
Trauma Watch

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SPOTLIGHT

Rural Texas lacks access to trauma care

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Disparities in access to California’s trauma centers remain despite greater utilization

Although admissions to California’s trauma centers have increased in recent years, there remains a “large disparity” in access to trauma centers, depending on patients’ proximity to a trauma center, according to a study published in the January *Journal of TRAUMA Injury, Infection, and Critical Care*.

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Systems initiatives reduce HAIs in trauma unit, study finds

System-based initiatives to reduce health care-associated infections in trauma patients can be successful if implemented with an evidence-based plan, staff education commitment, electronic documentation, and auditors, according to a study published this month in the *Journal of TRAUMA Injury, Infection, and Critical Care*.

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➤ SPOTLIGHT

1 Rural Texas lacks access to trauma care

Emergency and trauma care in many areas of rural Texas “is simply nonexistent, or limited to one ambulance and a part-time EMS crew,” the *Texas Tribune* reported. Trauma centers in El Paso and Lubbock provide services for approximately one-half of the state. However, in remote counties in West Texas, South Texas, and the Panhandle—where many hunting and ranch accidents and four-wheeler crashes occur—residents often live more than one hour from a trauma center. Trauma care has improved “slightly” in recent years as a result of advocates’ efforts to bolster support for rural hospitals and ambulance services, the *Tribune* reported. Border patrol helicopters and some private medevac services now transport trauma patients out of remote areas. According to the director of advocacy for the Texas Organization of Rural and Community Hospitals, state lawmakers can improve trauma care in rural Texas by ensuring the sustainability of small local hospitals that can stabilize trauma patients and transport them to major trauma centers (Ramshaw, 1/5, available through www.texastribune.org).

➤ IN THE JOURNALS

2 Study finds geographic disparities in access to California’s trauma centers

Although admissions to California’s trauma centers have increased in recent years, there remains a “large disparity” in access to trauma care, depending on patients’ proximity to a trauma center, according to a study published in the January *Journal of TRAUMA Injury, Infection, and Critical Care*. Seeking to determine if efforts to reduce disparities in access to trauma care have been successful, researchers from the University of California-San Francisco examined records for trauma patients admitted between 1999 and 2006 to a Level I or Level II trauma center in California—drawn from the California Office of Statewide Health Planning and Discharge Patient Discharge Database—and calculated proximity to a trauma center using a program based on the Halversine formula.

KEY FINDINGS

- Among the 752,706 cases that met the study criteria, 336,621 (44.7%) were treated at a Level I or Level II trauma center.
- Across the study period, injury severity increased, with 9% of injuries classified as severe in 1999, compared with 12.6% in 2006. Concurrently, the percentage of patients with traumatic injury admitted to a trauma center increased from 39.3% in 1999 to 49.7% in 2006.
- Among trauma patients with an injury severity score >15, 82.4% of those who resided in a county with Level I or Level II facility were admitted to a trauma center, while 30.8% of those who resided in a county without a Level I or Level II facility were admitted to a trauma center.
- The likelihood of receiving care in a trauma center was 0.11 ($p < 0.0001$) for trauma patients living farther than 50 miles away from a trauma center, compared with those living fewer than 10 miles away from a trauma center.
- The likelihood of admission to a trauma center was 0.35 ($p < 0.0001$) for severely injured patients who resided in a county without a trauma center, compared with those residing in counties with a trauma center.

Although encouraged to find that a rising proportion of patients with traumatic injuries were treated at trauma centers, the researchers expressed concern that the increase failed to affect all patients equally. They recommended further research “to identify factors that impede the treatment of patients with trauma in [trauma centers]. They also cited the need for improved coordination between county-based trauma systems and consideration of a more integrated arrangement—both functionally and financially (Hsia et al., “Disparities in trauma center access despite increasing utilization: Data from California, 1999 to 2006,” *Journal of TRAUMA Injury, Infection, and Critical Care*, January 2010, available through www.jtrauma.com).

