Approved by: Trauma Services, MEC

DEPARTMENT: Collaborative Practice	POLICY TITLE: Performance Expectations for Physicians Caring for Trauma Patients
Page 1 of 3	REPLACES POLICY DATED: 11/13
EFFECTIVE DATE: 9/15	REFERENCE NUMBER: 900-CC-111

PURPOSE:
To establish standards and guidelines for the response, care, and management of trauma patients by physicians participating in their care.

POLICY:
When a request for consultation has been made, it is the responsibility of the consulting physician to provide an in-person evaluation of the patient in a timely manner. The consulting physician cannot request the ED Physician to transfer the patient to another facility without an in-person evaluation. After in-person evaluation, if the consulting physician determines that the patient needs to be transferred to another facility, it is the responsibility of the consulting physician to make the transfer arrangements.

Trauma Surgery

1. The trauma surgeon must evaluate all Level One activation patients within 15 minutes of patient arrival. This requirement cannot be fulfilled by physician extenders.
2. The trauma surgeon will ensure evaluation of the trauma patient within 30 minutes of notification by the ED Physician of the need for admission or consultation. The evaluation can be performed by the Trauma Surgery Resident or Mid-Level provider as deemed appropriate by the Trauma Surgeon on duty as long as communication with the trauma surgeon is documented.
3. The trauma surgeon is responsible for coordination of all aspects of the patient's care even if no true "general surgical injuries" are present. This is designed to avoid fragmentation of the patient's overall care.
4. If the patient has multisystem trauma involved, the trauma surgeon will remain the attending physician until the time of the patient's discharge or transfer to Rehabilitation or Long-Term Care.
5. Each trauma surgeon will obtain 16 hours of trauma-related CME per year. The Trauma Medical Director is required to obtain these hours from sources other than facility events.
6. ATLS certification is mandatory for all trauma surgeons.
7. All trauma surgeons participating on the trauma call panel are required to attend 50% of all Trauma Services Committee and Trauma Peer Review Committee meetings.

Orthopedic Surgery

1. The trauma orthopedic surgeon will work with the trauma surgeon in coordination of care of the trauma patient.
2. The Trauma Orthopedic Surgeon must be available and at the bedside within 30 minutes of the time that the ED or trauma surgeon determines that their expertise is required. This requirement cannot be fulfilled by physician extenders. If the Trauma Orthopedic Surgeon is not available for that period of time, then the back-up call physician must be activated.
3. If, after an in-person evaluation of the patient, the trauma orthopedic surgeon is unable to provide specialized care within their scope of practice, it is the responsibility of the trauma orthopedic surgeon to contact the needed providers who can provide the service and make the necessary arrangements to care for the patient. It is not the responsibility of the ED physician or trauma surgeon to make these contacts.
4. Each Trauma Orthopedic Surgeon will obtain 16 hours of trauma related CME per year. The Trauma Orthopedic Liaison to the Trauma Peer Review Committee is required to obtain these hours from

sources other than facility sponsored events.

5. The Trauma Orthopedic liaison will attend 50% of all Trauma Committee meetings.
6. The Trauma Orthopedic liaison is responsible for ensuring current treatment protocols for the care of orthopedic trauma injuries including (Orange Book, 2014):
    i. Type and severity of pelvic and acetabular fractures that will be treated at the institution as well defining any potential transfers out,
    ii. Timing and sequence for the treatment of long bone fractures in multiply injured patients
    iii. Washout time of open fractures
7. The trauma surgeon will remain the attending physician until the time of the patient discharge for all multisystem trauma patients. In the case of the trauma patient who is determined to have only orthopedic injuries, it is appropriate for the patient to be transferred to the orthopedic surgeon as the primary attending after 48 hours.

Neurosurgery

1. Neurosurgery will work with the trauma surgeon in coordination of care of the trauma patient.
2. Neurosurgery must be available and at the bedside within 30 minutes of the time that the ED or trauma surgeon determines that their expertise is required. This requirement cannot be fulfilled by physician extenders. If Neurosurgery is not available for that period of time, then the back-up call physician must be activated.
3. If, after an in-person evaluation of the patient, the neurosurgeon is unable to provide specialized care within their scope of practice, it is the responsibility of the neurosurgeon to contact the needed providers who can provide the service and make the necessary arrangements to care for the patient. It is not the responsibility of the ED physician or trauma surgeon to make these contacts.
4. Each Neurosurgeon will obtain 16 hours of trauma related CME per year. The Neurosurgery Liaison to the Trauma Peer Review Committee is required to obtain these hours from sources other than the facility sponsored events.
5. The Neurosurgical liaison will attend 50% of all Trauma Committee meetings.
6. The Neurosurgical liaison is responsible for ensuring current treatment protocols for the care of neurotrauma injuries including timeliness of placement of intracranial pressure monitors, management of increased intracranial pressure, timeliness of operative intervention, and compliance with current Brain Trauma Foundation guidelines.

Sub-Specialties (OMFS, Plastics, Thoracic, Ophthalmology, and Urology)

1. Subspecialists are required to respond in a timely fashion, 30 minutes, as determined by the patient's condition and the consulting physician (i.e. ED Physician, Trauma Surgeon)
2. Subspecialists will evaluate the patient personally within the requested timeframe (and in no case longer than 24 hours after initial consultation).
3. If, after in-person evaluation of the patient, the subspecialist is unable to provide specialized care within their scope of practice, it is the responsibility of the subspecialist to contact the needed providers who can provide the service and make the necessary arrangements to care for the patient. It is not the responsibility of the ED Physician or Trauma Surgeon to make these contacts.
4. As a general rule, the trauma surgeon will remain the attending physician until time of discharge for

all multisystem injured patients. However, there may be instances when a trauma patient is determined to have only an isolated single system injury; then it would be appropriate for the patient to be transferred to the subspecialist as the primary attending after 24 hours.

5. Each subspecialist panel will identify a representative to serve as a point of contract and disseminate pertinent information to others. In addition, all subspecialists may be asked to review cases or discuss their own cases for TPR.

Emergency Department Physician

1. The ED physician will work with the trauma surgeon in coordination of care of the trauma patient.
2. The ED physician is responsible for timely notification of the trauma surgeon or appropriate admitting physician once an injury likely to require admission is identified. Although patient work-up may still be in progress, early notification will allow for more efficient patient care.
3. Each ED physician will obtain 16 hours of trauma-related CME per year. The ED Physician Liaison to the Trauma Peer Review Committee is required to obtain these hours from sources other than facility-sponsored events.
4. Successful completion of an ATLS course at least once.

Anesthesia

1. The anesthesiologist will work with the trauma surgeon in coordination of care of the trauma patient.
2. The anesthesiologist must be promptly available for all airway emergencies, vascular access issues, and operative interventions for all trauma patients.
3. The Anesthesiology Liaison is required to attend 50% of all Trauma Peer Review meetings.
4. ATLS is recommended but not required.