BARNES-JEWISH HOSPITAL
TRAUMA SERVICES POLICIES/PROCEDURES

TITLE: Physician Personnel

SUBMITTED/REVIEWED BY: Julie Nash, RN, MSN, Manager
Trauma Services

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Policy Statement

A. A safe and efficient care of the injured patient depends on the orderly assignment and transfer of specific responsibilities extending from the pre-hospital phase, through the Emergency Department, operating room, intensive care, floor care to discharge and post-discharge care.

Purpose

A. To outline selected roles and responsibilities among personnel charged with care of the trauma patient.

Procedure

A. While each physician shares a moral, ethical and legal obligation to provide the best possible care to each patient, different physicians occasionally propose diametrically opposing approaches to the clinical problem at hand. The trauma patient may deteriorate dramatically while differences are identified and resolved. For this reason, the Trauma Service endorses the principles taught in the physician provider course on Advanced Trauma Life Support of the American College of Surgeons' Committee on Trauma.

B. Care of the trauma patient is an activity of the Emergency Medicine Division of Washington University and the Section of Acute and Critical Care Surgery, which is a service of the Section, of Washington University School of Medicine and Barnes-Jewish Hospital. The Administrative and Patient Care Directors include:

1. Chairman, Department of Surgery: Timothy J. Eberlein, M.D.
2. Chief, Section of Acute and Critical Care Surgery: Grant Bochicchio, M.D.
3. Director, Division of Emergency Medicine: Brent Ruoff, M.D.
4. Co-Directors, Burn/Trauma/Surgical Intensive Care Unit:
   John Mazuski, M.D. & Walter A. Boyle, M.D
5. Director, Trauma Center, Dr. Douglas Schuerer, M.D.
6. Director, Trauma Anesthesia: Peter Nagele, M.D.

C. Trauma victims are often admitted through the Emergency Department. The Emergency Department is responsible for identifying the patient as a trauma victim, notifying the trauma team and providing and documenting initial care. The Emergency Department physician team on South Campus includes:

1. The Emergency Medicine Attending: a member of the full-time staff of the Division of Emergency Medicine who has satisfactorily completed the A.T.L.S.™ provider course.
2. The Emergency Medicine Resident: PGY 4 or 5 who has satisfactorily completed an A.T.L.S.™ provider course
3. Other Emergency Medicine housestaff

D. Trauma surgeons are members of the staff of the Department of Surgery of the Washington University School of Medicine and active medical staff member of Barnes-Jewish Hospital. Each has

specialized training and/or experience in the global management of the trauma patient. Trauma Surgeons include:

1. Attending Trauma Surgeon: board-eligible or certified member of the full-time surgical staff who has completed residency training in general surgery. A.T.L.S.™ provider. American College of Surgeons guidelines requires the first call attending to be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 15 minutes as per ACS "Resources for Optimal Care of the Injured Patient" document, 2014.

2. Surgical house staff and LIPS as needed.

E. Anesthesia services are essential to the safe management of the trauma patient. Functions may include (but are not limited to) establishment and maintenance of airway and ventilation during survey, resuscitation and evaluation; preoperative sedation and analgesia; traditional intraoperative management including critical care services associated with invasive monitoring, and post-traumatic and post-surgical consultative assistance with specific reference to pain management. Anesthesia providers include:

1. Attending Anesthesiologist: board-eligible or certified member of the Department of Anesthesiology who is qualified to provide anesthesia and take responsibility for intraoperative and extraoperative anesthetic management of the injured patient.
2. Senior Anesthesia Resident or Certified Registered Nurse Anesthetist: individual qualified to provide the full range of anesthetic services under the guidance and auspices of the Attending Anesthesiologist. While non-physicians, CRNAs fulfill responsibilities identical to those of senior resident personnel and therefore, are included here.

