

Civilian Trauma Care And The Defence Medical Services – A Prospectus For Partnership?

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“Patients in civilian disasters fare better when treated by the techniques of experienced war surgeons”

[1] Edward D Churchill, Professor of Surgery at Massachusetts General Hospital and US Theatre Commander for Surgery for the Mediterranean during WWII.

A generation of military doctors and surgeons, brimming with knowledge reaped from their experiences of treating wounded servicemen, returns home from high-intensity operations. Familiar with swift triage and aero-medical evacuation protocols, sophisticated transfusion strategies, new limb-salvage techniques and data-based quality assurance, their return is co-incident with a recently published report publicising glaring deficits in civilian trauma care and a rising political will to make substantial improvements.

Such was the situation in the United States in the late 1960's [2]. Over the next two decades Federal legislation led to the evolution of trauma care systems and, shepherded by ex-military surgeons and clinicians, processes and outcomes for the injured improved drastically. Two generations on and it is the trauma services of the United Kingdom that face criticism and re-organisation [3, 4]. However, despite universal acknowledgement of the quality of Defence Medical Services (DMS) deployed trauma systems, and a dearth of corporate trauma experience within the UK's secondary care structures, there is still considerable ambiguity about the role of DMS personnel in staffing, managing and leading nascent civilian trauma networks.

In 2009, a London-wide tendering process was completed that will see the country's first civilian trauma system launch in April 2010 [5]. Impelled by the Department of Health's new programme of work to encourage the development of regional trauma networks, and guided by the National Director for Trauma Services, Strategic Health Authorities around the country are scrutinising this enterprise with considerable interest. Currently each of the four newly designated Trauma Networks in London are undertaking many of the same processes that characterised the evolution of the Joint Theatres Trauma System: Generating and harnessing existent in-patient clinical capability, agreeing pre-hospital care and by-pass protocols, co-ordinating data collection, defining quality assurance systems, benchmarking, and planning for training and education [6].

However, the efforts to generate and staff the Capital's new trauma system have largely been free of any DMS involvement, although two military clinicians formed part of the assessment team used to evaluate each of the candidate trauma networks. Whilst it is encouraging to note that key NHS figures, including the National Director for Trauma Services, have visited Camp Bastion, and that constructive relationships are flourishing between DMS managerial and clinical authorities and their civilian counterparts, the mechanism by which the new NHS trauma landscape will be able to systemically profit from the clinical and

organisational knowledge embodied by the DMS has yet to be forged. Equally, a fresh vision is required as to how the DMS will harvest the opportunities generated by these new civilian structures. The existing seven year old concordat is a facilitating document that spans areas of mutual interest to the Ministry of Defence (MoD) and UK Departments of Health (DH), but it does not address the emergence of trauma care systems [7]. Strategic guidance on this matter from the MoD/DH Partnership Board - set up in its wake and constituted in three work programmes directed at operations, policy and workforce, is awaited. Other formal relationships - maintained between the defence and civilian Deaneries and training authorities, and Joint Medical Command and NHS Trusts - are necessarily focused on the immediate realities of specialist training and contractual placement rather than the exciting possibilities offered by the new NHS trauma agenda currently being fashioned.

The arguments for a more systemic and less ad-hoc engagement of this agenda may seem obvious, but are worth re-stating, as are the implications. For the major trauma centres, access to a staffing pool of highly trained and experienced military trauma clinicians who can work in a trauma system without having to be shown how, would pump-prime the system and lessen the need to recruit overseas in the absence of locally trained staff [8]. Similarly, systemic exploitation of military trauma protocols, governance mechanisms, simulation training, rehabilitation structures and resilience management schemes would provide templates of excellence for civilian trauma centres. For the DMS, benefits include ready placement of clinicians within assured trauma programmes in an elite cadre of tertiary institutes, and opportunities for bilateral educational, training and research partnerships. In particular, the siloing and de-skilling of military clinical personnel that is an ever-present threat during periods of reduced operational workload would be avoided [9]. Creative use of staff could lead to financial savings for both organisations as infrastructure costs are shared and economies of scale are applied.

Whilst placement of staff in major trauma centres – particularly in inner-city teaching hospitals, remote from service populations - would not suit some DMS clinicians, it can be anticipated that many DMS secondary care clinicians will inevitably be located in large volume institutions, as provision of 24/7 emergency care in District General Hospitals declines. High-volume hubs are the ever-more likely solution for complex emergency secondary care, driven by governance requirements to concentrate cases and expertise, current public expenditure realities, and the impact of the European Working Time Directive. Equally, as new trauma systems come in to being, the DMS will need to robustly re-appraise relationships with Trusts and Deaneries not forming part of the new dispensation in favour of those that do

There has therefore never been a better time for the Defence Medical Services, an organisation whose stock has rarely been

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higher, to place itself at the centre of the current drive to reconfigure civilian trauma services. The efforts of those military clinicians selected to shape clinical policy within the Department of Health's trauma working groups should be matched by a novel top-level memorandum, setting out a vision for formally embedding the DMS within new UK trauma systems. Cultivating a talent base from DMS staff and positioning them to populate key appointments within future UK trauma systems will propagate a self-sustaining military-civilian trauma architecture, one that assures the future of trauma care in both organisations and spearheads the same improvements for civilian trauma care that have been so successfully rendered to wounded service men and women.

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