



Bone and Joint Decade
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Engaging Governments in Trauma Care

By: Tom Fullan, International Ambassador, Bone and Joint Decade

Global Trauma Care continues to be a challenge in both industrialized and developing countries. The benefits to governments in improving law enforcement as well as medical care have a tremendous impact on the reduction suffering, the cost of care and the wellbeing of a society.

This paper addresses one concept of making a measurable impact in how we approach this issue.

This concept is built on the founding principles of Patient Focused, Partnered Care (Fullan et al). The model developed by this author provides for the integration of knowledge transfer and team work among the following communities, physicians and surgeons, governments, hospital administrators and the private sector.

Trauma is the fastest growing area where we can see an impact on the burden of disease. Governments of late have tended to focus on road traffic trauma. However there is a growing interest in industrial trauma especially in emerging countries[1]. As an example of unreported cases is in India, where in 2005 there was on 48,000 reported cases and 1000 deaths in a population of 1.3 billion people.[2] Obviously far lower than the real incidence.

I think what is more alarming is the incidence of natural disasters such as Cyclones, terror attacks, railways, tsunami, earth quakes, floods and riots. Government with our collaboration need to engage in broad range planning led by the orthopedic community to effect profound change for preparation and response to mass disasters

By 2020 the WHO projects 548,000 deaths a year and 15,314,000 disability-adjusted life years (DALY) lost to trauma. The economic impact of this alone on all countries diverts precious resources away from the most needy. [3-6]

The quality of life in so many countries sinks to unacceptable levels. This spiraling economic monster serves to drain governments. The Partnered Care philosophy places this collaborative team in a position of leadership. If we follow the notions of "Servant Leadership" (Greenleaf) then we choose lead, educate, and accept our respective talents and stand side by side with our governments and make a difference our societies so desperately need.

Certainly within our immediate grasp there is Pre - hospital care. Hospital reception & resuscitation and Hospital in patient care. We also need to encourage WHO processes [10-14]. The illustration for needs assessment [13, 19-21] has been accomplished in Canada, Australia and the United States.

Pre Hospital Gaps:

- ❖ Lack of state organized emergency ambulance services. The vast majority of ambulances are used for inter-hospital transfer - not for primary response
- ❖ Finding a suitable vehicle at the accident site is not easy
- ❖ Persons who shift the victims are usually untrained public
- ❖ There is no linkage with hospital trauma services
- ❖ Crash victims are often taken to the nearest hospital, regardless of the hospital's capabilities for dealing with trauma

Hospital Reception and Resuscitation Gaps:

- ❖ Development of Emergency Medicine as a recognized specialty has not yet occurred in low and middle income countries (LMC)
- ❖ Organized trauma reception and resuscitation don't exist in many hospitals in LMC.
- ❖ There is often no warning of the pending arrival of major trauma patients and therefore no preparation
- ❖ Attendance to a trauma patient is often delayed. Triage at hospital can be ineffectual or performed by non-clinical staff
- ❖ In most LMC hospitals there is no trauma team and there is no interdisciplinary approach to trauma reception
- ❖ There is a single system approach to care, which is problematic when dealing with severely injured road crash patients who have multi-system injuries
- ❖ Few hospitals have dedicated equipped space for major trauma assessment and resuscitation
- ❖ Senior surgical, emergency or anesthetic presence in the setting of the initial trauma management is uncommon

Hospital in-patients Gaps

- ❖ Post resuscitation care received in hospital is usually coordinated by anesthetists and surgical staff
- ❖ Organized State Trauma Registries or data collection systems do not exist, making objective assessment difficult
- ❖ In LMC high rate of unexpected deaths are reported post resuscitation as compared to the global indices

One of the ways we can impact these gaps is to establish or improve a National Trauma Care Grid by:

- ❖ The establishment of Tertiary Trauma Centers & The designation of specific hospitals of various levels to care for trauma patients
- ❖ The concentration of trauma expertise at these centers
- ❖ Increasing staff numbers and experience at Trauma Centers
- ❖ Development of agreed triage and transfer protocols and improved education, training and research programs
- ❖ Training staff in trauma reception and resuscitation
- ❖ Supplying adequate equipment & drugs to Trauma Centers
- ❖ Integration and coordination between the service providers
- ❖ Major trauma database to be established to enable system monitoring & computerized data collection and record-keeping

Two key non healthcare requirements:

- ❖ Policy development which recognizes the socio-economic burden of injury and commits governing institutions to reform present, inadequate systems of care
- ❖ Funding

Our role is:

- ❖ Dynamic data mapping of infrastructure, capabilities and incidences
- ❖ Influence & shape policy framework with various stake holders
- ❖ Building public opinion through awareness campaigns
- ❖ Capacity building of infrastructure for development of trauma care including manpower & facility creation
- ❖ Continual technical training & knowledge up gradation of healthcare providers

Promote Research for improving outcomes

- ❖ Focus on Government, Media, Rural and Urban Physicians and Private delivery organizations

Our philosophy could well be: Patient Focused Partnered Care– Improving the Lives of People and creating Measurable Enduring Results

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About the Author:

Tom Fullan is an International Ambassador for the Bone and Joint Decade and speaks on trauma and governmental issues in over 30 countries. Tom is active in the BJD Canadian National Action Network, The International Society for Simulation in Healthcare, a member of the Global Emergency and Surgical Preparedness Committee of the WHO as well as the Canadian College of Health Service Executives. Tom has been a member of hospital and foundation boards in addition to assisting government committees develop and execute strategic plans. Tom is President of his own consulting firm and has developed an innovative approach to global medical education as well as been engaged with both specialty and Fortune 500 corporations in developing and executing strategic initiatives.