F. Multisystem injuries of the trauma patient often demand simultaneous, complex invasive interventions. It is the policy of the Trauma Service to consult the SICU Attending concerning all patients admitted to the Burn/Trauma/Surgical Intensive Care Unit. Intensive Care physician providers include:

1. Attending intensivist: full-time staff member of the Department of Anesthesia and/or Department of Surgery assigned to the Intensive Care Unit.
2. Surgical Critical Care Fellow: trainee who has completed postgraduate training in a related specialty and is taking advanced training in intensive care.
3. Surgical Critical Care Housestaff: PGY 5, 3, 2 or 1 surgical, anesthesia or ED housestaff, or other assigned to duty in the intensive care unit.
4. Attending physician responsibility for the trauma patient will remain with the attending trauma surgeon throughout the patient's hospital course including intensive care. Decisions regarding major diagnostic and therapeutic interventions will remain the province of the attending trauma surgeon. However, it is expected that the critical care team will provide minute-to-minute care, including management of unanticipated emergencies.

G. Optimal care of the patient with multisystem injuries often requires prompt consultative and operative assistance from subspecialty services. It is the policy of the Trauma Service to consult subspecialty services when appropriate. Such consultation serves two purposes. First, it may provide for improved patient care. Second, it extends the educational experience of subspecialty fellows and housestaff who otherwise may not have contact with trauma patients.

1. As specified in the Guidelines for Level I Trauma Centers as published in the Bulletin of the American College of surgeons, as well as in the Missouri Statute 19CSR 30-40.430, subspecialty consultative response (senior resident or attending physician) is anticipated within thirty (30) minutes of paging. This includes but is not limited to cardiothoracic, OB, orthopedic, vascular, ophthalmology, maxillofacial, ENT, plastic, urology, replantation and neurosurgery

2. Injuries to selected anatomic regions occasionally fall within the purview of more than one subspecialty. Although the Attending Trauma Surgeon is ultimately responsible for the selection of consults, the Trauma Service subscribes to the following guidelines:
    a. Maxillofacial Trauma: ENT or Plastic Surgery may be consulted for assistance with maxillofacial injury management. Resident notification will be made on the basis of the published rotation.
    b. Thoracic Injuries: The attending trauma surgeon may consult cardiac or thoracic Surgery when a major thoracic injury is suspected or identified including cardiac, great vessel, or pulmonary hilar injury. The attending trauma surgeon or the trauma senior resident will notify the cardiac or thoracic senior surgical resident in-house It is the responsibility of the cardiac surgical resident to notify his or her chief resident and the attending cardiac surgeon on-call whenever a cardiac repair is necessary on an trauma patient. At the discretion of the attending trauma surgeon, the attending cardiac surgeon, and the cardiac resident in-house, the cardiac wound will be managed intraoperatively by the attending trauma surgeon and the cardiac resident. Postoperatively, the trauma patient will normally remain on the Trauma Service unless cardiopulmonary bypass has been required for the repair. However, it remains at the discretion of both the attending trauma surgeon and the attending cardiac surgeon as to which service is most appropriate to deliver postoperative care.
    c. Genitourinary Injuries requiring surgical reconstruction: Consultation should be obtained from the Genitourinary (GU) Service in a timely fashion per protocol
    d. Spinal Injuries: In the event of suspected or confirmed spine injury, consultation will be directed toward the Neurosurgery or Orthopedic Service. Resident notification will be made on the basis of the published rotation.
    e. Skull and Intracranial Injuries: Neurosurgery should be consulted for these type of injuries.
    f. Pregnant patients: OB should be consulted for pregnant patients per protocol.
    g. Pediatric Injuries: Care is provided to the victims of injury of all ages without regard to ethnicity, belief, or ability to pay; however patients who have not reached their 15^{th} birthday will be stabilized and referred to the pediatric trauma center at SLCH as soon as practicable and possible.

Resources/References

American College of Surgeons, Committee on Trauma "Resources for Optimal Care of the Injured Patient,2014"

Approval

Dr. Douglas Schuerer, Medical Director, Trauma Services Date of Approval 10/2015