Current State of Trauma Services in Saudi Arabia

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ABSTRACT
Trauma is a major public health problem in Saudi Arabia and a leading cause of mortality and morbidity in young age groups. In 2018, traumatic injuries caused by road traffic accidents were the leading cause of death after ischemic heart diseases. Therefore, a new road safety system is important to reduce the incidence of road accident trauma. First aid care by bystanders to road accidents must be improved to become an effective part of pre-hospital care and avoid aggravation. Moreover, trauma centers need further training and education to provide a high level of trauma care. However, literature about trauma care in Saudi Arabia is lacking. Thus, this paper aims to provide an overview of the Saudi trauma system, emergency medical services, and healthcare providers’ training and education efforts.

Keywords: Trauma, trauma system, trauma mortality

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TRAUMA OVERVIEW

Trauma is a major problem in Saudi Arabia and a leading cause of mortality and morbidity in young age groups. In 2018, injuries caused by road traffic accidents were the leading cause of death after ischemic heart diseases. Globally, around 1.2 million people are killed in road accidents each year and 90% of the deaths occur in developing countries. In 2015, the World Health Organization (WHO) estimated road traffic fatalities in Saudi Arabia at 27.4 per 100,000 population, whereas countries such as the US, UK, and Australia had fatality rates between 2.9 and 10.6 per 100,000 people. In 2013, road accidents killed one person and injured four others every hour in Saudi Arabia. The Saudi Ministry of the Interior reported 7661 road fatalities (88% male), which is considerably higher than that of other causes of trauma death, such as falling, asphyxia, and burns.

The increasing global population and the rise in vehicle ownership worldwide are expected to increase road traffic deaths by up to 1.9 per 100,000 by 2020. The number of registered vehicles in Saudi Arabia in 2013 was eight million, nearly double the number 30 years ago. In 2018, Saudi women gained the right to drive a car, which may further boost the number of registered vehicles. The increase in car registrations is associated with increasing road traffic casualties. In the past 25 years, 29 studies in Saudi Arabia were about road traffic accidents. However, studies about the status of trauma and trauma care in Saudi Arabia remain lacking despite the development of the country’s Vision 2030. The vision, a development plan to reduce the country’s dependence on oil, aims to develop public services, such as health and education, and increase the employment rate, particularly for females. Information in the literature about trauma care in Saudi Arabia is incorrect or misleading. Therefore, the present paper provides an informed overview of the Saudi trauma system, emergency medical services (EMS), and the impact of training and education on healthcare providers.

TRAUMA SYSTEM

Trauma is defined generally as any violence or external force that causes physiological or psychological injury. Trauma systems provide a comprehensive care approach for injured patients by building cooperative links between the local healthcare system and the emergency medical system or services. The trauma system aims to ensure that injured people are appropriately cared for, triaged, and transferred to the correct facility with necessary urgency. Therefore, competent professionals are required to perform these steps to ensure that care management is delivered smoothly. The fundamental trauma system components are shown in Figure 1.

The trauma system requires eight fundamental elements to provide the correct care for injured people at the appropriate facility in the shortest possible time:

- leadership
- professional resources
- education and advocacy
- information management
- finances
- research
- technology
- disaster preparedness and response: conventional and unconventional

Correct implementation of a trauma system and its elements reduces the risk of death among injured patients by 15% – 20%. Trauma systems were first recognized and established in the US and subsequently in the UK, Australia, Canada, Hong Kong, and other developed countries. These countries differ in implementation because of local policy, population, and geographical variations. The US first recognized the need for a trauma care system in 1966, when two trauma centers were established in San Francisco and Chicago. Trauma center facilities continued to increase over the decades; by 2002, 1,154 centers at
different trauma levels (I, II, III, IV, and V) were built across the US. In 2005, trauma centers at levels I and II were accessible to 69.2% of the US population within 45 minutes by air or road emergency services. The US trauma system reduced trauma mortality and confirmed the relationship between reduced road traffic death rates and the presence of a trauma system. The reduction of trauma mortality after serious injury was between 15% and 25%.  

