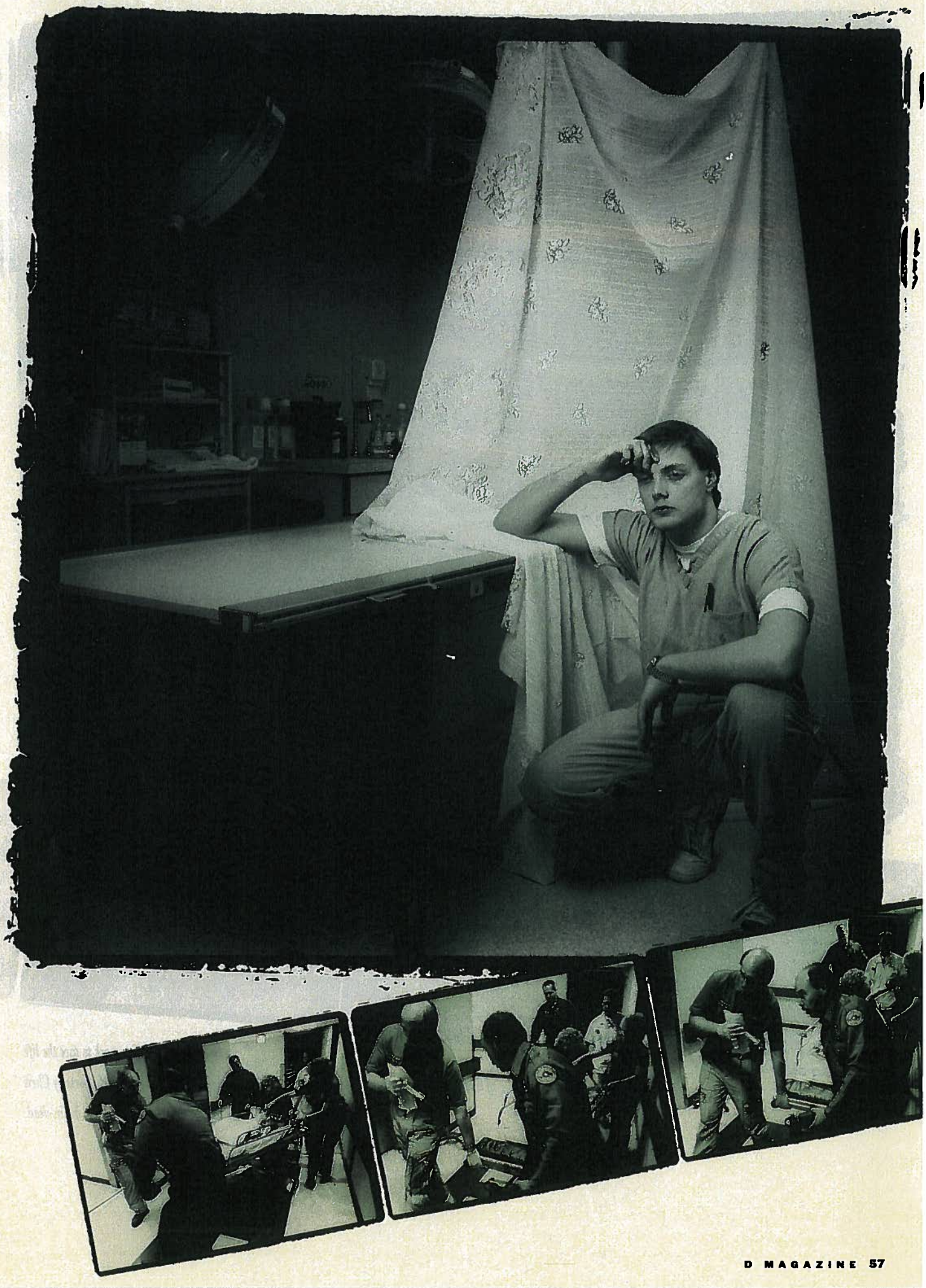
Your chances of receiving good medical care after a life-threatening accident are getting worse. Unless something is done soon, trauma care in Dallas could die.

