tal course. More important than the mortality group, however, is the surviving group. Data here support the fact that patients who survive the initial insult progress to rehabilitation. Acute-care hospitalization among patients in the survival group is long and resource-intensive. Such a situation is likely to tax the resources of nontrauma centers.

Our experience at MIEMSS supports other study conclusions, namely, that outcome from a major traumatic injury is best managed in specially designated trauma centers.

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Response

To the Editor:

We are grateful for Dr Gerold's comments and appreciate the opportunity to respond to them. First, the limitations of the Glasgow Coma Score (GCS) are well known and generally accepted. However, using the GCS is helpful in stratifying the patients relative to the severity of injury.

As Dr Gerold notes, the GCS does have use in the prediction of the patient's outcome. Our patients' outcomes correlated well with their initial GCS. The surviors' scores averaged 9.6, compared with an average GCS of 4.1 among nonsurviving patients.

Dr Gerold criticizes the fact that the GCS imparts no information concerning the extent or type of injury; however, this information is provided in the text of our article. Furthermore, because our study was not intended to be a multifactorial analysis of cranial gunshot wounds, we elected not to include several factors that Dr Gerold noted were absent (shock, coagulopathy, caliber, or number of wounding projectiles).

He is captious of our "failure to consider functional outcome...." However, our article clearly states that 57% of the patients who survived their injuries were classifed as good or mildly disabled according to the Glasgow Outcome Scale of Jennett and Bond.

On another point, Dr Gerold contends that our data "contradict a national experience that demonstrates traumatic morbidity and mortality are reduced when patients are cared for in designated trauma centers." Yet, our article compares mortality and morbidity data from major centers throughout the country with mortality and morbidity rates from our small patient population. Our results compare favorably, if not slightly better, in both categories with the other cited studies.

Similarly, Dr Gerold's data from the Maryland Institute for Emergency Medical Services System (MIEMSS) does not discredit our results. The mortality figure of 73.6% he cites, adjusted to 62.6% when the 10 patients who died of cardiac arrest on admission to the trauma center are considered, is higher than the mortality rate of 43% in our population.

His results merely reflect the discharge GCS measurements and the fact that the majority of surviving patients were discharged to home, another acute-care hospital, or a rehabilitation facility. Dr Gerold's data does not indicate a functional outcome level as does our data; therefore, a comparison is not possible. Nonetheless, even if we were to assume that all of the 24 patients (26.4%) who survived had a satisfactory recovery, this statistic is lower than the 12 patients (57%) in our study who made good functional recovery or had only mild disability.

We completely agree with Dr Gerold's comment that cranial gunshot wounds can be devastating injuries with high morbidity and mortality. At the time our study was conducted, no regional trauma center service system existed in the Philadelphia area; patients were routinely taken to the closest medical facility for treatment.

We believe our article is important because it demonstrates that patients with cranial gunshot wounds can indeed be treated in a community hospital setting and do as well, if not better, than the statistics from designated trauma centers would indicate. We make this statement with the understanding that a community hospital intending to provide such care must make the appropriate commitment to do so.

Our comments are not meant to take anything away from the

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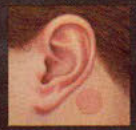

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importance of trauma care. However, many patients may not have access to regionalized trauma center care. Yet, many neurosurgeons practice in community hospital settings. Our intent was to provide data demonstrating that inherent limitations of community hospitals do not, by themselves, doom patients with cranial gunshot wounds to inferior care or unsatisfactory outcomes. We believe our data support this claim.

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Clarifying physicians' liability when notifying third parties of HIV risk

To the Editor:

In "Lose a piece of the rock: Physician liability for failing to notify private third parties of HIV risk" (*JAOA* 1991;91:45-50), Drs Isaacman and Closen conclude, "A physician who fails to disclose a patient's HIV infection to identified or reasonably identifiable sexual or needle-sharing partners (or both) may become embroiled in a negligence claim based on failure to warn."

I would like to clarify this point, at least as it pertains to the Florida state law 455.2416,

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