THE FAMILY DOCTOR AND THE INITIAL MANAGEMENT OF INJURIES

Report of a symposium arranged by The College of General Practitioners and The Institute of Accident Surgery, Birmingham.

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This symposium sponsored by The Wellcome Foundation was held in London on 12 and 13 May in the Wellcome Building, Euston Road, N.W.1.

Many general practitioners have a very sketchy knowledge of first aid, but this does not mean that they are useless at the scene of an accident. It is important to know what to do and what not to do to an injured person. " Masterly inactivity " or well judged restraint can only be based on keeping informed on the relevant changes and advances in medical and surgical practice. Not all doctors engaged in family practice have time or opportunity for keeping in close touch with these advances.

This symposium was most successful in presenting modern theory and practice. The subjects discussed by surgeons from The Institute of Accident Surgery, Birmingham, provoked good and sustained discussion from some of the eighty or more general practitioners who attended.

Mr P. E. London (surgeon, Accident Hospital, Birmingham) presented a first class paper and discussed *Severe Injuries, Shock and Haemorrhage.* One of the most important effects of serious injury is bleeding. The clinical condition of the patient is not always a reliable guide to the extent of the bleeding which depends on the amount of vascularity of the injured tissues. The surface appearance of a wound is an unreliable guide to its importance. He showed a large number of excellent colour slides. The important point is to recognize that bleeding may occur underneath the patient from a wound on the back of the body. The clothes soak up some of the blood and while the patient is lying on his back, the blood that escapes is not seen.

He reminded the audience that severe bleeding will produce all the signs of low blood pressure, weak and rapid pulse, pallor and cold extremities. If no bleeding is found on careful examination only then is it justified to assume that bleeding is internal. In the initial treatment it was essential to apply a pressure dressing to the

wound, to keep the patient as quiet as possible and transfer to hospital as early as possible. This did not mean a rapid ride in the ambulance but a smooth one. The use of a tourniquet was not advised nor was the giving of morphia indicated unless the patient was to go on a long journey. Then the giving of a small quantity intravenously would be considered.

Mr L. D. Abrams (surgeon, Queen Elizabeth Hospital, Birmingham) discussed the clinical features of *Chest Injuries* in the early stages. The treatment should be directed to restoring the effectiveness of the mechanical breathing efficiency of the respiratory tract. For the surgical team in the hospital, this may mean tracheostomy, bronchial toilet, aspirating blood and air from the pleural space, and resuscitation by blood transfusion within a short time of the patient arriving in hospital. The family doctor can do much to keep the patient alive until the ambulance arrives to take the injured to hospital. The airway must be cleared. Seal any sucking-holes in the chest wall. A conscious patient may be made more comfortable in a sitting-up position; or, the patient may feel more comfortable lying on the affected side. The wound may have a large pressure pad applied after it has been sealed. He warned the audience about the small penetrating wound which allayed suspicion if the patient appeared well. The physical signs of injuries of the chest wall may seem difficult but complicated, but obstructed or distressed breathing, deformity of the chest wall and paradoxical movement, open pneumothorax, and cyanosis are readily recognized.

Colonel J. Watts, RAMC, demonstrated most efficiently and rapidly the use of the pre-pack plaster bandage, These bandages were most useful if the patient had to go on a long ambulance journey. The firm bandage relieved much pain and the patient could travel in comfort and safety.

Mr Walpole Lewin (neurosurgeon, Addenbrooke's Hospital, Cambridge) in defining *Head Injuries* said it was better to include all the injuries above the neck, affecting the facial skeleton as well as the cranium and its contents. The general practitioner is concerned with all grades of head injury, and at all stages. The treatment of minor head injuries is important if morbidity is to be reduced and some points in their management are discussed, including the the care of scalp lacerations. The initial assessment of the severe head injury with unconsciousness includes diagnosis, the search for evidence of other injury, and fitness for transport to hospital. An effective airway is paramount and measures to secure this are described. It is suggested that the care of head injuries in this country is essentially a combined task for the general practitioner and the hospital, and that no rigid division of responsibility is likely

to succeed. He stressed the importance of clearing the airway of solid and liquid matter and where possible to have the head a little lower than the rest of the body. Repeated examination to make certain that the breathing has not become obstructed is essential. Dressing the scalp wounds and treatment of face and jaw wounds was also discussed with a clear airway taking priority.

Dr A. Crampton Smith (anaesthetist, Radcliffe Infirmary, Oxford) presented a film on *Respiratory Resuscitative Techniques* demonstrating the superiority of " Mouth to Mouth " artificial respiration over all methods. The narrative of this excellent film, in colour, with sound track, was spoken by Dr Peter Shafar. There was very little that was left unsaid. Dr Crampton Smith answered many questions and comforted those who felt they would have to abandon the traditional methods of Schafer and Silvester and the more recent method of Holger-Nielsen and others.