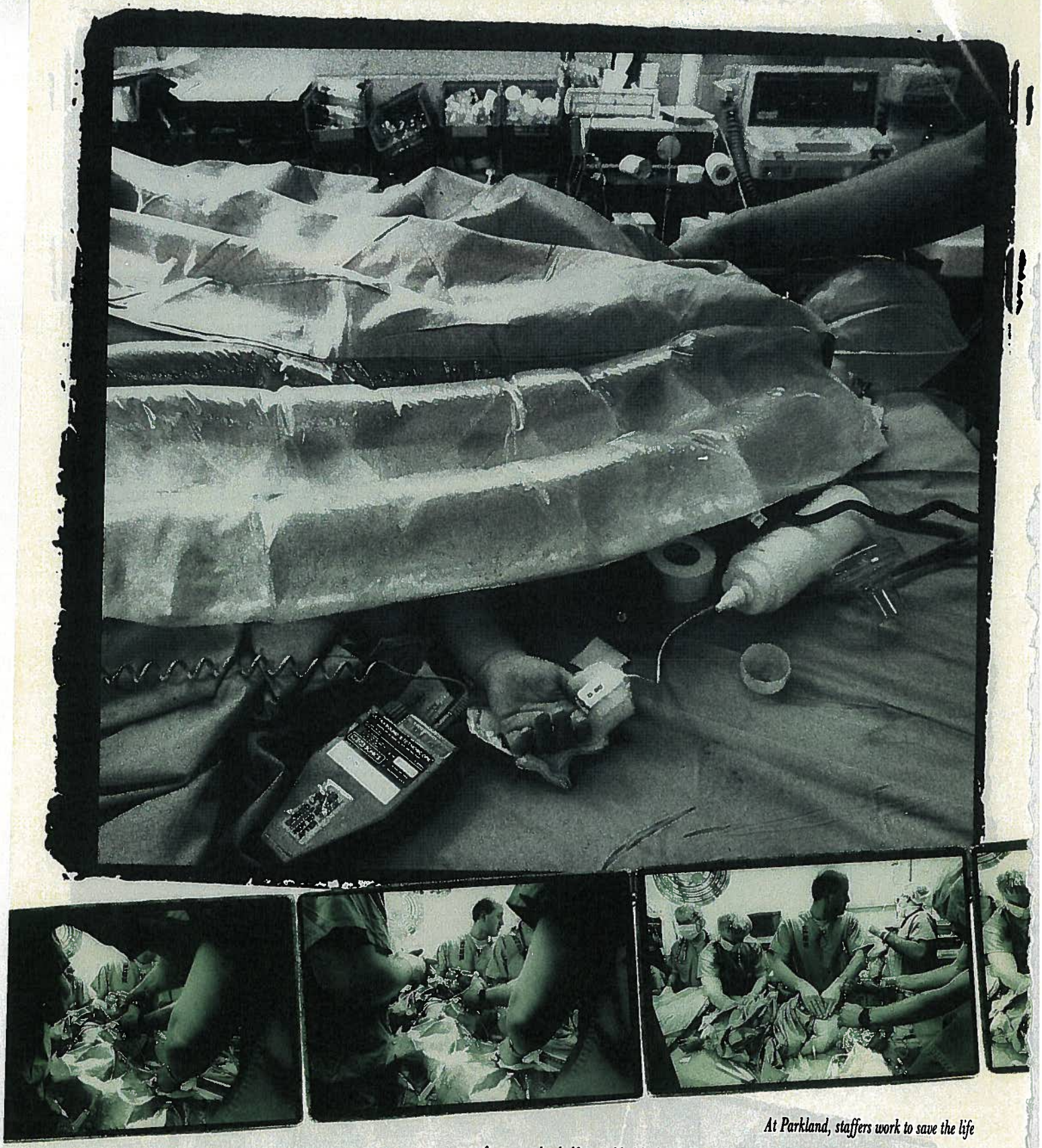
BY ROD DAVIS

THE WARM weather had just broken and a norther was dumping hard rain on rush-hour traffic when 75-year-old Giles Wilson* felt his chest go tight. He couldn't keep his pickup on the slick streets near Josey Lane in Carrollton and veered off sharply, brushing a utility pole before plowing into a tree. Carrollton EMS (Emergency Medical Services) responded in three minutes, but Wilson was unconscious with dangerously low blood

*The name has been changed at the request of the family.

PHOTOGRAPHS BY DAVID MACKENSIE





At Parkland, staffers work to save the life of a two-and-a-half-year-old girl, the victim of a drowning accident. Despite CPR efforts by Chris Chermansky, a first-year resident, the little girl was finally declared brain-dead.

of the emergency health system that whether you're an Addison lawyer or a South Dallas hood, if you run into bad luck, it won't get any better in a hospital.

OBVIOUSLY, SOMETHING SO HORRENDOUSLY DANGEROUS and screwed up as trauma care in America didn't start that way. In the early 1980s, trauma was seen as the front line of medicine and medical education—a boon to communities! A chance to save the otherwise doomed, to put technology and brains against death and to triumph! For example, hospitals interested in the lucrative field of organ transplants could see the pragmatic, if never publicly stated, advantage of a continous intake of potential donors. Trauma care also appeared to be an excellent revenue source in its own right. A quarter-million-dollar billing to a patient treated for serious trauma, not counting rehabilitation revenues, was not inconceivable. Nice money if you could get it.

Which was the catch. Trauma centers correctly gauged community need, but were completely mistaken about payment. Volume rose as fast as compensation plummeted. Nearly 70 percent of trauma costs go unpaid, and the rate rises to 88 percent for penetration trauma, the big new genre thanks mostly to drug wars. About 30 percent of Baylor's trauma admissions are knifings and shootings. The share climbs to 50 percent at Parkland. Under that financial hemorrhage, hospitals could literally go broke saving lives. Statewide, hospital losses to uncompensated trauma totaled about $220 million in 1989. Add another $50 million for physicians who, like hospitals, depend on insurance claims for payment. Add everything, start to finish, necessary to save the lives of people who can't pay.

If the system collapses, trauma victims in the Dallas area will be left with only one place to take the badly injured—a place already crushed with the homeless and the poor.

Who's to blame? Pick your villain. The most obvious is the catastrophic lack of adequate health insurance in America. An estimated 37 million people have no insurance at all, and perhaps 13 million more have policies so restrictive—take a look at your own—as to leave huge gaps in reimbursement. In Texas, 26 percent of the total population is uninsured, and it's a safe guess another 10 percent is underinsured, meaning one in three of us won't be able to pay a hospital bill in full. The situation is even worse when underpayment for Medicaid patients, about 60 to 70 percent of hospital cost, is factored in. Nor is insurance coverage likely to improve in a state with an 18 percent poverty rate, a rapid increase in immigrants, workers who typically aren't insured by their employers, and an ongoing recession.