In the UK, the trauma care system had some deficiencies that were highlighted in a report by the Royal College of Surgeons (RCS) in 1988. One-third of the fatalities were preventable, and two-thirds of noncentral nervous system injuries resulting in death were possibly preventable, with the main causes of death being hypoxia, inadequate hemorrhage control, delayed surgery, and missed injuries. Improvements in trauma care were proposed by the development of pre-hospital care, training doctors in Advanced Trauma Life Support (ATLS), improvement of audit programs to monitor progress, and increasing research into major trauma outcomes. From 1989 to 1997, trauma care improved and trauma mortality reduced by almost 40%. In 2003, in accordance with RCS criteria, “perfect” trauma care was only provided in 21% of hospitals in England, Wales, and Northern Ireland. In 2010, London launched a reformed trauma system, which was rolled out in regional areas in 2012. In 2017, England had 27 trauma centers (11 for adults and children, 10 for adults, 5 for children, and 1 collaborative center). For injured patients who reached one of these centers alive, their chance of survival improved by 19% over the previous trauma system.

INJURY PREVENTION

Injury prevention is the first component of a trauma care system, and it plays a substantial role in reducing mortality and disability. The Saudi Government’s prevention component was to implement improved road traffic regulations to increase driver and passenger safety in conjunction with a high standard of trauma care, with the goal of reducing road traffic accidents. The factors influencing road accidents are identified in Haddon’s Matrix, which aims to understand the injuries caused and the epidemiological approach to their control. Haddon’s Matrix illustrates the interaction between three factors: humans, vehicles and equipment, and environment. Based on these factors, road accidents in Saudi Arabia should be lower than other countries. Among the human factors, alcohol is banned; hence, driving under the influence of alcohol is considerably less common. The literature shows a high risk of injury related to drinking alcohol and driving. In the environmental factors, Saudi Arabian conditions are predominantly dry and clear, with snow and black ice being a rarity. Driving in snow or on black ice increases the risk of accidents.

The Saudi Government introduced regulations, such as mandatory use of seatbelts by drivers and passengers. High-speed driving coupled with low seatbelt use has been associated with many deaths and severe injuries for Saudi car users. In 2010, the Government introduced regulations to implement road safety and speed cameras, with fines imposed on drivers caught speeding. The introduction of speed cameras significantly reduced mortality and the severity of injuries among road traffic casualties. In 2017, a study investigated the differences in trauma mortality and injury severity between 2005 and 2014 at a Saudi trauma center and after the implementation of the speed camera system.

Injury severity (n = 6196) was measured by the Injury Severity Score (ISS) (scale of 1–75, with 75 indicating most severe injury) and the Glasgow Coma Scale score (GCS score) (scale of 3–15, with 3 indicating deep coma). Results showed the mean for both measurements in order (mean pre-implementation: mean post implementation p value) ISS (16.0: 13.5 p < 0.001) and GCS (11.8: 12.2 p < 0.001). The mortality rate significantly reduced (pre-implementation: post implementation p value) (184: 50 p < 0.001). Despite the improvement, road accident fatalities and trauma remained a concern for the Government and researchers. Areas for further improvement were sought. The pre-hospital care system plays a major role in reducing trauma mortality by triaging and managing injured patients and then transferring them to the appropriate level of trauma center. The implementation of trauma care systems shows improved outcomes for injured people, with some differences between countries. However, the other main components of a trauma system need to be added to the current state of Saudi trauma care.

PRE-HOSPITAL CARE

Pre-hospital care is the second component of an effective trauma system. High-income countries have few pre-hospital trauma deaths because of improved treatment at the pre-hospital stage.
Pre-hospital care provides urgent intervention for injured patients, such as bleeding control, airway security, and safe transportation to an appropriate facility. The US pre-hospital system of care is delivered through emergency services, such as police, firefighters, and ambulance crews, which attend each instance of road trauma. Most US states follow national categories for rescue services by using four levels of emergency medical technician (EMT). The four levels are based on education and qualifications: EMT first responder or trainer, EMT-B basic, EMT-I intermediate, and paramedic.

Pre-hospital treatment in the UK is provided by the National Health Service ambulance service and emergency paramedics. The UK Government instituted specialist training for paramedics in the early 1990s. By 1996, all pre-hospital trauma care was being provided by paramedics. Globally, pre-hospital care is primarily provided by trained emergency personnel of different levels, demonstrating the effectiveness of pre-hospital care in reducing trauma mortality.

