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Trauma Centers Lack Capacity to Deal With Major Bombing

By THOMAS M. BURTON

Many hospital emergency and trauma facilities in the U.S. are routinely stretched so thin that they would have trouble treating the onslaught of victims a terrorist bombing might create, according to emergency-medicine experts and government and private studies.

Today, several studies show, big-city hospital emergency departments are often so swamped that they must re-route ambulances elsewhere. Many urban hospitals lack sufficient medical staff, beds, equipment and "surge" plans to provide optimal care for potentially hundreds or thousands of patients from a large bombing, emergency and trauma doctors say.

The reasons include a relative lack of funding nationwide for trauma and emergency care. This shortfall, doctors contend, hasn't improved in the decade since Sept. 11, 2001, because millions of dollars have gone for stockpiling drugs, masks and equipment to combat biological terror threats rather than conventional threats. What's more, trauma victims tend to be disproportionately young and uninsured, leaving hospitals to absorb the cost of their treatment. Dealing with trauma patients also is expensive because of the 24-hour staffing required.

"Trauma care is one of the worst-compensated things hospitals can be involved in," said Arthur L. Kellermann, former chairman of emergency medicine at Emory University in Atlanta and now head of Rand Corp.'s public-health and preparedness program. "We have largely focused on adding drugs and stuff" for bio-attacks.

No one questions the need for preparing against such bio-weapons as plague viruses. However, explosives are "the most probable method of attack against the U.S.," Dr. Kellermann said, citing intelligence reports to Congress.

The majority of states have a system of designated facilities to handle the most severe injuries. The criteria include having trauma surgeons and operating rooms available 24 hours a day. They are swamped, however. "Even in responding to day-to-day demands, the emergency and trauma care system in the United States is often stretched beyond its capacity," concluded a 2007 report from the National Academy of Sciences' Institute of Medicine.

More than one-third of states lack regional systems that route trauma patients swiftly to the closest accredited trauma center, said Brent Eastman, chairman of the American College of Surgeons' governing board. Because of the costs, some hospitals have dropped out of such systems or eliminated emergency rooms during the past decade.

The solution, in Dr. Kellerman's view, starts with more staffing to allow surge capacity to quickly ramp up capacity by 20% or 30% if necessary. But, he said, hospitals need to have a plan to quickly clear the emergency room, cancel elective procedures and admissions, increase triage areas and immediately discharge patients who can safely leave.

The federal Centers for Disease Control and Prevention commissioned a study by a panel of 14 doctors who concluded in a 2007 report that, "To assume we can provide the same level of care for large numbers of victims from terrorist bombings as we do for victims of a bus crash is self-deceiving....Without immediate federal assistance, many, if not most, communities would have difficulty caring for a surge of victims."

Gregg Pane, head of hospital preparedness at the U.S. Department of Health and Human Services, said hospitals are actually "much better prepared than we were five or 10 years ago, but certainly a big incident in a city would be a challenge."

A 2008 report from the House Committee on Oversight and Government Reform considered whether trauma and emergency departments at 34 urban U.S. hospitals could deal with hundreds or more patients from a major bombing. None of the sites studied—in New York, Washington, Los Angeles, Chicago, Houston, Denver and Minneapolis—"had sufficient critical care capacity to handle this volume," the House report concluded.

The committee staff surveyed the hospitals on a typical day, and found 20 of 34 emergency departments were already "functioning at or over capacity." Three of five trauma centers in Los Angeles surveyed that day were diverting ambulances elsewhere. In Washington, "there were no available spaces in the emergency rooms" of the two Level 1 trauma centers surveyed.

In an article last year in the Journal of the American Medical Association, Kobi Peleg, head of disaster medicine at Tel Aviv University, wrote with Dr. Kellerman that Israel is better prepared for sudden mass-casualty events than the U.S. Factors, they said, include building expandable facilities and routinely avoiding emergency-department overcrowding. Some Israeli hospitals, for instance, have installed oxygen and power lines in interior corridors so that they could be used for patients in a mass emergency.

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