Every aspect of health care is reeling from the funding crisis, but more so in trauma. Typical accident victims are young people, who tend to take chances, believe they are immortal, and carry no insurance. About 75 percent of motorcyclists who are hurt and who aren't wearing a helmet also aren't insured. People who suffer crime-related injuries, which account for about 26 percent of trauma admissions, tend not to be covered; the same goes for drunk drivers, who account for an estimated half of all serious or fatal automobile injuries.

Many hospitals can't take the strain. In Los Angeles, half the 23 hospitals that accepted trauma five years ago have dropped out of the system. Southern Florida is virtually a death zone for the seriously injured, with only one hospital in Miami serving as a trauma center for more than two million people. Houston's Hermann Hospital, after losing $14.5 million—nearly the loss at Baylor—ran a newspaper ad last year announcing it was quitting the trauma business. The immediate result was a two-day stackup of patients in the hallways at county-funded Ben Taub, the only trauma center left in a city twice the area of Dallas. But worse news was to come. In 1989, before the Hermann defection, Ben Taub admitted 3,800 trauma patients. This year, it projects 9,750, a figure so enormous the hospital has begun to curb some secondary services in order to handle the volume. Hermann has been brought back into the system on a limited basis, but could leave again at any time.

No statute law, no medical ethic, no hospital charter anywhere mandates that a hospital must provide trauma care to the community, which is why most don't. On the average, inner-city hospitals lose $2 million to $3 million a year on trauma services alone. Factoring in the losses from emergency rooms, which have become virtual family clinics to the poor or uninsured and recover an average of only 43 percent of costs, the overall national drain on hospital care (not just trauma) to the indigent approaches $2 billion.

In some cases, these losses may represent simply a "smaller profit," as one physician commented, rather than an overall deficit. In fact most hospitals, run by profit-driven corporations or management companies, earn their fair share of the $600 billion U.S. health care industry. And some of the losses can be attributed to outrageous charges from the hospitals as well as physicians. If a hospital, for example, charges $1,200 per day for a room and the doctor $320 for his labor, but the insurance companies say the room is worth only $1,000 and the doctor's charge $280, respectively, the difference can be accounted for as a loss. Nonetheless, multimillion dollar losses of any kind, especially when traceable to a specific operational center, are inconsistent with corporate requirements to keep medicine marketable. The obvious solution for a hospital contemplating investing millions to set up a trauma unit today is to forget about it.

While the situation is frightening in the cities, only about 25 percent of the country has any trauma services at all. If you're traveling in rural Texas, as little as three counties away from Dallas, your chances of dying from injury are 35 times what they would be if you were here. But not even urban living is a comfort. Only eight hospitals in five Texas cities offer Level I trauma care: Dallas (3), Houston (2), San Antonio, Galveston, and El Paso.

Austin, the capital, doesn't. It nearly stopped providing trauma care at all a year ago when its neurosurgeons, balking at big increases in uncompensated cases and at long hours on call, effectively struck. They only came back to work when the hospital, a Level II center (most but not all types of trauma), agreed to guaranteed shift compensation, a buy-out arrangement also being tried in California. Shift payment, at $1,500 or more per doctor, forestalls immediate physician flight, but really only intensifies the budgetary plight of hospitals, which must then absorb both their losses and those of the doctors.

The only thing more appalling than watching all this happen is watching ourselves let it.

The response from the city of Dallas has been not only to deny a desperately needed expansion of the EMS fleet and paramedics this year, but to actually *cut* the EMS budget and heel-drag on funding of improvements to Biotel triage capabilities for more efficient routing of ambulances.

The state, which four years ago "mandated" a trauma network for Texas, doesn't have one, although a new study says trauma costs Texans $4.5 billion a year in direct care, rehabilitation, and lost years of productivity. Although some legislation may be introduced to reimburse either participating hospitals or patients, the chances of passage in a pinched economy are slim.

The federal government has not only slashed Medicaid payments, which fund indigent care, and Medicare, which helps the elderly, but has stalled for years in setting up, at minimum, an emergency trust fund for trauma hospitals. And only about 2 percent of national

pressure and an erratic heartbeat. It was difficult to tell which acronym of the trauma trade, MI (myocardial infarction) or MVA (motor vehicle accident), was about to kill him. Paramedics called Biotel, the medical hot line, which immediately patched through Dr. Nilda Garcia, a 27-year-old, second-year surgical resident serving as "pit boss," or shift supervisor, in the surgery emergency room at Parkland. The medics wanted to take Wilson to Trinity Medical Center nearby, but Garcia said no. Parkland was 25 minutes away via I-35 in pounding rain and snarled traffic, but Wilson had "multisystem" injuries, especially to the abdomen. Anything but "definitive treatment" at a Level I trauma center, the designation for state-of-the-art facilities, would be a waste of time.

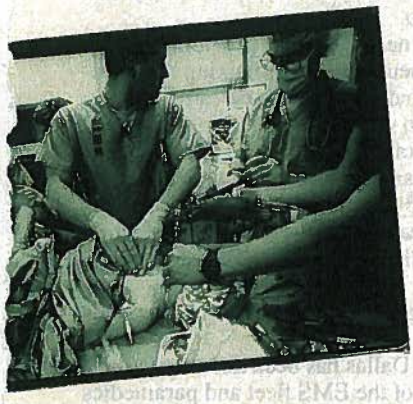
So Wilson headed south. Garcia alerted the four-member trauma team from rounds. As soon as the paramedics burst through Parkland's ER door pushing the stretcher cart, doctors and nurses were in tow, checking vital signs, questioning the paramedics for details of the accident.

Giles Wilson's workingman's plaid shirt and cotton trousers were cut away as he was given resuscitation, IVs, and checked for other injuries. His face was battered and his stomach bloated with air and blood. Interns applied CPR and residents administered atropine and the paramedics stood to the side, wet and wondering. Twenty minutes later, Dr. Matthew Pompeo, a third-year resident, "called" the code. Giles Wilson was dead.