3 System-based initiatives reduce trauma ICU hospital-acquired infections, study finds

System-based initiatives to reduce trauma patient health care-associated infections (HAIs) can be successful if implemented with an evidence-based plan, staff education commitment, electronic documentation, and auditors, according to a study published this month in the *Journal of TRAUMA Injury, Infection, and Critical Care*. Noting that trauma patients are at high risk for HAIs, researchers from **Vanderbilt University Medical Center** sought to determine the success of adopting evidence-based principles to reduce such infections in the trauma ICU. Targeting ventilator-associated pneumonia (VAP), catheter-associated urinary tract infections (CA-UTIs), and catheter-associated bloodstream infections (CA-BSIs), the researchers implemented several infection reduction strategies—including modifying clinical processes, adhering to HAI bundles, providing ongoing staff education, and utilizing informatics tools, such as procedure forms and checklists. To gauge the initiative’s success, the researchers analyzed the number of infections per 1,000 device days of 1,953 patients admitted to the hospital’s trauma ICU from pre-implementation in January 2006 to post-implementation in April 2008.

KEY FINDINGS

- Of the 1,953 patients included in the study, 278 had documented infections; 213 patients had VAPs, 57 patients had CA-UTIs, and 40 patients had CA-BSIs.
- Across the study period, all infection rates declined, with a statistically significant decline in the number of CA-BSIs and CA-UTIs. Specifically, between 2006 and 2008, CA-UTIs decreased by 76% ($p=0.02$), and CA-BSIs fell by 74% ($p=0.05$)

Commenting on the findings, the researchers said that the importance of educational initiatives and process audits “cannot be overemphasized,” adding that “even the best informatics tools” will not succeed if implemented alone. For example, the researchers mandated education programs for all trauma/ICU nurses, residents, and respiratory therapists as part of the initiative’s launch and created online teaching modules that focused on optimal infection reduction strategies. In addition, informal audits were conducted during team multidisciplinary rounds, while formal audits were conducted through electronic checklists and dashboards.

Despite the initiative’s success, the researchers noted implementation challenges, such as achieving collaboration from multiple disciplines to develop protocols, educate staff, and create effective audit systems. Moreover, they said that administrators must realize the potentially significant increases in nursing workload as part of implementation of such an initiative. Nevertheless, the researchers concluded that the strategy holds “great promise” for reducing the costs, morbidity, and mortality associated with HAIs (Miller et al., “Systems initiatives reduce health-care associated infections: A study of 22,928 device days in a single trauma unit,” *Journal of TRAUMA Injury, Infection, and Critical Care*, January 2010, available through www.jtrauma.com).

➤ TRAUMA HEADLINES

4 Prince George's Hospital (Md.) keystone of new regional emergency response initiative

U.S. Senator Barbara A. Mikulski and Congresswoman Donna F. Edwards (both D-Md.) recently secured \$2.5 million in federal funding for a new state-federal partnership to boost the national capital region's ability to respond to a large-scale medical emergency resulting from biological, chemical, or nuclear attacks, the Prince George's *Gazette* reported. Dimensions Health Care's **Prince George's Hospital Center** (PGHC)—a Level II trauma center in Cheverly, Md.—will serve as a central facility in the regional emergency response initiative, which will also include Malcolm Grow Medical Center on Joint Base Andrews and the University of Maryland Medical System. The funding—which was signed last month into law as part of Congress' Consolidated Appropriations bill—will support training for health care providers, including how to use respirators, protective suits, and decontamination showers. According to Paul Blackwood, vice president of planning for Dimensions Health Care, the initiative will result in improved surge capacity in the event of a public health disaster (McGill, 1/8, available through www.gazette.net; U.S. Senator Barbara A. Mikulski release, 1/8, available through <http://mikulski.senate.gov>).

5 John Peter Smith Hospital (Texas) verified as Level I trauma center

Fort Worth, Texas-based **John Peter Smith Hospital** (JPS) recently was upgraded from a Level II to a Level I trauma center by the ACS, the *Star-Telegram* reported. Previously, Tarrant County was the largest urban county in Texas without a Level I trauma center, and the most severely injured patients had to be flown to Dallas or Lubbock for treatment. According to Dr. Raj Gandhi, JPS' director of trauma services, the hospital could receive state designation as a Level I trauma center as soon as next month, which would enable the hospital to receive reimbursement for uncompensated care through Medicaid and the Children's Health Insurance Program. Despite attaining Level I status, JPS will continue diverting severe burn cases to the renowned burn unit at Level I **Parkland Memorial Hospital** in Dallas (Spangler, 1/8, available through www.star-telegram.com).