Professor William Gissane (surgeon-in-chief, Birmingham Accident Hospital) took the chair of a panel of speakers at the after lunch session. The others were Colonel J. Watts, RAMC, Mr P. E. London, Dr R. S. C. Fergusson (general practitioner, Sutherland) and Mr F. A. Richardson (officer-in-charge, London Ambulance Service.) The subject for discussion was " The Role of the General Practitioner in a Disaster." The panel discussion, prompted by questions from the audience, limited the definition of a disaster in this sense, as an accident resulting in 50 or more casualties. Only civil accidents were considered and no mention was made of Civil Defence in Nuclear War. Professor Gissane maintained that the proper place of the surgeon was at the hospital and not at the scene of the accident. That was the place of the general practitioner who was familiar with taking charge of events in this environment of turmoil and chaos. As one member of the audience summarized it, the surgeon would remain in his Ivory Tower while the general practitioner would proceed with the cleansing of the Augean Stables of the accident. This was not said with any malice. It was felt that the hospital team properly organized and prepared were more useful than rushing individually or even as a team to the scene of the disaster. In addition to discussion of prepared plans for some areas, excellently summarized by Dr A. Bookless, special methods of transport were discussed. Although the helicopter had great value under certain military situations it was not of such great value in civil life. The need for ensuring the comfort of the patient in a well designed ambulance was discussed at length. Professor Gissane voiced the opinion of the audience when he said that there should be a well thought out plan for dealing with casualties in general, at all times. This plan should be capable of efficient expansion in time of a major disaster. There should not be a " new plan " or special

plan for dealing with a disaster involving more than 50 casualties. This only leads to confusion and chaos and delays the treatment of the seriously injured. In conclusion, he reminded the public and the medical profession in general that the family doctor is the most important member of the team.

The Rt Hon. Lord Taylor of Harlow, M.D., F.R.C.P. (medical director, Harlow Industrial Health Service), took the chair for the Sunday morning session. He introduced **Colonel J. Watts,** O.B.E., M.C., F.R.C.S., (Professor of Military Surgery) who discussed *Minor Injuries.* A minor injury can be defined as one where no danger to life or limb exists and which is followed within a short time by complete recovery. No injury, however minor, should be neglected or treated inconsiderately since lack of care, even if it does not give rise to complications, may often precipitate psychogenic overlay. Minor injuries can be classed as open or closed with the proviso that any apparently minor open injury may, if improperly treated, become the site of infection which in turn can be fatal. Open injuries should be converted into closed injuries by skin cover as soon as practicable. This will usually be achieved by careful and atraumatic suturing.

Closed injuries. Although some fractures may be regarded as minor injuries, most minor injuries involve damage to soft tissue only. This damage may be considered under the headings: contusion, laceration, stretching, and haematoma. Treatment of even the most minor injury requires careful assessment between the requirements of rest to relieve pain and prevent further haemorrhage and swelling, and the requirements of early restoration of function to prevent adhesions and muscle wasting. Neglected measures of early care are: elevation and pressure bandaging to control and alleviate swelling, splinting where necessary even in soft tissue injuries, relief of pain by the application of cold compresses, volatile sprays, or local anaesthetics. Once the initial phase is over, attention should be directed to the early restoration of function by graduated exercises, which should be continued until recovery is complete. In general, failure to achieve complete recovery within 3 weeks should arouse suspicion of some major underlying lesion. He also discussed the thorny question of tetanus prophylaxis. In a one and a half day symposium with papers of great clinical excellence, Colonel Watts' contribution was a *tour-de-force.* The audience of general practitioners responded to his good humoured, provocative presentation, packed with practical methods. He was on his feet answering questions and elaborating points raised for about forty minutes, "batting all round the wicket.".

Lord Taylor stressed the urgent need for a national policy of

immunization in tetanus prophylaxis. From the discussion it was quite clear that there are wide differences in urban practice and rural practice; and even in these areas there are wide differences in the same sort of practice. There are difficulties of choice between passive immunization with antitetanic serum (ATS) and active immunization with tetanus toxoid.

Mr I. F. K. Muir (plastic surgeon, Mount Vernon Hospital, Middlesex) presented his paper on *Burns*. He discussed incidence and types with excellent colour slides. The majority of burns are due to domestic accidents and tend to fall into certain types according to age and sex. Infants: severe burns due to cots catching fire. Toddlers: scalds due to upsetting kettles and saucepans. Boys: accidents with bonfires, fireworks, etc.

Girls and older women: this group provides the largest number of severe burns due to dresses and night-dresses catching alight.

Men: least often involved in domestic accidents, burning paint, paraffin.

Old people: contact burns due to falling against fires during faints.

He demonstrated the inflammability of dresses made of cotton or flanelette which was "puffed up" cotton; also the rapid burning of artificial silk which dropped to the floor and caused further spread of fire. Nylon or similar fibres were the safest, because when the wearer withdrew from the fire, the flames were self extinguishing. Shock may develop and this can be more accurately decided by estimating the surface area involved by the burn. There is a great multiplicity of local treatments. None is ideal for all cases. The fate of an area of burned skin is decided at the time of the injury. A burn of the partial thickness of the skin will slough and form a granulating area.

The meeting closed with thanks to the sponsors, the speakers and the organizers.

Bibliography

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MEDICAL REPORT ON AN INTERNATIONAL ATHLETICS MEETING

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The Maccabiah Games are held every fourth year in Israel; in the year which follows an Olympic Games. Jewish athletes the