GUEST EDITORIAL

TRAUMA PREVENTION

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Trauma is a disease that disproportionately affects the black community. Black men are six times as likely to die from homicide as white men. In fact in large central cities, it is estimated that black men have a one in 20 chance of being murdered before the age of 30.[1] Black women are four times as likely to die from homicide than their white counterparts. Black children are two times as likely to die from non-motor vehicle accidents than are white children. In terms of motor vehicle accident mortality, figures from 1979 indicate that the death rate for black children was 17 percent higher than that for white children.[2] The consequences, both direct and indirect, of this type of violence in our lives is mind-boggling. The rising number of impoverished black female single-parent households, the disproportionate number of black men in prison, the 20 percent unemployment rate among black adults, and the almost 50 percent unemployment rate among black teenagers can be traced to this epidemic of trauma. Because of the wave of violence, many of our elderly feel imprisoned in their homes, afraid for their lives when they venture out. Some of us have accepted this epidemic of violence as a "natural consequence" of life in the 20th century. This state of affairs is clearly unacceptable.

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But why trauma prevention? A number of general surgeons with additional experience or training in trauma (traumatologists) have taken up the banner for better trauma care nationally. A strong case is being made for regionalization of care, for preparation of guidelines for acceptable trauma management, and for specialized centers prepared for handling around-the-clock trauma patients. These efforts are long overdue and will certainly improve the acute care that these patients receive (which has been the European experience). This approach does not, however, address the causes of this problem and thus will not change the incidence of injury in our communities.

The benefits of a prevention program are really twofold. First, it allows for organized and progressive community growth, where adults and children can reach and realize their fullest potential. Second, it will represent a tremendous savings in medical care delivery costs and may allow the shifting of health care dollars to other vital areas such as nutrition, exercise, and healthy lifestyle development. For men less than 65, injury and poisoning represented the second highest per capita health care dollar expenditure in 1983.[3] With these goals in mind let us review some of the pertinent data on intentional injuries. We must use this information to outline what must be done and

how it can be achieved, if we are to stem the rising tide of unnecessary deaths in the black community.

Homicide

Homicide is a well-researched area, with much baseline data. For this reason we will begin here. It is clear that friends and family members are usually involved either as victim or perpetrator in the typical primary homicide scenario.[4] As one might expect, almost 50 percent of homicides are initiated by an argument.[4] Alcohol has been implicated in almost half of the homicides that occur in large central cities such as Atlanta, Miami, and Washington, DC.[5] Illicit drug use looms large in this picture as well. Several researchers have noted the environmental cues that make violence an acceptable coping mechanism in this society, the most notable being television. In addition, poverty, crowding, poor housing, and limited educational experiences contribute to this sociocultural milieu that leads all too frequently to intentional injury.

Injuring Instruments

In terms of injuring instruments, handguns are implicated in roughly 50 percent of homicides with stabbing instruments second at 20 percent.[6] Although not homicide data, a review of the trauma admissions at Howard University Hospital for the last six months involving penetrating injury reveals a striking disproportion of stab wounds. Sixty-three percent stabbing and 47 percent gunshot wounds were recorded during this period. If handgun availability declines, we undoubtedly will see an increase in intentional injuries involving stabbing instruments and other weapons.

Prevention of Injury

Given this as a backdrop, what can we do? What must we do? First, we must change the sociocultural milieu that breeds trauma in our communities. We must create an environment where our adults and teenagers have employment. An environment where adequate housing and health care exists. An environment where the community takes on the responsibility for crime prevention. A drug- and alcohol-free environment. At first glance this might appear to be something that only the government can accomplish. Although government support in this critical area would be beneficial, quite frankly none will be forthcoming, given the present administration's posture on domestic programs. There are, however, enough resources in the black community to make this a reasonable, obtainable goal. What it will require is a commitment from black churches, elected officials, and businessmen. Pilot projects of this nature are in the initial phases. Second, we must outline a timetable of objectives for injury prevention in the black community.

The 1990 National Objectives for Injury Prevention[7] did address urban violence prevention as a priority for improved health status, but the recommendations set forth were inadequate and incomplete. For example, only one age subset (15 to 24) was cited in the objectives for homicide control, when in fact, the death rate is highest in the 25 to 34 age subset and second highest in the 35 to 44 age subset. Different prevention approaches undoubtedly may be required for these various subsets. Also, no mention of socioeconomic status was made in the objectives. This seems unusual in that there are data showing an inverse relationship between employment and suicide rates. In the section on drug use, the recommendations seemed to imply that improvement will exist if things just don't get any worse, ie, by 1990 the proportion of adolescents 12 to 17 years of age who abstain from using alcohol or other drugs should not fall below 1977 levels. To fill this obvious void, we submit the following recommendations:

1. To reduce the present homicide rate among black men by more than half of each age subset by the year 1995. For the 15 to 24 age group from the present 84.3/100,000 to 40/100,000. For the 25 to 34 age group from the present 145/100,000 to 60/100,000. For the 35 to 44 age group from the present 110/100,000 to 50/100,000
2. To reduce the present homicide rate among black women by more than half for each subset by 1995. For the 15 to 24 age group from the present 18.4/100,000 to 9/100,000. For the 25 to 34 age group from the present 25.8/100,000 to 10/100,000
3. To reduce the prevalence of poverty in the black community from the present 33 percent level to less than 10 percent by the year 1995

4. To achieve a dramatic reduction in drug addiction and alcoholism in the black community, with prevalence and incidence rates dropping by more than half.

Implementation

To assess and evaluate our ongoing efforts, each urban community should document its intentional injury rate, the associated mortality and morbidity figures and should chart the community's progress toward these goals on an annual basis. Close liaison with local law enforcement personnel and health department officials will help in this regard.

Finally, we must encourage and initiate the development of alternative individual strategies (new coping mechanisms) for dealing with trauma-predisposed situations. Relaxation response, meditation, exercise, and other techniques might be utilized by a given individual in an attempt to ease stress and prevent future intentional injury. The real key here rests with changing the lifestyle that leads inevitably to these injuries.

Surgeons who care for these trauma victims must take the lead in this fight. We must continue to deliver quality acute medical care to these patients. Simultaneously we must work just as feverishly to put ourselves "out of business" by eliminating these injuries altogether. Only in this way can we fulfill the greatest charge of a physician, "to eliminate pain and suffering" through prevention.

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