6 St. Elizabeth Health Center (Ohio) unveils renovated Level I trauma center

St. Elizabeth Health Center in Youngstown, Ohio recently completed a renovation of its Level I trauma center, increasing its capacity and speeding time to treatment, the *Vindicator* reported. The construction project expanded the hospital's two trauma rooms, which now feature a mobile and adjustable digital X-ray unit on a trolley, a bedside ultrasound machine, and an improved infusion device. In addition, the rooms are equipped with a browselow—the color-coded tool that helps clinicians quickly identify medication doses appropriate for pediatric patients based on height. St. Elizabeth last year treated approximately 2,000 trauma patients (Barron, 12/17/09, available through www.vindy.com).

7 Archbold Memorial Hospital (Ga.) redesignated as Level II trauma center

John D. Archbold Memorial Hospital in Thomasville, Ga., recently was redesignated as a Level II trauma center, WCTV reported. The announcement followed a successful onsite review conducted by the State Office of Emergency Medical Services and Trauma. Archbold Memorial is one of 16 trauma centers in Georgia and the state's only trauma center south of Columbus, Macon, and Savannah (Ali, 12/24/09, available through www.wctv.tv).

➤ HEALTH REFORM HEADLINES

8 Reform provision to accommodate obese patients could strain hospitals

A brief provision in the Senate's health reform bill that would require hospitals to purchase medical equipment able to accommodate obese patients may have an "enormous" impact on facilities' expenses, *HealthLeaders Media* reported. The provision would empower the Architectural and Transportation Barriers Compliance Board to set standards ensuring that individuals with "accessibility needs"—a phrase many experts agree would include obese and morbidly obese patients—have access to care. The board would require that hospitals, EDs, clinics, and physician offices contain medical equipment—such as examination tables, scales, and X-ray machines—that meets these patients' unique needs and allows them "independent entry to, use of, and exit from" medical equipment. According to *HealthLeaders Media*, hospitals worry that the costs of accommodating these patients may prove overly burdensome. For example, a 16-slice CT scanner that is able to hold a morbidly obese patient is 10% more expensive than a normal-size machine; sturdier, appropriately sized chairs cost about \$450 more than the regular version. The provision may be especially taxing on small facilities, a health lawyer noted, stating that they not only have smaller budgets but also space constraints that may prevent compliance with the requirements. While clinicians agree that this equipment would help provide better quality care to obese patients, some oppose the provision's broad scope and contend that such requirements should account for regional differences in the incidence of obesity. An assistant professor of radiology at Harvard Medical School, for example, suggested that some communities may be able to share one facility's larger and sturdier equipment, and thereby cut costs (Clark, *HealthLeaders Media*, 1/14, available through www.healthleadersmedia.com).

9 Despite marathon negotiations, deal on health reform remains elusive

Following a marathon session of closed-door health care negotiations, Democratic leaders say they are nearing resolution on health care reform, but have still not reached a final deal, *CQ Today* reported. During more than eight hours of negotiations last week, President Barack Obama, Democratic leaders, and White House officials discussed "all aspects" of the legislation and reported "significant progress" on reconciling the differences between the Senate and House of Representatives' health care bills. Although no details were released on where exactly progress had been made, the Associated Press reported that House and Senate leaders aimed for middle ground on hotly debated issues, including how to finance the overhaul, the extensiveness of government subsidies for lower-income Americans, and restrictions on insurance coverage for abortion services. Continuing his recent role in health care negotiations, Obama was a strong presence in the meeting last Wednesday, during which he reiterated his support for a tax on 'Cadillac' insurance plans, a proposal that labor leaders strongly oppose and caution may cost Democrats union support during midterms. Labor leaders also were present at the negotiations to discuss the implications of the tax, which they contended will unfairly burden union members. Negotiators reportedly reached a deal to include the tax in the final version of legislation.

