A tale of two islands—
trauma care in New Zealand

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It was the best of times, it was the worst of times, it was the age of wisdom, it was the age of foolishness, it was the epoch of belief, it was the epoch of incredulity, it was the season of Light, it was the season of Darkness, it was the spring of hope, it was the winter of despair, we had everything before us, we had nothing before us, ...” so opens A Tale of Two Cities by Charles Dickens.1

The Major Trauma National Clinical Network has published its first report based on data from the New Zealand Major Trauma Registry (NZMTR). However, it is not a report on the state of admitted major trauma across New Zealand. The report contains data only from the three regions that make up the North Island. It provides no insight into the South Island with a quarter of New Zealand’s population and more than half of this country’s landmass. Christchurch Hospital is the only tertiary level South Island centre to have collected major trauma data over the last year. Major trauma represents only a fraction of admitted trauma, but it has had no means, due to a lack of staff, to enter this data consistently onto the NZMTR. In contrast, every single North Island hospital that admits major trauma submitted data to the NZMTR. Data from Christchurch Hospital suggests that the South Island population have an even greater incidence of major trauma and higher mortality rates with equivalent injuries to those in the North Island.

The established trauma services of the north, especially Auckland and Hamilton with their specialist multidisciplinary trauma teams—including trauma surgical specialists and trauma fellows, trauma clinical nurse coordinators and trauma registry data entry and analysis personnel—have no equivalence in the South Island. The superior trauma care in the north begins even prior to a patient’s arrival at hospital. Medically staffed helicopter retrieval services are able to transfuse blood prior to hospital arrival. Yet the greater distances of travel and high trauma incidence suggests such pre-hospital care would be life-saving down south. There appears to be a wide gulf in trauma load, trauma systems, trauma funding and outcomes between the north and the south. The nearest equivalent to a North Island trauma service that a patient admitted with major trauma to a South Island hospital receives may be an encounter with a trauma clinical nurse specialist tasked with data collection, generally with no specific SMO oversight. In the south, patients with multi-system trauma are admitted into a ‘best-fit’, ‘single-organ’ surgical specialty or even a medical team. Despite the best of intentions, a lack of expertise in contemporary trauma care, challenges with coordinating multi-system trauma requiring multi-specialty care, difficulties associated with elderly patients with trauma and their medical comorbidities means that there are likely to be differences in the standards of care between the North and South Island centres. Without the commensurate North Island trauma services, their ability to collect all admitted trauma data and enter major trauma data onto the NZMTR, the South Island remains terra incognita on the national trauma registry. Possibly, conveniently veiling the wide separation in trauma care and outcomes between the North and South Islands.

In the provision of trauma care the South Island appears to be some 40 years behind the US,2 nearly 20 years behind Australia3 and 10 years behind Auckland.4 In the 1990’s, systemic errors in Australian trauma systems were identified as resulting in significant preventable trauma patient deaths.5 Since the establishment of a state-wide trauma system in Victoria, Australia, there has been a significant reduction in mortality.6 Cameron concluded that “Such
inclusive systems of trauma care should be regarded as a minimum standard for health jurisdictions”. The South Island does not appear to be progressing towards achieving such a minimum standard. Data capture while nascent in the south needs to be swiftly followed by the fundamental components of a trauma service. In the south, medical and nursing staff involved in the care of major trauma patients have waited for years for the local and national support required to enable us to progress to the standard of care available in Auckland and Hamilton. With our higher rates of trauma presentations the Mainland should be the leaders in trauma care in New Zealand. In the current climate of financial frugality there seems little prospect of funding being made available for detailed data collection, data entry onto the NZMTR and trauma care in the south to equal what is available in the north. Despite the substantial evidence from the North Island, Australia and North America that formal trauma services reduce mortality, morbidity and length of stays, the funding deficits faced by the southern and Canterbury DHBs seem insurmountable hurdles to matching the higher standards of trauma care available in the North Island tertiary level centres.

Incentive funding by ACC highlights the discrepancies in available trauma systems and exacerbates the gap between the north and south by disproportionately rewarding the established North Island Trauma Services.

In the South Island we do not feel we are on the cusp of establishing a world-class trauma system nor do we seem to be progressing to a North Island class of trauma system. The fundamental building blocks for a trauma service, which the paper by Civil refers to, have yet to be laid in the south. Any long-term vision to improve trauma care in New Zealand needs to start with bringing the south up to the North Island standard, then together we should aim to match the achievements in trauma care Australians take for granted. But without significant funding injections and high-level stewardship, trauma care in New Zealand will continue to be a tale of two islands, the haves in the north and the have-nots in the south.

Competing interests:
Nil.

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