It might have been his heart, or it might have been the wreck, but in truth Wilson's death was just another spin of the trauma turnstile. Before his pale, naked body had even been wheeled out of trauma room one, the gate was whirring again: a homeboy shot in the thigh and pretending he didn't know how it happened; a barroom brawler with blood-soaked fists pummeled into unconsciousness; a DWI in a neck brace brought in by the cops; a middle-aged woman from out of town groggy from a car wreck, not sure why she had to wait so long. . .

Eventually, they all walked out. Wilson might have, too, had his heart and age not been against him. The irony of his death was that he had such a fighting chance—quick EMS pickup and high-tech trauma care increased his survival odds 35 to 50 percent. It was not only better than nothing, it was better than many of us might get if we found ourselves broken and bleeding on city streets.

THE CRUSH OF CRIME, POPULATION, DRUNK DRIVING, GANG wars, and especially uninsured patients has put the Dallas trauma care system in a trauma of its own. In the range of calamities out there waiting to happen, trauma is what happens to you right before you die—unless you get help. Unless something is done before the end of this year, trauma care as we know it in Dallas could be dead. The three hospitals that provide it—Parkland, Baylor, and Methodist—will either stop doing so or be unable to cope with the load. That might sound alarmist if trauma shutdowns of more than 50 hospitals hadn't already occurred, with devastating results, in Houston, Miami, Los Angeles, Chicago, and other large, violent cities.



When and if that happens in Dallas, you might still get picked up by an EMS ambulance, and you might still make it through traffic to Parkland within the "golden hour" necessary to save your life in a severe emergency. But you probably won't get the attention devoted to Giles Wilson. You'll be much more likely to die in a hallway gurney because the 10 gang-war stabbings and shootings, the four passengers in a car that was hit by a drunk driver, and the farmer "medevaced" in by helicopter after his tractor tipped over in Lewisville are hurt even worse than you are and there's nowhere else that can take you and there just aren't any more nurses or doctors available and, unfortunately, you're out of time.

You know about heart disease, cancer, and AIDS, but the king killer among us is trauma—160,000 deaths a year in America. Eleven thousand in Texas. About seven times that number seriously and often permanently injured. If you're under 44, you're more likely to die of trauma—either "blunt," mainly auto accidents, or "penetrating," primarily gunshots and stabbings—than from any other single cause. Trauma is the leading killer of infants and children: the cause of half of all deaths under age 15. It is even more lethal among young adults—nearly four-fifths of all deaths of 15- to 24-year-olds, especially males, are due to sudden, dramatic violence to the body.

Trauma is not only widespread, it is fast increasing. Parkland, the county's only public hospital, last year treated a record 3,000 severe trauma patients—up about 30 percent from two years ago. Trauma admissions account for only a fraction of the 145,000 people (also a record) who came to the emergency room for treatment, but they're the most expensive part. More to the point, they're rarely paid for. The collection rate for trauma patients hovers at 27 percent, with an average per patient loss of $5,000—frequently much higher. A significant part of the $168 million Parkland currently provides in uncompensated health services to the indigent is traceable to trauma. And Parkland takes the lion's share: approximately 45 percent of the area's EMS trauma calls, compared to 36 percent for Baylor and 19 percent for Methodist. The rationale for the imbalance is not only that Parkland has a larger medical staff through the UT Southwestern Medical School, but that trauma care, especially for the indigent, is Parkland's job.

But it has become Baylor's burden. Never envisioned as a trauma hospital, Baylor has the misfortune to be located in an especially violent perch between East and South Dallas. Trauma simply walked through the door. In the last decade, Baylor has seen its emergency room traffic nearly double to more than 50,000 a year, bringing also a dramatic rise in trauma patients—2,332 last year. The strain has become a financial drain. Baylor currently posts $17 million in emergency room losses alone—about 40 percent from trauma care. Methodist, serving Oak Cliff, is the smallest of the three trauma centers, but saw 35,000 ER patients last year, including 1,243 for trauma. EMS trauma deliveries, about 15 percent on the average, have risen to as high as 21 percent in some months. According to Methodist, ER losses now approach $9.5 million.

You don't have to be a number cruncher to see the auto-destruct mechanism in these figures. According to Baylor Executive Vice President Bob Hille, "The collapse of the system is a very, very legitimate concern. If people hadn't been as cooperative as they have been, it would have collapsed before now."

Few things frighten the medical community in Dallas more than such assessments. If Baylor stopped being "cooperative"—which it could at any time and very nearly did last winter—the effect could be shattering. Baylor's trauma load would be shifted to Methodist and Parkland. Methodist President David Hitt says his facility has no plans to pull out of trauma care. Unlike Baylor, Methodist purposely set up a trauma capability in the early 1980s. But Hitt says if Baylor dropped out, Methodist would have to "reevaluate its role." Translated, that means that Methodist, unable to absorb a doubling or trebling of its load, might be forced to follow Baylor's lead. At Parkland, CEO Ron Anderson doesn't think his colleagues are kidding. "There is a very real danger," he says, "someone might pull out."

In that achingly possible scenario, Dallas, its suburbs, and surrounding counties (which also depend on the trauma system since they have none of their own) could be left with only one place to take the badly injured, a place already so crushed with homeless, poor, and other indigent patients you might have to wait hours—five to 10 is the national average and 12 is not uncommon at Parkland and Baylor—for treatment of serious, but not life-threatening, injuries.