Underscoring the pressure on the White House to reconcile the bills and finish the health care overhaul in the coming weeks, the AP reported that Obama will continue to participate actively in upcoming negotiations despite facing a slew of economic and international issues, including the recent earthquake in Haiti. However, strong resistance from rank-and-file legislators may hinder Obama's timeline, *CQ Today* reported (Herszenhorn, *New York Times*, 1/14, available through <http://prescriptions.blogs.nytimes.com>; *CQ Today*, 1/12, available through www.cq.com; Werner, *AP/Washington Post*, 1/13, available through www.washingtonpost.com; Brown/O'Connor, *Politico*, 1/13, available through www.politico.com).

➤ GENERAL HEALTH CARE HEADLINES

10 Lawsuit over patient death in Hurricane Katrina raising new concerns

A New Orleans jury may decide whether hospitals are liable for inadequate emergency preparedness in a trial involving a patient's death during Hurricane Katrina, the *New York Times* reported. The plaintiff's case argues that New Orleans-based Pendleton Memorial Methodist Hospital's inadequate emergency power systems, evacuation plans, and floodwater protection caused the death of 73-year-old Althea LaCoste, whose life support stopped working during the hurricane. According to LaCoste's family, a \$10,000 submersible pump may have been able to prevent her death. Meanwhile, Pendleton Memorial contends that its emergency power system "met or exceeded" applicable electrical codes and standards and that Katrina was an unforeseeable "act of God." In addition, hospital executives said that expecting a facility to prepare for all catastrophes is "unreasonable." Complicating the case is a 2002 memo written by a Pendleton Memorial executive, estimating that protecting the generators and related buildings would be a \$7.5 million project.

The case already set precedent in Louisiana when the state Supreme Court decided that such allegations should be treated as general negligence, not medical malpractice, and therefore not be subject to the state's \$500,000 damages cap. Should the jury find for the plaintiff, the *Times* noted that hospitals across the nation may change the way they address disaster preparedness. Although Pendleton Memorial and many other health care institutions meet emergency preparedness codes and standards, facilities may still be unable to handle major catastrophes, as national standards are traditionally oriented toward "common disturbances," such as brief power outages, not prolonged emergencies. In addition, the *Times* reported that relocating generators to higher ground is not mandatory for Joint Commission accreditation, which, in combination with tightening hospital budgets and lack of government funding for such projects, may make disaster preparedness less pressing when compared to a hospital's immediate needs (Fink, *Times/Pro Publica*, 12/31, available through www.nytimes.com).

11 Catholic bishops instruct hospitals to sustain comatose patients

Under a recent directive issued by the U.S. Conference of Catholic Bishops, more than 1,000 church-affiliated hospitals are required to provide "life-sustaining" medicine, food, and water to comatose patients with irreversible conditions, the *San Francisco Chronicle* reported. The directive—which was issued in late November and took effect this year—came on the heels of the bishops' push to shape congressional health reform bills. While a previous directive allowed Catholic hospitals and physicians to individually decide whether a patient's burden outweighed the benefits of life-prolonging treatment, the new mandate—guided by Catholic teachings against euthanasia—says providing food and water "always" represents a "natural means" of preserving life and is "not a medical act."

Hospitals have long wrestled with questions over sustaining comatose patients; some have been ordered by courts to disconnect unconscious patients' feeding tubes when the patients' wishes were clearly established, and the 2005 Terri Schiavo case ultimately was addressed on the Senate floor. According to the *Chronicle*, while the bishops' decree courts controversy and has sparked resistance from patient advocates, it does provide an exemption if life-prolonging care would be "excessively burdensome." Moreover, the spokesperson for one Catholic hospital alliance suggested that providers may find ways to bypass the mandate, such as transferring a patient to another facility (Egelko, *Chronicle*, 1/3, available through www.sfgate.com).

