Physicians' Success in the Advanced Trauma Life Support Program in Israel

Amir Shahar MD

Meir Hospital (Sapir Medical Center), Kfar Saba, and Sackler Faculty of Medicine, Tel Aviv University, Israel

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Continuous medical education and retraining are essential elements in modern medical practice. With regard to resuscitation of the severely injured, since actual real-time experience is relatively rare (1–2 daily admissions at each of the six level-one trauma centers in Israel), formal courses in primary trauma care have been the only option [1]. The adoption of the Advanced Trauma Life Support program by the Israel Defense Forces Medical Corps and the Israel Surgical Society was thus a blessed step towards creating a common language and standards among physicians involved in trauma care.

Owing to the limited resources available (instructors, trainees' time, direct and indirect costs), the only recourse was that IDF Medical Corps instructors provide the ATLS courses to appropriate candidates. These candidates include those most likely to encounter trauma — either in the field or in the hospital emergency department — and those most likely to succeed in the ATLS course.

However, when the first course was conducted, all the candidates and participants were physicians in active and reserve military service. The growing need by hospitals and medical centers, together with the significant volume of immigrant physicians who work in mobile intensive care ambulances and other emergency services, have created a gap between existing needs and what the ATLS courses supply.

Ben-Abraham et al. [2] tried to determine some of the parameters contributing to the success of participants in the course. It is not surprising that physicians with a surgical background are better candidates to pass the ATLS course. It is also obvious that proficiency in English is a significant predictor for passing both the written and practical examinations since the study material is in English. We should keep in mind that while medical students and physicians in Israel speak and read English (most medical textbooks are in English), immigrants from the former Soviet Union are far less familiar with the language.

Should the identification of these factors result in preselection of ATLS students?

Before considering this, the question to be asked is whether selection of candidates should be made at all. The answer is derived from needs and aims. Certainly, the adequacy of the ATLS program for surgeons is questionable. Yet, since its introduction to Israel (in 1990), the common standard of care of the injured patient was built by military medics, civilian paramedics, nurses and physicians. Except for the latter, i.e., physicians, it is *these* groups that are involved in trauma care — their field of labor being exclusively the battlefield, the streets or the emergency room. Those less frequently exposed to resuscitation of the injured are the physicians, including surgeons. Therefore, formal training and re-certification are essential to maintain an acceptable standard of skills, and the ATLS course should be mandatory for all physicians who might be involved in trauma care — either during their military service or on the scene (streets, mobile intensive care unit, emergency room).

Moreover, the Scientific Council of Israel (The Board of the Medical Professions) now demands that the ATLS course, which is to be an integral section of the training in the surgical professions, be successfully completed. This, together with the establishment of trauma centers, the National Trauma Registry, and quality assurance, will unquestionably improve the care of the injured.

The results of the study by Ben-Abraham et al., published in this issue of the journal, emphasize the difference between physicians from different medical schools and cultures. The mass immigration of Jews from the former Soviet Union in the late eighties included a large number of physicians, and it is quite clear that their success in the Board examination is considerably lower than that of local graduates. Given that a common standard of training is required in most western countries, and is being adopted by the Ministry of Health, *Magen David Adom* (the Israeli equivalent of the Red Cross) and the Scientific Council, there is no alternative to the ATLS course. Clearly, steps must be taken to improve the course's success rate. This means tough regulation, including a pre-reading requirement for course participants.

A question not raised concerns the fading knowledge that was gained in focused courses. It is no less important than the prediction of success, and warrants study.

The issue of effectiveness and costs has been investigated by other authors [3], who suggested various types of training together with tests to evaluate the courses and the participants' results. Both types of training show substantial benefits. These researchers also suggest induction courses for physicians who are less likely to be involved in primary trauma care.

Implementation of the ATLS program during the clinical years of medical training could eliminate some of the questions raised by Ben-Abraham and co-workers. Nonetheless, critical thinking and a reevaluation of both the curricula and the selection of students are essential, even in today's modern medical training.

References

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Correspondence: Dr. A. Shahar, Deputy Director, Meir Hospital (Sapir Medical Center), 25 Tshnernichovsky St., Kfar Saba 44281, Israel. Tel: (972-9) 747 2559; Fax: (972-9) 747 1730; email: ae-shahar@prontomail.

It is said that for money you can have everything, but you cannot. You can buy food, but not appetite; medicine, but not health; knowledge, but not wisdom; glitter, but not beauty; fun, but not joy; acquaintances, but not friends; servants, but not faithfulness; leisure, but not peace. You can have the husk of everything for money, but not the kernel.

Arne Garborg

Capsule

Low back pain

A review by Gunnar B.J. Andersson states that although the literature is filled with information about the prevalence and incidence of back pain in general, there is less information about chronic back pain, partly because of a lack of agreement about definition. Chronic back pain is sometimes defined as back pain that lasts for longer than 7 to 12 weeks. Others define it as pain that lasts beyond the expected period of healing and acknowledge that chronic pain may not have well-defined underlying pathological causes. Others classify frequently recurring back pain as chronic pain since it intermittently affects an individual over a long period. Most national insurance and industrial sources of data include only those individuals in whom symptoms result in loss of days at work or other disability. Thus, even less is known about the epidemiology of chronic low back pain with no associated work disability or compensation. Chronic low back pain has also become a diagnosis of convenience for many people who are actually disabled for socioeconomic, work-related, or psychological reasons. Some people argue that chronic disability in back pain is primarily related to a psychosocial dysfunction. Because the validity and reliability of some of the existing data are uncertain, caution is needed in an assessment of the information on this type of pain.

The author concludes that back pain of at least moderate intensity and duration has an annual incidence in the adult population of 10–15%, and a point prevalence of 15–30%. The prevalence rises with increasing age up to 65 years, after which it drops off for unknown reasons. The outlook for patients with back pain is generally excellent, with 90% or more recovery over 3 months. Unfortunately, for individuals who did not recover within this time the recovery process is slow and their demand on the health-care system is large and costly; these individuals are also a cause of major disability and absence from work. Back and spine impairments are the most common impairment among young and middle-aged people. Although back pain seems to be equally common in men and women, back and spine impairments are more common in women than in men. Disability trends indicate large increases in all developed countries. Among the factors that contribute to long-term disability are age, location of symptoms, and legal, socioeconomic and psychological factors. Rates of surgery for back pain have increased rapidly over the past 15 years, whereas rates of non-surgical hospital admission have decreased. Compared with other developed countries, the surgical rates in the USA are high, but there are also large variations between different U.S. regions. To reduce chronicity, disability and cost, preventive measures should be explored. Unfortunately, attempts to prevent the occurrence of back pain have been unsuccessful, and prevention of the negative consequences of a back pain episode may be more fruitful.

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