The management of trauma in Canada

Michael Gross, MD

In this issue of the Journal (page 23), Kortbeek has reviewed the treatment of trauma in Canada, using Calgary as an example.

There are some important lessons to be learnt from the trauma experience. The first is that trauma in Canada was only advanced when there was a multidisciplinary group of interested participants who used American College of Surgeons documents as a basis to set up a uniquely Canadian system. The second is that the trauma system concentrates expertise in the delivery of care in surgery care centres but is heavily dependent on good communication and outcome analysis to demonstrate the efficacy of these tertiary care centres. The third, and probably most important, is the growing understanding that most of the tools used to analyse trauma outcomes are somewhat crude and are not easily applied to all patients who present to a trauma centre. Any trauma registry is only as good as the information put into it. Analysis of trauma injury severity can demonstrate differences between centres but is not always applicable to all patients, and crude analysis of death and morbidity does not allow for adequate understanding of disabilities after treatment at a trauma centre and their impact on the population and on individuals.

In some respects trauma systems seem to have come of age. Significant Canadian statistics demonstrate that centralized trauma treatment programs are of benefit to trauma victims. Increased sophistication in the analysis of treatment programs is required. Appropriate evaluation of the costs to the community and to the individuals and the disabilities suffered as a result of the treatment of trauma are necessary. For example, an analysis of the outcomes of head injury would demonstrate an increased number of patients who are disabled as a result of their trauma but who according to the overall Trauma Injury Severity Score (TRISS) have done very well. The cost and impact of those disabled patients on their families and their caregivers are as yet unexplored. More research in this area must be done by dedicated scientists with epidemiologic training and understanding if the case is going to be made for continuing the traditional postinjury trauma treatment.

Dr. Kortbeek does discuss injury control, and again Alberta has demonstrated the way with a program aimed at teenagers and the effects of drinking and driving. The question must still be asked as to whether the trauma systems of Canada have had more of an impact on legislation with respect to drinking and driving than Mothers Against Drunk Driving.

Trauma treatment is an excellent example of a situation in which a more aggressive approach to prevention has to involve political action, based on expert results from expert centres and a clearer identification of the problems. If future Canadian trauma victims are to be appropriately treated, it behooves us as a profession to become more active in delineating the true costs to society and invoking the appropriate processes of education, prevention and indeed punishment for recidivists such as recurrent drunk drivers.

Professor of Surgery, Dalhousie University, Halifax, NS. Member, Editorial Board, Canadian Journal of Surgery

Correspondence to: *Dr. Michael Gross, Rm. 4879, Queen Elizabeth II Health Sciences Centre, 1796 Summer St., Halifax NS B3H 3A7*