12 *NEJM*: Hospitals can cut infection risk with 'relatively simple' techniques

Hospitals could use two “relatively simple” methods when preparing patients for surgery to reduce hospital-acquired infections, according to a pair of studies appearing in the *New England Journal of Medicine*, the *New York Times* reported. The first study—which included 849 patients at six U.S. hospitals—revealed that patients who were prepared with a chlorhexidine–alcohol scrub were 41% less likely to develop a surgical site infection than those prepared with the commonly used povidone–iodine scrub and paint. The second study, meanwhile, screened a total of 6,771 patients at five Dutch hospitals and found that nasal carriers of *Staphylococcus aureus* who underwent a surgical procedure were at a 58% lower risk of infection if treated with mupirocin nasal ointment and chlorhexidine soap than patients who were not.

Commenting on the findings in an accompanying editorial, a physician from Virginia Commonwealth University in Richmond wrote that the two studies offer “remarkably safer strategies” for all patients requiring surgery, suggesting that chlorhexidine–alcohol should replace povidone–iodine as the standard for preoperative surgical scrubs. However, he recommended that, because the benefit of mupirocin nasal ointment and chlorhexidine soap for all patients remains unclear, the method should primarily be used for high-risk procedures including implants and coronary-artery bypass grafting, among others.

Although the new methods may force hospitals to spend more upfront—with one researcher estimating that chlorhexidine-alcohol costs about \$12 per patient compared with \$3.50 for povidone-iodine, the *Times* noted—experts not associated with the studies say that savings from preventing infections “dwarfs” the methods’ additional costs (Belluck, *Times*, 1/6, available through www.nytimes.com; Smith, *MedPage Today*, 1/6, available through www.medpagetoday.com; Darouiche et al., *NEJM*, 1/7, available through <http://content.nejm.org>; Bode et al., *NEJM*, 1/7, available through <http://content.nejm.org>; Wenzel, *NEJM*, 1/7, available through <http://content.nejm.org>).

➤ SPECIAL FEATURE

13 A bystander’s story of Kennedy’s death at Parkland Memorial Hospital

By Dr. Robert V. Walker, past president, American Board of Oral and Maxillofacial Surgery (ABOMS)

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Dr. Walker told this story at the ABOMS Oral Certifying Examination Dinner, February 2009.

Everyone seven years of age or older on Friday, November 22, 1963, and is still alive today, knows exactly where he was and what he was doing on that date. It was the day President John F. Kennedy was shot in Dallas, Texas, and brought to Parkland Memorial Hospital for emergency care where he died. During that time, Kennedy was enduring a decline of support from a strongly conservative city. With his ebullient good spirit and confidence, he alone decided to include Dallas on a whirlwind trip through Texas to calm the uneasiness—and, hopefully, to raise a few dollars for his political needs. I was then well into my seventh year as full-time head of the oral surgery residency program at Parkland, and I had become comfortable and enthusiastic about my career at this institution and with my faculty position at the University of Texas Southwestern Medical School. I was in the hospital for long hours every day almost seven days a week. It was not by chance that I happened to be in the hospital on that infamous day. It was the place I lived and worked. Everyone involved in Kennedy’s care was a close colleague and friend. Events of the day devastated each of us, and there is no joy in recall of the extreme intimacy and sadness of the happenings.

Having finished with surgery on the morning of November 22, 1963, I was at lunch in the cafeteria of Parkland with Dr. M. T. "Pepper" Jenkins, Chairman, Department of Anesthesiology, and Audrey Bell, R.N., Operating Room Supervisor, when Kennedy was brought to our emergency room after being shot by an assassin during a motorcade carrying the President to a luncheon at the Dallas Trade Mart.

