Pakistan has a unique pattern of disease burden. On the one hand infectious diseases are still widely prevalent and on the other hand non-communicable conditions like trauma, hypertension, diabetes mellitus, coronary heart diseases, cancers etc. also consume lot of health care resources. The proper management of trauma patients can minimize injuries-related adverse outcomes. This helps in diversion of health care resources to other priority areas.

From Pakistan, a comprehensive injury related data is not available. Hospital based statistics are not a true reflection of actual burden of this condition. In one of the reports it was pointed out that the records of Pakistan Police Department, where first information reports (FIRs) are registered, document less than 2.5% of all the fatalities and serious injuries related to motor vehicles accidents. Trauma is important for another reason as well. Most of the victims of trauma are young adults who are the main bread earners for their family and contribute towards economy of the country. The loss of this essential manpower and morbidity related to trauma in this age group, results in economic burden in a resource constraint health care system.

Injuries related to trauma, if managed in an organized way, can improve survival rate of the victims. The initial treatment that patients receive at arrival in a health care facility, dictates further course of the disease. The term coined as “the golden hour” is a subject of debate. Regardless of the origin of the term, the key objective is to transfer the patient to a trauma center where a proper treatment can be initiated at the earliest. The purpose is to prevent irreversible state that leads to death. In order to rationalize the approach to trauma victims, Dr. James Styner envisioned an approach that changed the strategy of management of patients brought with injuries. According to him health care delivery system was inefficient and had to be changed. In 1978, a new approach was introduced for providing care for persons who met with life threatening injuries. Initially it was meant for physicians working in rural setup but later it was made available for all the doctors by the name of the Advanced Trauma Life Support (ATLS) program. It was developed by The American College of Surgeons (ACS) and its Committee on Trauma. The goal was to provide a systematic and concise training in the early care of patients with trauma.

The philosophy behind this program, which is one safe way of treating trauma patients, is to establish a priority where greatest threats to life are treated first. For this detailed history, a conventional approach is not needed at the time when patient is brought to emergency room. The assessment and care provided are done under primary and secondary surveys. Life threatening injuries are diagnosed and treated in primary survey simultaneously. The mnemonic ABCDE is the common language of ATLS program. Detailed history and assessment and treatment of all other injuries are done in secondary survey. A plan is made during the management, as to transfer of the patients whose needs exceed the available resources at primary facility, to a place with expertise and resources. An en route care of trauma victims is also taught. All this can be done by single physician with the help of nurse and para-medical staff.

In Pakistan, trauma care is not provided in an organized way. It is commonly observed that trauma patients are transferred to tertiary care hospitals on a pretext that facilities do not exist. Trauma patients are not provided even basic treatment. This practice must cease as minimal resources are needed for management of life threatening injuries. Skills can be learned by all physicians and there should be no distinction between surgeons, physicians or general practitioners. Another observation that the care trauma patients receive at tertiary and district level hospitals, is far from satisfactory; concept of trauma team is almost non-existent so that the practical care is fragmented and does not deliver as it should.

In order to meet this dire need, the College of Physicians and Surgeons Pakistan (CPSP) trained a group of senior doctors at United States that took student provider course and after a successful certification of instructor course, established the Skill Lab at main office of CPSP in Karachi. ACS gave license to the CPSP to start ATLS student provider and instructor courses, the first in this region. In the year 2007 with the collaboration of faculty from ACS, first student provider and instructor courses were held. Since then 47 student provider courses have
been conducted in six cities of Pakistan till March 2012. In each course 16 students were enrolled. The impact of such course is still being evaluated. No randomized controlled trials are available to document the usefulness of this approach though evidence to contrary is also not available in literature. The main point of debate remains the urgency of transfer of trauma patients to health care facility and pre hospital care provided. In some countries pattern of trauma and available facilities are also point of conflict in adopting this approach.9,10

With increase in number of specialties in surgical and allied discipline, care provided to a multiple injured patient is apparently fragmented. Each specialty physician limits care to his or her own field. This approach is not appropriate for a patient who can not be compartmentalized. It is time that multidisciplinary trauma teams be constituted in all hospitals where different surgical disciplines are available. A general surgeon is usually the In-charge of the team. Working in an organized way and speaking a common language shall improve the total care and outcome for trauma patients. It is expected that all health care providers shall take ATLS student course which is one safe way of managing trauma patients.

REFERENCES