EMS in Saudi Arabia

EMS are an organized pre-hospital system that aims to care for injured and sick patients and transport them to a hospital if required. Pre-hospital care in Saudi Arabia is provided for the civilian population by the Saudi Red Crescent Authority (the history of the SRCA is described elsewhere). The SRCA’s services are distributed throughout the 13 regions of Saudi Arabia. In 2015, the SRCA had 384 centers and more than 1965 vehicles, covering all cities.

Separate pre-hospital care services are provided in military areas and industrial locations, which have their own facilities, vehicles, and staff. Personnel assigned to the Medical Service in the Armed Forces (MSD) provide pre-hospital and in-hospital care for all military areas. The MSD has 24 hospitals and 147 clinics responsible for all medical care for military personnel, civilian defense workers, and their families. The MSD also has mobile hospitals to provide medical care during combat and military training.

Injured patients receive pre-hospital care from one of Saudi’s EMS, but it is also common for injured patients to receive initial care from bystanders. Effective early treatment given by bystanders in nontraumatic cardiac arrest improves outcomes for out-of-hospital cardiac arrest patients. The frequency of the first aid given by bystanders and the outcomes have been studied in a systematic review. A 5.8% reduction in mortality was observed after first aid given by a bystander. The importance of bystander intervention to control bleeding and clear the airway was underlined.

In Saudi, bystanders can hamper the efficiency of EMS workers by crowding the scene and trying inappropriate interventions. Saudi bystanders often do not have a high level of trust in paramedics and sometimes try to transfer the injured person to the nearest hospital themselves, regardless of the patient’s condition. However, the SRCA has developed its EMS dispatch protocol to consider public behavior. Bystanders can call 997 to communicate with emergency dispatch. The SRCA has also developed an app for smartphones to speed up lodging an accurate request for EMS. Educating and training bystanders could help minimize the obstacles they present and help improve the quality of pre-hospital care for trauma victims. Training and education for EMS personnel have been improved recently, and EMS core competencies have been developed for an EMS degree.

EMS personnel are eligible to practice their skills after registering and receiving a healthcare practitioner license from the Saudi Commission for Health Specialties. The minimum degree for an EMT is a diploma equivalent to three-and-a-half years of education. The EMT also requires a qualification in Basic Life Support, Pre-Hospital Trauma Life Support (PHTLS), or International Trauma Life Support (ITLS). A PHTLS or ITLS is mandatory for EMS personnel, including doctors. EMS personnel who have a bachelor’s degree or higher are required to provide Advanced Cardiac Life Support and Pediatric Life Support. The SRCA also has doctors who attend trauma scenes and a medical director to ensure the highest quality of service is provided. The role of EMS personnel is to provide life-saving treatment at the scene and to transfer patients to the correct medical facility for the severity of their injuries.

ACUTE CARE FACILITIES

An acute care facility is the third component of a trauma system, which is provided by trauma centers depending on their capability. Trauma centers should provide leadership for the overall trauma system and be committed to injury prevention initiatives, training, and research. Their responsibility is to provide multiple specialist medical interventions to manage trauma patients with multiple injuries from arrival until the completion of their recovery and rehabilitation.
The Ministry of Health (MOH), along with other governmental and private sector providers, is the main provider of healthcare in Saudi Arabia. The country has 494 hospitals and 75,225 beds, equivalent to one bed for every 445 people. In 2018, the MOH managed 284 hospitals with a budget of approximately $24 billion (9.20% of government spending). In addition, 163 hospitals were run by other governmental sectors and 47 private hospitals. Trauma centers showed a lower trauma mortality than nontrauma centers. King Abdulaziz Medical City (KAMC) is one of the largest hospitals in the capital, with a total capacity of more than 700 beds, 132 of which belong to its emergency department. KAMC is equivalent to a level-1 trauma center. However, studies on the effectiveness of trauma centers for injured patients in Saudi Arabia are lacking.