Sheer pain and discomfort won't be the only results. "Somebody could die," says Hille. "It might not be somebody in a drug deal at all. It could be someone from North Dallas. That's one thing the community fails to recognize." What he means is that trauma overload could ripple out so far into the already faltering structure

health research funding is earmarked for trauma prevention and control.

Years of talk and squabbling among the insurance companies, hospitals, doctors, corporations, and politicians have produced exactly nothing in the way of a national health policy. Even something as comparatively straightforward as "no-fault" health insurance, similar to that used in automobile policies, seems impossible to legislate.

In other words, the only thing holding the system together is what can only be considered the altruism of doctors, nurses, paramedics, and other health workers, and the institutional conviction of a handful of hospitals.

The debacle should not be blamed on the poor, who tend to suffer major accidents at twice the rate of the more affluent, and whose communities tend to suffer what the Department of Health calls "disproportionate" trauma inequities. That the poor are without insurance is not a moral failing on their part; rather, it is a call to morality among the rest of us.

Moral action in resolving the trauma crisis, however, has an added, less noble incentive: It is also self-serving. After all, if trauma rooms close for the poor, or the criminal, or even the drunk, they also close for your baby, your younger sister, your husband, and you. Ask not, therefore, for whom the siren wails; it wails for thee.

JOHN WEIGELT HAS LISTENED TO THE WAIL OUTSIDE Parkland for the last 15 years. As director of the trauma department, he also has seen the wail's aftermath. A curious vision has developed in his mind. Each cutting, shooting, or crushing victim wheeled into his hands is like a window to the past. His patients are effects that up to an hour before need not have had causes. If the drunk hadn't driven, the cyclist had worn a helmet, the gun hadn't been available, the electric outlet had been checked, the ice on the porch had been sanded down... the past would not have become the bloody present. "It's often said accidents happen, that it's fate," says Weigelt, a thin, intense 43-year-old who used to be a veterinarian. "But when you look at it thoughtfully, it's usually a stupid mistake that precipitates a horrendous outcome."

Like a shock therapist, Weigelt makes the rounds of local schools, where he tells children—the primary victims of the "hidden epidemic"—how bad trauma gets, looks, smells. If only people would think. If only people would do a little more. If only they'd wear seat belts, get out of the drug trade, stop drinking and driving. If they'd see how much easier it would be, all things considered, to cut the burdens and pain of trauma by not inviting it in the first place.

His advice generally goes unheeded. He remains as tied to the trauma turnstile as do the stupid, the careless, the evil, and the unlucky. You have to wonder why he sticks with it. He might as well try to deter the Black Plague. It can't be money. Faculty pay is nice, but not lavish. It can't be home life. With 12-hour days and three call nights a week—and call nights are always work nights—Weigelt sees photos of his kids on his desk as much as he sees the real thing. It can't be serenity. Like most trauma surgeons, he has too much of the lean and hungry look: perpetually pale, sleep-deprived, wired as a mongoose in a cage full of cobras.

"I don't believe in burnout," Weigelt says, when asked why he doesn't feel it. "I believe in dissatisfaction. You become dissatisfied with your job, your values, and you change. No, I'm not dissatisfied. Does it happen? Yeah, it's real. It may happen to me one day, but so far I enjoy helping the people I see and the stimulation of being around the residents. I'm part of a medical activity I believe provides a real community service." He really talks that way, just like out of a Frank Capra movie.

You wish more physicians were like John Weigelt. But for every doctor who believes in community service there are a dozen who prefer the regular hours and higher pay of private practice. The preference is understandable—but it's also a central part of the

See D.O.A., page 70

If It Happens to You . . .

- **An EMS ambulance should arrive within about five minutes after someone calls 911.**
- **You will be examined, stabilized, and treated as your injuries warrant.**
- **If you are conscious, you may request to go to a particular hospital, based on personal choice or insurance coverage. Many insurance policies, such as for HMOs or PPOs, specify certain hospitals if needed. If you go to another, you may be liable for your bill.**
- **Paramedics may override your request based on your condition. If you have no preference, or are unconscious, you're usually taken to the closest hospital.**
- **If your injuries are treatable only at a Level I center, you will be taken directly to Parkland, Baylor, or Methodist, generally based on the advice of a doctor contacted through the Biotel dispatcher.**
- **Because of current overcrowding, the three trauma hospitals are now, through Biotel, attempting to redistribute patient loads. Although you may be closer to Baylor, for example, it is possible you will be routed through to Parkland or Methodist instead, if they can treat you faster.**
- **Once in the ER, you will be triaged (i.e., assigned a priority) at once. If you have life-threatening injuries, you won't wait. But if you're going to live, even though you may be seriously hurt and in pain, you may face delays ranging from minutes to hours, based on how your injuries rank in comparison to those of others.**
- **The bottom line: If you break your arm or cut your hand with a paring knife—in other words, if it hurts but you'll live—you may be better off requesting a less-crowded hospital. Most coronaries, too, are treatable at non-trauma hospitals such as Presbyterian, St. Paul, Humana, etc. But for the big hurt, your first choice is the same police officers make: Parkland. In the very worst cases, it's the best place to be.** ***—R.D.***

A Rehab Nightmare

The cost of trauma care does not end at the emergency room. Severe injuries leave many patients in need of long-term, expensive rehabilitation, something few can afford. They either do without it, or the costs are absorbed by tax-supported hospitals. According to the State Department of Health, uncompensated rehabilitation costs in Texas run about $1.7 million per year.