During the meal with Ms. Bell and Dr. Jenkins, a "stat" call was repeatedly being made over the hospital's audible page system for the Chair, Department of Surgery, Dr. G. Tom Shires, who, on this day, was at the medical school in Galveston, Texas, to give a talk. This was in 1963 and there was no such thing as belt-worn page devices or cellular telephones to immediately contact an individual. A page system had speaker boxes located in all public areas of the hospital such as the cafeteria, hallways, waiting rooms, doctor and nurse lounges, etc. It was the common way to quickly contact needed staff and personnel. Parkland Hospital is the busy receiving hospital of Dallas and Dallas County staffed with a very large number of interns and residents. With many physicians-in-training always in the hospital, the pecking order in surgery is deep from the newest interns to fourth or fifth year residents to take care of all surgical matters. I had never heard Dr. Shires being paged because the buffering arrangements below him took care of all surgical calls before any could reach him. Hearing, "Dr. Tom Shires, 'stat', Dr. Tom Shires, 'stat,'" being paged was startling to the three of us at lunch. There was something plenty amiss just in listening to those words. Dr. Ron Jones, a third year surgery resident, also at lunch, quickly responded to the page, by hurrying to a nook in a wall of the cafeteria housing telephones for answering pages. The three of us watched Dr. Jones rush to the telephones, talk briefly on one of them, hang up, run to our table and say with almost breathless restraint, "They've just shot Kennedy and they're bringing him here." We were briefly stunned. I thought to myself, "Ron's not right! Nobody would shoot Kennedy!" But all of us sprang to our feet. Pepper shouted, "I'm going to the operating room to get an anesthesia machine and will see you in the emergency room." Audrey and I rushed out a side door of the cafeteria to take a back stairway down one floor to the emergency room. On entering from the hall, the first person I ran into was the First Lady, Jacqueline Kennedy. She was dressed in that lovely pink suit—and from the waist down, it was covered with blood. An immense wave of nausea engulfed me when I realized that, "they did shoot him." Jackie looked so lost in the emergency room and there were more people than I could ever imagine being in the place. There was only modest security maintained at that time. If a door had a sign written on it, "Do Not Enter", people simply did not go past it. And here the area was filled with unknown people. No one seemed to be caring for Jackie—she was vacantly wandering around, face streaked by tears and eyes filled with disbelief. I stood near her briefly not knowing what to say or do, and I, numbly, just left her, alone, with space between her and a lot of people. I made my way through the crowd to a hallway outside Trauma Room 1. Our emergency room was huge and well run for that era through the insistence and demands of Dr. Shires that such a state-of-the-art facility be a part of Parkland. Even though the motorcade was headed in the direction of Parkland, the reputation and excellence of the hospital's emergency care capability was largely the reason Kennedy was brought here. There were four designated Trauma Rooms, 1, 2, 3, and 4, in the larger overall area. Trauma Rooms 1 and 2 were opposite each other and separated by a large hallway. Trauma Rooms 3 and 4 were adjacent to Rooms 1 and 2, respectively.

There were two shooting victims in the lead car of the motorcade, President Kennedy and Governor John Connally of the State of Texas, who was also grievously injured with a life threatening gunshot wound of the chest. After arrival at the Parkland emergency room, Kennedy was wheeled into Trauma Room 1 and Connally was taken to Trauma Room 2. There were a LOT of people in the hallway separating the two rooms and there was a large group of well dressed dignitaries, a part of the motorcade, huddled at the end of the corridor. They looked totally out-of-place. In my hurry to Trauma Room 1, the only person I recognized was Mayor Earle Cabell whose wife, less than 30 minutes earlier, had presented a large bouquet of roses to Jackie as a show of amity from the City of Dallas for the Kennedys on their arrival by plane several minutes before noon. Cabell later became a senator from Texas. The door to Trauma Room 1 would normally be closed during treatment of a patient but it was open as staff and doctors moved briskly in and out of the room.

