

TRAUMA GOVERNANCE IN THE UK DEFENCE MEDICAL SERVICES – A COMMENTARY

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Hardly a day goes by without media criticism or comment in relation to the care of injured British military personnel whether this be in relation to one of the two theatres of operation, the Royal Centre for Defence Medicine (RCDM) or during subsequent aftercare. Exactly how good is the care given to British military casualties? How many unexpected deaths or survivors are there and how does outcome compare with civilian and military counterparts?

Staff at the Academic Department of Military Emergency Medicine (ADMEM) have created a robust data collection and audit system that would be the envy of most civilian hospitals in the UK. In my own hospital trust an overburdened trauma audit and research co-ordinator struggles to collect data and make UK TARN returns. Junior doctor involvement is patchy and affected by interest (or lack of it), motivation and clinical commitments. The military have an advantage with dedicated deployed trauma nurse co-ordinators and (now) a well resourced staffing infrastructure for data processing and continued data capture at Role 4.

The use of over 60 performance indicators spanning pre-hospital care, resuscitation, surgery, post operative care and documentation provides specific assessment fields to compare performance in both theatres of operation. The use of AIS 98 and AIS 2005 (US Military) coding systems permits benchmarking to civilian and other military allies delivering combat casualty care.

Compared to civilian systems the military has certain advantages. All fatalities are subject to post mortem examination through a single coroner's system and usually the same pathologist. ADMEM attendance and prompt post mortem reporting permits close scrutiny of injury patterns, especially if they are related to new assailant technology, and opportunities to improve personal body protection. In civilian life preventable measures may take years before agreement is reached and implementation of changes achieved.

In civilian practice morbidity and mortality meetings are often held monthly and attendance is often sporadic. The military have established a weekly multidisciplinary review involving a phone conference between the theatres of operation, RCDM and the military rehabilitation facility at Headley Court to discuss all patients admitted in the previous two weeks and to raise, address and resolve clinical issues of interest and concern.

In addition, the military have established regular peer review with external validation to identify unexpected survivors and unexpected deaths, something which does not routinely take place in civilian practice and is often only part of a specific research project.

Having established an effective governance structure I foresee two important opportunities. First, extension of data capture to develop an end to end audit (from injury to discharge) and to capture functional outcomes and return to work data. Second is the appropriate exploitation of data. Whilst some information may be militarily sensitive, the majority should form the basis of papers publishing outcome data and answering such questions as "How well do our penetrating head injuries do?", "What is the functional outcome of a gunshot wound to the femur?" and "How does British combat casualty care compare with our allies?"

The military will only reassure its critics by publishing clinical results both good and bad. ADMEM have produced a robust data capture and governance structure that should allow the military to go on a publishing offensive rather than forever remaining on the back foot.