We Need Better Care Coordination for Polytraumatized Patients

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Drs. Stinner, Brooks, Fras, and Dennis of the Vanderbilt University Medical Center, Nashville, Tennessee, bring to light the important question of "communication" surrounding the efficient and appropriate care of the polytraumatized patient. Comparing their disparate experiences during residency with their common level one trauma center experience at Vanderbilt University Medical Center, it is commendable that they collectively worked to publish a commentary that argues the simple point that "we can do better."[1]

While leading with an arguably overarching condemnation of the current "system," the article is not only provocative but is also largely accurate, sad to say. Communication is the cornerstone of quality medical care but unfortunately, for a myriad of reasons, the input and feedback loop between orthopedic trauma and critical care/trauma is often sporadic—the result of each service being siloed.

Measures have been taken to mitigate this potential deficiency—implementation of trauma care managers and nurse coordinators, and the inclusion of orthopedic trauma residents in trauma surgery rotations—but these are a poor substitute for interservice interactions at the fellow or attending level.

I am certain that these issues resonate with every orthopedic surgeon who has assisted in the care of the polytraumatized patient. We all know and can remember the "cleared" patient who was brought to preoperative holding for surgery only to be delayed because of elevated lactate, decreased hemoglobin, or inadequate resuscitation—stemming from a mismatch in communication between services on timing. And certainly we will recall in these circumstances the concomitant collective frustration of a delayed operating room, case-cart chaos, and unfair accusations of control-desk chicanery.

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Although the Vanderbilt model may not be a clean fit for every trauma system, I commend the authors for exposing the proverbial "elephant in the room." And while we may not agree that we live in a "constant state of chaos," costly errors or miscommunication undoubtedly exist. Since the downside of performance improvement actions is exceedingly low, it behooves us to find ways to develop regular communication schemes in the interest of better care coordination for the polytraumatized patient. ■

Reference

1. Stinner DJ, Brooks SE, Fras AR, Dennis BM. Caring for the polytrauma patient: is your system thriving or surviving? *Am J Orthop.* 2013;42(5):E33-E34.

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