As I entered the crowded room to quickly check whether or not Kennedy had facial or jaw wounds, I was struck by how large a man Kennedy seemed to be. He was lying supine on a gurney with his feet extending slightly off of it toward the door. His head was at the opposite end on the edge of the gurney with a seeming infinite cadre of doctors working feverishly in efforts at resuscitation of him. These colleagues included Doctors Pepper Jenkins, Malcolm Perry, Charles Baxter, Robert N. McClelland, and Kemp Clark, a neurosurgeon who eventually signed Kennedy's death certificate. Brain injury was considered to be the cause of Kennedy's death. Dr. James Carrico, second year surgery resident, the first to see and minister aid to Kennedy on arrival in the emergency room, was around but I do not recall seeing him among those in Trauma Room 1 during my short stay in the room. As a second year surgery resident, he was "Pit Boss" (surgery resident in charge of the emergency room) on the day when Kennedy was shot and he was the first advised in the emergency room that Kennedy was being brought to Parkland. Jim was a very bright guy, and he knew that among Kennedy's several health issues that he had Addison's disease, a problem requiring steroid medication during a period of extreme stress. Jim assessed the situation correctly. A second year oral surgery resident, Dr. Don Curtis, was in the emergency room visiting with his good friend, Carrico, when notification of Kennedy's shooting was received. Carrico quickly asked Curtis to do a lower limb venous cutdown for large intravenous (IV) fluid infusions and that he (Carrico) would procure, calculate and administer the steroid dosage that Kennedy required because of his Addison's disease. Standard emergency room protocol at Parkland required, when possible, the quick establishment of four limb IV lines for rapid early crystalloid infusions for all patients with penetrating or perforating gunshot wounds with large blood loss. The words by Carrico were barely said before Kennedy was suddenly wheeled into the emergency room amid monstrous commotion—and the usual standard treatment for all gunshot victims was immediately begun. Curtis did the right leg venous cutdown and standard IV infusions were also begun in Kennedy's right and left arms. Curtis was later given the same intense scrutiny and questioning by the Warren Commission as was everyone involved in Kennedy's care. Curtis, of Amarillo, Texas, recently retired after a 44 year local leadership career in oral surgery.

Because Kennedy's head on the gurney was at the opposite end of the small room and there were many doctors attempting in his resuscitation, I slowly worked my way around the room behind those next to the carriage for a quick look at his face and jaw. A tracheostomy had already been done through or near a bullet exit wound of the anterior neck and attempts were being made to oxygenate the patient via an endotracheal tube. There were no visible marks about the face or jaw. There was clotted blood and debris about the facial area but it appeared to be the residual of much doing around the cranial, facial, jaw and cervical areas. I never touched the patient. Even though Kennedy was lying in a supine position it was easy to visualize a much too large hole in the right occipital area of his head with matter exuding from it and collected on the gurney next to the head. There was nothing hopeful about that wound. I carefully made my way out of the room totally discomfited by the whole scene. Carrico finished his surgery residency at Parkland in 1967 and he enjoyed an illustrious academic career at the University of Washington School of Medicine, Seattle, where he was Chair, Department of Surgery, 1983 – 1990. He returned to Dallas in 1990 and served as Chair, Department of Surgery, University of Texas Southwestern Medical Center, 1990 – 2000. He died in 2002.

Once in the hallway, I looked into Trauma Room 2 where urgent care was also being given to Governor Connally. One of the assassin's bullets had gone through Connally's upper right chest, shattered the right wrist, and settled in his left thigh. Dr. James H. Duke, Jr., a third year surgery resident, and an emergency room intern, whose name I cannot recall, had already put in a right chest drainage tube, applied occlusive dressings in an attempt to seal the bullet entry and exit chest wounds, and placed a foley catheter, and were now doing a cutdown on his right ankle. Things were quietly and efficiently being done in this room while there was still a good deal of fuss going on across the hall and in the larger part of the emergency room. Connally was shortly afterward taken to the operating room for definitive care of his wounds where Dr. Adolph H. Giesecke, Vice Chair, Department of Anesthesiology, provided general anesthesia for him.

Dr. Robert Shaw, Chief of Thoracic Surgery, Dr. James Bland, resident in thoracic surgery, and Dr. Duke provided the surgical care of his chest wall and lung wounds. Dr. Charles Gregory, Chair, Division of Orthopaedics, and Dr. William Osborne, resident in orthopaedics, did surgical repairs of the shattered right wrist. Concurrently, Doctors Shires (who immediately flew back to Dallas on being told that the President and Governor had been shot and were at Parkland), Baxter, and McClelland operated on Connally's left thigh. Connally recovered well from his grave wounds, but his death 30 years later in 1993 was caused by complications of right pulmonary fibrosis which was a consequence of the bullet damaged lung. In addition to being Governor of Texas, he served the nation as Secretary of the Navy and Secretary of the Treasury at different times. He unflinchingly gave credit many times to Parkland and his physicians for his longevity.