**POSTHOSPITAL CARE**

Trauma is the main cause of disability and, according to WHO, is associated with moderate to severe disability for more than 45 million people annually. Posthospital care is the last component of trauma system care, which aims to provide care for patients with sustained and potentially disabling injuries. This type of care is often the longest and the most difficult phase of care for patients and families. Moreover, the rehabilitation care tends to provide care in different and complex patterns of injuries, and the quality of this care can be challenging. However, some lines of evidence show an improvement in quality of life after injuries, and others shows functional outcome even a year after injury in trauma centers. However, in Saudi Arabia, despite having posthospital rehabilitation units, evidence that these units are effective in postinjury care for traumatic patients is lacking. One potential solution in improving care for trauma systems and posthospital care is the establishment of a data registry or trauma registry; such registries are key in evaluating the effectiveness of any intervention for patients care and outcome.

Information management is one of the eight fundamental elements of an effective trauma system, which encompasses the idea of a trauma registry. Trauma registries have existed for more than three decades and are designed to provide information about injured patients to trauma facilities to help improve the quality of trauma care. In a recent global review of trauma registries, the National Trauma Data Bank in the US published 288 studies, the Victorian State Trauma Registry in Australia published 45 studies, and the Trauma Audit and Research Network in the UK published 13 studies. A trauma registry was established in Saudi Arabia at KAMC in 2001, and it has dramatically increased studies in trauma. By contrast, studies on trauma and trauma training effectiveness for EMS practitioners in Saudi Arabia are absent.

**Training and education**

Trauma education and training for healthcare providers are crucial in building an effective trauma system. Trauma education aims to improve the quality of trauma care delivered by increasing knowledge, skills, attitudes, and relationship objectives. Multiple methods, such as lectures, workshops, discussion, skill stations, and scenarios, are available to teach skills and knowledge. Credentialed trauma courses have been established for many years and dramatically increased skills in ATLS, PHTLS, and ITLS.

In 1978, the first ATLS course was conducted in Nebraska, US, by the American College of Surgeons, which then distributed it widely. In 2019, the ATLS course was made available in more than 80 countries worldwide. It is a three-day course for doctors using lectures and practical exams. At the end of the course, participants are required to pass multiple-choice and practical exams.

In the late 1980s, a PHTLS course was developed in the US to meet the needs of EMS professionals. Today, it is a two-day course providing trauma skills and knowledge for paramedics and EMTs, conducted by the National Association of Emergency Medical Technicians. ITLS is another critical course for EMS professionals, first run in 1985 when it was known as Basic Trauma Life Support International. The new name “ITLS,” approved in 2005, better reflects its global nature. It is a two-day course that includes lectures and practical exams. Evaluating performance outcomes and practitioner confidence gained from the international course is challenging because of its various training and education components.

Healthcare providers in Saudi Arabia practice according to their practitioners’ license, which must be renewed every 5 years. Continuing education and training courses is required to renew a practitioner’s license. Education and training are crucial in building a trauma system, but the impact of trauma training courses on trauma mortality outcome is unclear. Evidence in support of ATLS training reducing
trauma mortality is still lacking. Furthermore, the management of injured patients by ATLS-certified doctors is worse than that by noncertified doctors in nontrauma centers. The impact of trauma training and education on healthcare providers in the Saudi trauma system needs to be determined. Whether or not trauma training in Saudi Arabia improves the confidence of healthcare providers in dealing with trauma patients is unknown. Healthcare providers are expected to be confident when dealing with trauma cases. However, a previous study on participants involved in Early Management of Severe Trauma training reported low practitioner confidence in rural hospitals. This low confidence even after attending the course is correlated with the frequency of managing trauma cases. Improved training enables paramedics to provide advanced levels of care and is expected to improve outcomes, but some studies do not support this finding. The current status of trauma training and education in Saudi Arabia is unknown, and further research is warranted to evaluate the impact of training courses.

CONCLUSION
Trauma is a major public health problem in Saudi Arabia, and the implementation of a new road safety system is important to reduce road traffic accidents. First aid care by bystanders to road accidents must be improved to become an effective part of pre-hospital care and avoid aggravation. The quality of trauma care at trauma centers needs further assessment, and the effectiveness of trauma training and education of healthcare providers requires evaluation.

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