Even a single case can drain a hospital's financial resources. Consider Willie Porter, 20, who has been under constant treatment in Parkland's Surgical Intensive Care Unit C since a December 1989 car accident severed his spinal cord and left him paralyzed from the neck down. As of mid-February of this year, Porter's bill approached $1 million.

In effect, Porter has taken up permanent residence at Parkland. No other hospital will accept him because of the uncompensated expense. Since he must breathe through a ventilator and requires constant nursing care, doctors say it is unlikely he will ever leave the SICU. The plight of patients like Porter means not only a financial hemorrhage for Parkland, but the loss of already scarce intensive care beds.

—Stacy Haymes

PAUL QUINN, from page 55
sional contacts to "put some customers into Paul Quinn" by establishing a national police training academy, or looping the college into the prestige, power, and millions of the Superconducting Super Collider—that's the other roads a ways. Morgan's eye is on the college's nearer future, specifically next fall. He speaks excitedly of the new engineering program that will be in full swing then, and of the continuing education program featuring evening and weekend classes.

Even as he speaks, Morgan promises, Paul Quinn and DCCCD officials are putting the finishing touches on a new tandem technology degree program—the first of its kind in the area. DCCCD campuses and Paul Quinn will share each other's facilities for research and teaching, and exchange faculty as guest lecturers or consultants. Linkages will be established between the financial aid departments of the two schools to expedite the exchange of information.

It is the Morgan-Cottrell one-two punch that both men believe will bring what's needed most—a hefty endowment. By inviting to Paul Quinn's current 25-member board such political and financial heavyweights as Bush, Dallas Housing Authority director Alphonso Jackson, and Jette Campbell, partner with Peat Marwick, among others, Cottrell is bringing money to the table while Morgan explores other avenues for funding. Morgan's strength lies in catching the attention of donors—hence the planned course offerings in pre-nursing and allied health, communications, coaching, sports management, and entrepreneurship.

"We're lucky to be here," says Morgan. "Without the help of the many companies and organizations that readily pitched in and helped get this campus functioning, we'd be light-years behind. It's been a miracle. I mean, people and companies came to our rescue to give the campus running water, heat, and livable accommodations. I can't say thank you enough."

IF THE GHOST OF BISHOP COLLEGE HOVERS over Paul Quinn, you'd never know it by talking to Morgan or Cottrell. But even these remarkable men will not be able to boost the college to prominence alone. Aspirations are high, but the money supply remains insufficiently low.

Among the college's biggest concerns is the renovation of its campus, estimated to cost some $11 million in view of the fact that funds for the renovation are lacking and some of the buildings are in bad disrepair, the Southern Association of Colleges and Schools placed the school on a one-year warning in January. SACS is not yet threatening to jerk Quinn's accreditation, as it did Bishop's, but campus officials can expect a visit next fall from a criteria and review committee, says SACS executive director Dr. James Rogers.

From where such money will come is still up in the air. UNCF funds earmarked for Paul Quinn's relocation were quickly exhausted in November, bringing an abrupt halt to construction projects. There is also an estimated $150,000 shortfall in the college's operational budget, which is largely funded by corporate donations. Presently a bond package is being prepared, Morgan says, and he is confident that it will pass.

"I've got to get him some help," Cottrell says of Morgan, explaining that about $60,000 will buy the college a full-time comptroller, and that Morgan needs other essential administrative aides. Some help has come in the form of newly installed Bishop John Bryant, who arrived recently to replace Bishop Robert Lee Pruitt on the board of trustees after Pruitt was convicted of cocaine possession. Cottrell believes that the clergyman will be a real asset to Paul Quinn, explaining that "he understands that running a college is a business."

The bottom line is that continued support from the community is crucial. And Reginald Gates sees a worrisome detachment on the part of Dallas's African-American community. "There are many ways to lend community support," says Gates, "but many of us who are graduates of black schools don't even send our own children to black schools."

"Dallas is a philanthropic city of white people who came from generations of givers," says Fisk University's Ethel Barnes. "Blacks haven't historically been able to be those kind of givers, and the few that were able were afraid that their dollars would prompt white benefactors to stop giving."

Indeed, according to Barnes, who used to be Bishop's public relations director, the very support that allowed Bishop College to survive in the Sixties drove some potential black supporters away. "Blacks feared the white community's control over Bishop," she says. "It was kind of strange but they really thought like that, and actually, there were some white people who wanted to take control of Bishop."

Some believe that if blacks don't put forth an effort today to keep Paul Quinn afloat, the [illegible] time when the black community will have to become self-sufficient," says a former Bishop College public relations official. He fears that because of Bishop's failure, that won't happen any time soon.

But despite enormous obstacles, Cottrell, Morgan, and Paul Quinn are inching toward respectability in America's college ranks, especially among other predominantly black colleges.

"Think of us as a potential gold mine for black Dallas, black Texas, and black America," says Morgan. Or rather, as Niara Sudarkasa, president of historically black Lincoln University in Pennsylvania says, "Singly any one of us [black colleges] might seem to be replaceable. As a group, we're irreplaceable. We're America's gateway to opportunity." ■

Cecil Sharp is a freelance writer and editor of the Dallas Weekly.

D.O.A., from page 61
trauma crisis. Ultimately it is the rebellion of the doctors, not the hospitals, that causes emergency room doors to close. Baylor, in particular, feels acute pressure from its on-call physicians, who, in exchange for hospital rights, have to "take call." When Baylor's trauma admissions went through the roof, the doctors' hours did, too. Their incomes, meanwhile, went down, not only because of non-compensation, but lost appointments with their regular patients. A 59-year-old Baylor neurosurgeon in on a recent Sunday afternoon spent the next 17 hours treating seven gunshot cases. Monday morning he had to face scheduled surgeries in his private practice. "Neither mentally nor physically was he up to doing that any longer," says Baylor's Bob Hille. "He told me, 'How'd you like to have been my fourth or fifth or seventh patient?'" Or the next day's. If the doctor had been too tired to operate, his patients would have had to wait weeks or months for rescheduling. "The web of this moves all throughout the system," says Hille.