Kennedy was pronounced dead at 1:30 P.M. Central Standard Time, less than an hour after he had been shot. There was confusion still to come because Secret Service Agents were determined to get Kennedy in a casket and returned to Washington, D.C. as quickly as possible. There was an awkward confrontation between the Agents and Dr. Earl Rose, Medical Examiner at Parkland, over removal of the body before an autopsy was done as required by Texas law for all cases of instant death as had happened to Kennedy. I was still in the emergency room and was witness to this ugly scene which was repulsive under the circumstances. The Agents won out. The casket left the hospital around 2:05 P.M. for rapid transport to Love Field airport where Air Force One was waiting. The ambulance arrived at Love Field about 2:14 P.M. and the casket was taken aboard Air Force One via its rear gangway while many federal officials waited in the front of the plane. After the casket was appropriately covered and secured in the rear and an honor guard stationed at its side, Vice-President Lyndon B. Johnson was sworn in as President of the United States in the stateroom of Air Force One by Judge Sarah B. Hughes. First Lady Jacqueline Kennedy stood to the left of Johnson and Lady Bird Johnson stood on the right side of her husband during the short ceremony. There were a few close friends present as witnesses. Air Force One became airborne at 2:48 P.M. headed for the nation's Capitol city—and Dallas was left with a tragic piece of history.

Almost the same distressing scenario was repeated two days later, Sunday, November 24, 1963, after Lee Harvey Oswald, the highly suspected and likely assassin who had been captured by Dallas Police, was shot point-blank in the stomach by Jack Ruby during live, nation-wide television coverage at the Headquarters of the Dallas Police Department. Millions of Sunday morning TV viewers watched with horror at this brazen and outrageous attempt at murder directly in the presence of numerous Dallas Police officers and detectives. The mortally wounded Oswald was rushed to Parkland and underwent immediate surgery done by Doctors Shires, Perry, McClelland and Jones. Oswald had lethal bullet injuries to the aorta, vena cava and multiple abdominal organs. He died on the operating table. The most important person for possible information about the shooting of Kennedy and Connally was now gone. The sordid Oswald story is a lengthy tale. It is mentioned because of its direct tie to Kennedy's death.

Sadly, many of the players cited in this short and incomplete homage are also gone. Kennedy, Jackie, Johnson, Lady Bird, Hughes, Ruby, Connally—and Oswald—are dead. And so are Shires, Carrico, Jenkins, Clark, Gregory, Baxter, Shaw, and Bell. Each of these individuals enjoyed unbelievably successful careers in medicine and nursing. Still around are Giesecke, who became Chair, Department of Anesthesiology, and is now retired; McClelland, the intellectually gifted surgeon and probably the most reliable and knowledgeable historian related to the Kennedy assassination, is Professor Emeritus and still at UT Southwestern Medical Center; Perry, an eminent vascular surgeon, is retired, lives in East Texas, and flies his own plane back and forth to Dallas to remain active in UT Southwestern surgical affairs; Duke, who became a highly recognized television personality in hosting his own nationally syndicated television show, Dr. Red Duke's Health Reports, and an acclaimed trauma surgeon, remains very active at UT Medical School at Houston; Curtis who was a prominent oral surgeon in Amarillo, Texas, but is now retired; Jones who joined the faculty at UT Southwestern in 1964, was named Acting Chair, Department of Surgery, 1974-1976, and assumed the Chair, Department of Surgery, at the prestigious Baylor University Medical Center in Dallas, 1976 to the present; and forgive me, I have temporarily lost track of Bland and Osborne.

In the brief span of a little over three hours, on November 22, 1963, the City of Dallas was cautious in welcoming the President of the United States, warmed and cheered him lovingly during a motorcade through the downtown, watched in terror as he was shot through the neck and head on leaving toward a noontime speech, waited in silence and grief while he quickly died at Parkland Hospital, and mourned with the world as he departed the city for Washington, D. C. and the bestowal of reverence and interment as a noble leader. There is no measure of the sadness felt by everyone on Kennedy's tragic death in our community.

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