Toward the All-Inclusive Trauma System

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During a 2-day period at Skamania Lodge in Stevenson, Washington, overlooking the Columbia River Gorge, a multidisciplinary group of health care providers reviewed data available on trauma systems in North America in an attempt to clarify future directions. Like the explorers Lewis and Clark, whose journey brought them down the Columbia River, the participants knew where they wanted to go, but to reach their destination, they first had to review the progress made during previous decades and analyze the available information. One destination long advocated by American College of Surgeons Committee on Trauma and extensively alluded to at the conference is an inclusive trauma system.¹

The inclusive trauma system as a concept has been incompletely defined. The term can be broadened to include all the phases of injury care from prevention to acute care to rehabilitation, as well as to include all the disciplines involved with injuries: surgeons, emergency medicine physicians, pediatricians, nurses, trauma coordinators, emergency medical services, and multiple nonmedical groups with vested interests in the national trauma system. It can also imply inclusiveness of all patients injured by any mechanism.

Although extensive work has been done to optimize care of injured patients at designated trauma centers, at least 90% of Americans are still managed outside designated trauma centers. During the past 2 decades, expanding information regarding optimal emergency medical care has improved processes of care, including a greater reliance by emergency medicine physicians and nurses on outpatient care.

The emergency medicine discipline, pediatricians, and many other medical specialists have asserted their capability to manage injured patients in hospitals other than designated trauma centers, providing an advantage patients likely respect: care close to their homes without transfer to a geographically remote regional trauma center. Emergency medical services have also undergone a substantial maturation and frequently find it impractical to follow the principles of "scoop and run." The use of designated trauma centers exclusively for the majority of injuries may lead the emergency medical service personnel outside their primary service area.

At the symposium, the majority of participants vigorously advocated the development of an Institute of Injury within the National Institutes of Health to foster research to guide planners who will be determining the future direction of trauma systems. To accomplish the next phase of trauma system development, we need to work toward achieving a consensus on the definition of an "inclusive system." The individuals involved in that consensus development should include patients and professionals from disciplines involved with injury care throughout all of its phases. We must improve and refine our emergency medical services triage tools to better define patients who will most benefit from direct transport to a designated trauma center.
The United States needs a national injury registry that includes all patients admitted to hospitals because of injuries to accurately track injury incidence as well as to provide information to guide resource distribution among prevention, acute care, and rehabilitation research. To achieve adequate public and legislative interest and approval, injury professionals must present a unified front.

The Skamania Symposium succeeded in developing consensus on action items necessary to improving our trauma systems. Also necessary is all-inclusive multidisciplinary and grass roots support to bring about these recommendations. Further symposia are needed to include representation from other established societies and associations that deal with injuries to develop consensus for adopting national recommendations concerning the future of trauma systems in America.

REFERENCE


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