Need of Integration, Coordination and Delivery for Trauma Care

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Everyone in present day set up talks of Trauma but now there is a marked shift from Trauma to what is known is Emergency Medical System (EMS). Any system of medical care and attention be at urban or semi-urban, has to have a health care, strongly founded in pre-hospital care and management relating to those cases which are likely to become cases of Emergency or Trauma in nature.

Trauma in general is not an emergency medical relief but all emergency medical relief includes Trauma. Again, Trauma is not necessarily a mental phenomena or phenomena associated with accidents only. Trauma is state of mind and it is an unusual condition of a person which warrants emergency medical interventions. It may be caused by factors beginning with traffic hazards to bumps and from factors of poverty to lack of care but definitely it poses a public health problem like it has roots in economic and traffic problems also.

Going by this definition, solutions are not single but there are multi-factorial packages involving several stake-holders and it believes that given a commitment against a time dimension with a good communication network, the problem can be solved if not eliminated. Like no one can avoid travel because it has caused accident earlier. One can avoid accident definitely and control death statistics if not avoid death. If he cares for better roads, safer cars and takes right decisions at the right moment, gets the benefit of right technology to the right place.

Any Traumatological handling has to have a pre-hospital component, an emergency care system loosely known as Trauma system and a rehabilitation package with training inputs both for handling and for operating at different levels in different ways and in different situation. For meeting any kind of unforeseen situation which has led to a Trauma related phenomena, the role of the Government can not be considered in isolation nor can be made monopolistic. It has to have a partnership with private stakeholders and it has to branch off to regions and pockets in particular city with different super-specialists disciplines and specialists as a part of the whole system. Expanding this, one can say that the protocols of treatment or handling knowledge or awareness have to be clearly chalked out, definitely identified and pre-supposedly planned through a joint partnership with different stake-holders who would get the right exposure and the right mental software training behind them to look forward and respond to these issues.

While building up the Emergency Medical System in a city like Ahmedabad-Gujarat, the following facts needs to be kept in mind for integrating, coordinating and delivering.

The Need No. 1:

Instead of doing any work isolated or singly, it is very much essential to have convergence of energy, synergy of purpose and synchronization of methods by integration of private and public, Government and Non-Government trusts and individuals who would be required looking to their excellence and strategic locations to help the Trauma Care, Pre-hospital and Emergency Treatment in the city. Such a process of identification has to be done in a mapped way, corresponding to the map of the town and geography of the location of the centers as well as the incidence of Trauma or Emergency Medical System.

The Need No. 2:

Integrating all into the association, it is necessary that all these private and non-Government along with Government systems should be integrated in the form of a society which will have a charter of support, article of association and with its own business guideline on “no profit no loss” to cater the cases, improve the technology, upgrade its working styles and care for the emergency cases and such association who have, for its working purpose, committees like on safety protocols, transports, tele-medicines and post-medical care just to suggest a few for illustration.

The Need No. 3:

Such an association should be centrally located preferably in the Government hospital for obvious reasons for better support system but shall have links with all the centers and there has to be a gradation of centers like Level-1, Level-2, and Level-3. Level-1 centers should be such which have technological excellence and are absolutely modernized and has all the systems of investigations and post care. While, Level-2 would be those centers which are not super-speciality linked but would be able to take primary care and Level- 3 would be those which are at least good at simple care, first aid techniques and having ambulance cover for transportation. This definition could be modified and revised in light of each city’s problems.

The Need No. 4:

The need for window: Such an association or a center should have a window particularly for protocols training of public at large. The public at large need to be sensitized and educated about the do’s and don’ts, pros & cons of handling, while, doctors who are unaware of protocols should be given details of the protocols and can be trained to handle such cases for a better uniformity and rational approach with this issue in operation terms.

The Need No. 5:

Communication is key link. The role of the communication is crucial and critical in EMS. The communication has to be free and devoid of blocks at all levels. The communication within the organization, communication with its satellite, communication of centers with Level- 1 to 3 centers and the communication of the doctors with the paramedicos as well the communication of the centers with relatives and public at large has to be designed in a scientific way and it has to follow the principles of technology. The use of wireless system, tele-medicine and other software needs can be part of this communication process. It can also have an element of a special telephone dialing facility known by the name of Help Line, which is nothing but standardized tool for messages being received and messages transmitted.

The Need No. 6:

A training schedule comes next which have to put training as a priority not only for paramedical staff but also of medicos with disciplinary staff and multi-disciplinary experts with outside experts and a joint conferencing in training on technical guidelines and techniques has to be done with self-help group who work wonders in such situations.

The Need No. 7:

Exposition and Exhibition: All this would be more effective if these are also brought for the knowledge of public through public exhibition and also through banners, workshops and round-the-years sessions so that people would go for such centers demanding the services of pre-hospital and hospital care in the same way they visit the hotel and pick up a menu card.

The Need No. 8:

Ambulance Prime Mover: In such a system, the ambulance has to be well designed and has to have fitments that serve the cause and satisfy the patient's need. Such an ambulance system has to be upgraded, made spacious and should be patient care oriented. Such ambulance can have communication links particularly now throughout the GIS system, which is using the system to locate the location and the movement of ambulance in a particular city through the satellite back up and digested methods.

It has been seen so far that the most important crucial variable is the time factor in handling emergency. It is therefore essential that hierarchy of care in a system have to take care of the span of the time for the patient and not the reverse viz. span of time required for a patient adjusting to the care hierarchy. It means simplistic terms that patient as first and last has to be guiding hallmark and specialist to the technician in such a way that there is a definite pattern, designed role, accountable duty, allocable response, standardization of procedure and uniformity of protocol. All these should automatically lead at a review stage to

measurement of performance in terms of procedure and uniformity of protocol. All these should automatically lead at a review stage to measurement of performance in terms of physical and non-physical variables including the state of mind and several experts can also work as third party monitoring the tools to study the effects and success of patient handling in EMS.

To sum up, the care hierarchy has to be so regulated that it becomes a time bound guided hierarchy. The specialists can not exchange their specialities at the cost of patients. The patient is the King with time as the as the factor and Doctor as the server. Such an EMS which will be governed by a council with the back up of the Government through the voluntary network and shall have the protocols ready with training given and counters rehabilitation, communication record keeping and ambulance would quality as ideal Traumatological Centre which would address the right patient through right person in the right vehicle at the right time. Conversely, if this is not followed and there is a delay in decision making or delay in approaching the right person, delay in transportation and delay within hospital, the EMS would collapse. Therefore, it is high time that the EMS should have the right components in most righteous way for the rightful patients at the right time without any modicum of delay in role play identification, ambulance care, communication mess up or rehabilitation in the post hospital phase.

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