ACCIDENT SERVICES OF GREAT BRITAIN AND IRELAND

ABSTRACT OF INTERIM REPORT, 1961

An Accident Services Review Committee was established in 1959 in Great Britain, working in liaison with the sub-committee of the Standing Medical Advisory Committee of the Central Health Services. This review committee has recently published its Interim Report.

The report, a small booklet of 45 pages,[1] is divided into sections. One section deals with the organization of a comprehensive accident service. It stresses the importance of a 24-hour service as its first requirement, and all that this implies, viz. the availability of experienced surgeons, anaesthetists, resident medical officers, nursing, theatre, and laboratory staff, etc. It recommends that the country be zoned into self-contained comprehensive services or 'accident service areas'. Each area is supposed to cover a population of about 1½ million people.

Within each 'accident service area' a three-tier scheme is to operate. The following are the three tiers:

1. The focal point is a Central Accident Unit which should be specially equipped to deal with the intricate treatment of special injuries and it should provide consultant opinion and services for accident problems occurring anywhere within the area.

2. Several Accident Units which should be fully equipped centres for the treatment of major and minor injuries generally.

3. A Peripheral Casualty Service in various forms providing for the treatment of minor injuries arising in the vicinity.

The importance of properly trained ambulance services and ambulance teams to convey patients from the peripheral casualty service to the accident unit or to the central accident unit, is stressed.

The Committee considers the possible merits of an Accident Hospital (a special hospital solely for the treatment of accidental injuries), but is unanimously of the opinion that all accident units of whatever size should be closely associated with general hospitals and should preferably be an integral part of them.

The Peripheral Casualty Service

The purpose of this service is to provide treatment for minor injuries, although it will in addition serve the needs of local casual patients. The siting and staffing of these centres will depend largely on the nature of the area. In general, the service at a cottage hospital or a diagnostic and treatment centre will be staffed by a rota of general practitioners in the area, assisted by nurses, trained ambulance personnel, and voluntary workers. In remote areas without these facilities, minor trauma would have to be treated in the doctor's surgery.

The local general practitioner will be as much a part of the accident service as the staff from the central unit, and this is stressed throughout the report. Now that accidents are a major hazard of modern life, all able-bodied and intelligent persons, particularly in the rural and semi-urban localities, should become acquainted with the principles of first-aid and, as an exercise in citizenship, be enrolled voluntarily on a list of those willing to give their services when called upon. The general practitioner would be the key person in this team.

The Accident Unit

The Committee recommends that an accident unit should always be part of a general hospital, and the unit will be staffed by the general surgeons, orthopaedic surgeons and other specialists on the staff of that hospital, and will be equipped to deal with patients with major injuries, including head injuries, burns, and thoracic, abdominal and vascular injuries. It will work in close cooperation with the central accident unit. The recommendation continues that the ratio of beds in the accident unit should be 25 per 100,000 population, but that the number of units in the accident service area would vary according to the nature of the locality. It will be uneconomical for the unit to have less than 25 beds and undesirable for it to exceed 100 beds.

The bed-occupancy of such an accident unit should be 75% rather than the more usual level of 90%. This will ensure that patients would always be admitted at once to the accident unit without altering the arrangements of the main hospital.

The accident service should communicate directly with the main hospital so that all other medical services that may be required will be available immediately.

Children need special consideration. Whenever possible, they should be admitted to paediatric departments of general hospitals having accident units, to children's hospitals in which there are accident units, or to separate accommodation for children in central accident units or accident units.

The Central Accident Unit

The Committee recommends that there should be one central accident unit, generally serving an area of at least 1,000,000 population, and probably in most cases a maximum of 2 million. This unit will usually be attached to the teaching hospital, although there may be areas where no teaching hospital exists, but in which it will be desirable to establish a central unit. This unit will have 4 functions:

1. To provide for the treatment of patients with multiple injuries who have been transferred from the accident units or elsewhere.

2. To act as a coordinating body for accident arrangements for the region.

3. To provide all services for major and minor injuries to the locality.

4. To undertake undergraduate and postgraduate teaching and research.

Since it must be accepted that this central accident unit will have its being within a teaching hospital, it is expected that the specialists in all the various specialities should be available from the teaching hospital for work within the central accident unit, which naturally will have to work on a 24-hour basis. The closest contact must of course be maintained between the central accident unit and specialist departments in the area.

As regards teaching facilities and teaching requirements in the casualty department, it is stressed that, as far as undergraduate teaching is concerned, a period of at least 3 months should be given which would replace the usual 'few weeks in the casualty department'. As far as postgraduate teaching is concerned it is recommended that the training of all surgeons, regardless of their ultimate specialization, should include a period of training in several of the major accident surgical specialities. At least 6 months of this training should be in an accident unit. 'It is hoped that the Royal Colleges and Corporations will review the requirements for the Diploma of Fellows so as to ensure that every surgeon spends adequate time in the study of trauma before obtaining the Fellowship.'

Finally, the Committee discussed whether it should recommend that accident surgery should be regarded as a speciality with consultants known as accident surgeons. It considers, however, that all surgeons should be trained in the treatment of all the common injuries as part of their basic training for any of the major surgical specialities, including 'general' surgery. The Committee has therefore decided against advising the appointment generally of accident surgeons, and believes that the recommended course of training, which affects the whole of surgery, is a sounder plan. The report concludes with a series of statistical tables setting out the well-known and steady increase of accident death rates year by year. Thus, from 1954 to 1958 the death rate per 100,000 population from motor accidents in males aged 15 - 22 rose from 26 to 35. In addition, an analysis of the most common causes of death showed that accidents of all kinds in the same age period caused 92 deaths per 10,000, whereas cancer caused 114, and cardiovascular disease 142. In the total population up to 85 years of age, accidents caused 174 deaths; this was exceeded only by bronchitis (275), cancer (435), and cardiovascular disease (782).

An appendix gives the floor plans of 4 of the major existing departments in Great Britain, viz. at Sheffield Royal Infirmary; at the Radcliffe Infirmary, Oxford; at the Sunderland Royal Infirmary; and at the Birmingham Accident Hospital.

1. Accident Services Review Committee (1961): *Accident Services of Great Britain and Ireland, Interim Report.* London: B.M.A.