Today, the three hospitals in the Dallas trauma network have among them 13 neurosurgeons—Parkland six, Baylor four, and Methodist three. Presbyterian has 11 all of its own. The question is this: Why stay at Baylor when you could have a comparatively sane and prosperous life at Presbyterian, or Humana Hospital-Medical City Dallas, or St. Paul—the city's three other major hospitals that resist participation in Level I trauma care?

"It takes a very special type of personality," says Dr. Dighton Packard, director of the emergency room at Baylor. "Most people tend to phase out after three to five years. They tend to be younger and like the challenge. It's immensely complicated surgery. A gall bladder is a gall bladder is a gall bladder. But a gunshot—every one is a new challenge. Let me put it this way: There are people who build the same kinds of houses and people who build custom houses. Trauma surgery is a little like building a custom house.

"And trauma is a different matter for specialists like neurosurgeons," says Packard. "Most of the time, the nature of a traumatic head injury is so devasting, the surgeon doesn't go in and operate and the patient gets well. He operates, and the patient does not get well. It's not rewarding surgery. Even if the patient lives, he's not the same."

Then there is the growing problem of malpractice insurance. Doctors at private hospitals such as Baylor and Methodist work essentially as subcontractors, and so are responsible for many of their operational costs, especially insurance. Non-paying patients have proven to be as likely as anyone else to find a slick lawyer to sue the doctor who saved their lives—huge billboards outside Parkland advertise the services of vulture law firms. But at $60,000 a year and more, malpractice premiums to fend off the vultures can put a physician into the red

whether feeding time comes or not.

It's no wonder the teaching schools, the primary pool for trauma surgeons, are not brimming with people who want to stay in. Southwestern Medical School, whose faculty and residents form the physician staff for Parkland, requires residents to rotate shifts in the emergency room and on trauma teams. It is rare to meet a young intern or resident who doesn't find trauma work excellent training and an exciting test of skills—and equally rare to find one who wants to become another John Weigelt.

Add to that a serious shortfall of qualified nurses—a problem made worse by the long training curve necessary to bring them on-line—and the trauma crisis looms not merely as a short-term budgetary problem, but a long-range death wish. The killer is at the edge of town, and it won't go away by pretending it's not there.

RON ANDERSON ISN'T A PRETENDER. Zealot might be a better name. He's been watching the crisis unfold, the costs skyrocket, and the halls fill with the injured—poor or not, criminals or school teachers, they're all human beings. He's fed up. "I grew up in Oklahoma, and we used to watch the state not put up crossing signs at railroad tracks until somebody got killed," he says. "I don't want to do that here. It's just not ethical to take patients and put them in compromised circumstances. I'm not going to let that happen. And I'm not going to roll over. I'll raise hell about it."

As new chairman of the board of the Texas Department of Health as well as CEO of Parkland, Anderson can raise more hell than most. And he's already put trauma on the bureaucratic and political agenda. But he's been to Austin enough times to know you don't count on the state for anything. Like his peers in the Dallas medical community, Anderson thinks the only solution for Dallas's problems has to come from Dallas.

That's why he's pushing a bold new plan: the Trauma Institute. A comprehensive center for the treatment, study, and especially prevention of trauma, the Institute would be set up in the Parkland complex and, like Parkland, be staffed through Southwestern Medical School. It would greatly expand Parkland's trauma capacity and also ease the burden from the less critical walk-in load that swamps the ER. It's still just an idea, but serious planning is underway, and if funding can be lined up, the Trauma Institute could be on-line by mid-decade.

Every other hospital in town supports the plan. Not only is it good for Parkland, and good for Dallas, it's a reprieve for the bottom line. Ironically, though, that's the weakness of the Trauma Institute concept: Anderson is the first to caution that, insofar as the Institute implies that a single trauma clearinghouse is the solution for Dallas, it diverts public attention from the harder truth, that trauma is "a community problem." No matter how big or grand Parkland becomes, it can't do it all. "Putting all your eggs in one basket," as Anderson says, is bad social planning.

But it could be good business. As Parkland's share of the trauma load grows, that of private hospitals shrinks. As trauma shrinks, so do a hospital's financial losses. Actually, losses don't shrink, they simply drift over to Parkland with the non-paying patients. So much for privatization. Business only privatizes the profitable. We pay for the rest as taxpayers.

And we pay twice. Uncompensated trauma costs are not only borne by the community through direct taxes, via Parkland, but also through increased fees at private hospitals. Through what are called "hidden taxes," hospitals make up for their non-paying patients by padding the bills for the rest of us. Anyone who stays in a hospital in effect subsidizes the indigent by paying excess charges commonly accepted in the hospital industry. For non-profit Baylor and Methodist, as well as public-funded Parkland, this double taxation is defended as a kind of unpleasant fact of urban life. And perhaps they have a point. But what about the other hospitals? They get to charge the same rates based on "hidden taxes" as the impacted facilities, and take nothing like the losses from non-payment. The surplus is profit.

> The only thing holding the system together is the altruism of doctors, nurses, and other health care workers.

Profit is a touchy subject. What Dallas really needs to solve its trauma crisis is not just a Trauma Institute, but a comprehensive system in which the burdens are evenly distributed. There is simply no reason that a mere three of the more than 80 hospitals in the Dallas-Fort Worth area should have to absorb all the burden of trauma care. Even if it made sense to consolidate major trauma treatment centers, as it may, the load on the participating hospitals in other areas, chiefly in non-trauma emergency room overload, could be greatly reduced.

Anderson says sharing non-critical ER load is one immediate way the other hospitals in the system could take some of the pressure off the three trauma centers. He also thinks the city badly needs a "northern tier" trauma center. Parkland, Baylor, and Methodist are all in the center of the city—the source of 65 percent of trauma calls—and within a few miles of each other. But anyone hurt in the far north, especially north of LBJ Freeway, faces serious problems. Northeast Garland is considered serviceable only by medevac helicopter in severe cases. The wall-encased North Dallas Tollway in rush hour could lock up an ambulance heading into town.

But creating a new trauma center is a formidable task. A Level I facility would cost tens of millions to set up and staff. Even a Level II center has to be operated round the clock, with on-site staffing or immediate access by critical specialists. A trauma center, according to American College of Surgeon guidelines, must also be a training school, so that it can conduct research and have enough residents and interns to provide depth for peak loads.

Should a hospital in Dallas have to take on that load? Bill Haire, executive director of Presbyterian, says no. "When you look at the resources and the costs, bringing another institution into the system might not be the right answer. There's a huge resource conservation issue to be ready at Level II or Level I. . .The cost to the system, to have Humana or Presbyterian become Level I or II far outweighs the 'burden' now." Anyway, Haire says, the real strain on the system is from overuse of ERs as family clinics. He says Presbyterian, with 38,000 ER admissions last year, and $2 million in ER non-payments, is sharing the burden plenty. As for a northern tier trauma center, Haire suggests Plano.

Ultimately, everything depends on transportation. Dallas is not like Miami, Los Angeles, or Houston—where traffic patterns and urban sprawl make a central trauma facility a potential morgue, not a hospital—but it could be. When EMS, operated by the Dallas Fire Department, was set up, 16 ambulances were envisioned to serve an expected annual patient load of 30,000. By 1983 the load had risen to 60,000. Next year it is expected to top 100,000. But the ambulance fleet has expanded to only 22 vehicles, which average 70,000 miles a year and 250 runs every day. Five years ago only three people a day required major trauma care; now the number has risen to 15.

Ambulances get the same misuse as the rest of the system. Only about 40 percent of runs are truly for emergency situations. The rest are for the same kinds of things that clog emergency rooms: flu, stomach aches, splinters, minor contusions—"little ditzle things," as they're known in the Parkland ER. People who may have no other way to get to a hospital, or who simply don't know how, call an ambulance. Thus not only does EMS have to serve more people, spread over a larger area, but they make far more pick-ups than they ought to. And they don't get paid either—72 percent of their charges, about $240 a run, have to be absorbed by taxpayers.

EMS has some good ideas to fix its end of the logjam, but its ideas have to get through City Hall, an idea morgue if ever there was one. One EMS plan is a two-tiered pickup system to put less serious cases on a lower priority. Another is the expansion of Biotel's medical advisory mission to a systemwide

triage program. The goal is to cut Baylor's share of trauma network admissions in half, down to about 16 percent, and send the remainder to Parkland, which feels it can increase its load from the present 45 percent to as much as 55 percent. Methodist would remain about the same as it is, about 19 percent.

So convinced was EMS that Biotel triage was necessary, it put the system on-line for a 90-day trial last March, hoping to convince City Hall, which had denied the $180,000 funding, that it would save money and possibly avert a Baylor pullout. Doing so was an act of spunk, and an admission that even the simplest initiative to save lives will die unless the lifesavers themselves take a moment to wipe the gore from their hands and do it alone, again.

SUMMERS ARE THE WORST, WHEN trauma rooms run full, ICU units are packed, and the main problem in treating the injured is finding enough beds for them in the surrounding hospital wards. But any night, any time of year, is exactly the night the system could break, either through EMS overload or a packed house at Baylor, where more than two major trauma cases at the same time maxes the system, shunting ambulances to Methodist, which has even fewer deep resources, or then to Parkland. At Parkland, the doctors and nurses take a lot of pride in being able to handle anything—no trauma patient has been diverted from Parkland in 20 months—but even Parkland has its limits.

The night before Giles Wilson was brought in, the ER didn't get any motor vehicle accidents, but made up for it with the gun and knife club: eight shootings, six stabbings in three hours. The rush began about 11 p.m., with a young woman shot three times in the arms and chest. Her blood pressure had dropped to 50, and she'd have been dead had the police not staunched the bleeding.

Just as pit boss Greg Rohn, a 26-year-old resident, called in the lead trauma team, he got hit with two other products of the right to bear arms. A 30-year-old Jack in the Box employee had been shot through her arm and abdomen during a robbery. A young man had been shot in the chest in a drug deal.

Rohn needed backup. He called in a team from general surgery. Half the ER's eight trauma rooms had filled. Then late-night romance bloomed. A man walked in on his own clutching his chest, stabbed by his girlfriend. A woman showed up, shot during a family argument.

Rohn juggled surgeons, nurses, and equipment. All victims were saved. The next morning, turning the shift over to Dr. Garcia for the next 24 hours, Rohn went home to sleep. "I like trauma," he said. "It's a rush. But the bottom line is, I don't wanna have a life that revolves around being called in all the time." He said he'll go into specialized practice: eye, ear, nose and throat. ■

Rod Davis is a D senior writer.