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EDITORIAL

Recovered trauma patient: Good luck and... until next time!☆

Paciente traumatizado recuperado: buena suerte y... ¡hasta la próxima!

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Usually traumas are considered one-time incidents with a significant component of chance and unconnected with one another. However, we have known for some time now that in certain groups of patients, traumas represent one chronic and recurrent situation where modifiable risk factors can be identified.[1] Almost all studies confirm that fifty percent of the traumas have something to do with the use of alcohol, illegal drugs and/or psychodrugs.[2,3] One characteristic of this group of patients is their high recurrence rate,[3] which gives them a sort of top-notch social-healthcare significance that translates into a higher short-medium term mortality rate.[4] In our setting, the alcohol-and-drug-related recurrence rate of trauma patients is close to 61.5%[3]; such a high percentage should make us look for alternatives aimed at reducing this phenomenon. From the ethical point of view, a passive attitude on this regard does not seem acceptable at all.

The tool suggested to reduce the recurrence rate consists of conducting one Brief Motivational Intervention (BMI) during the hospital stay with or without further reinforcement.[5] This intervention can be conducted by nursing personnel with specific training and whose ultimate goal is to make patients think on their behavioral patterns, while enabling them to find arguments they can use to modify their habits. We studied the effectiveness of BMI while reducing the recurrence rate of new traumas, and after a follow-up period of between 10 and 52 months, the result was a reduced trauma recurrence rate of up to 50% (from 25.4 to 13.0 per every 100 patients/year)[6]; a percentage that is consistent with the one found in former studies[7] and contributes arguments in order to carry out this initiative. The centers that treat trauma patients should be involved in this field and establish mechanisms so that, in the first place, they can identify what trauma patients use alcohol, and drugs, or have other risk factors involved and, in the second place, look for the best chance, during the hospital stay, to carry out the motivational intervention.

Carrying out the BMI consists of a semi-structured interview for some 30 or 45 min in order to promote changes in unhealthy lifestyles or behavioral patterns by solving the ambiguities that may exist and always with a non-confrontational style. It comes as no surprise that the

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emotional situation suffered after a severe trauma is an excellent opportunity that makes the patient very receptive, which in turn facilitates the success of this kind of initiatives. In Spain, the initiatives carried out in this area are almost nonexistent,[8] and in our opinion, the only way to revert this situation would be a decisive effort made from the healthcare institutions. This initiative has no commercial purposes whatsoever but, instead of this being a bonus, it seems some sort of a disadvantage since there is no business behind it.[9] This is why the healthcare administration should take the lead, speak about its utility, and promote the necessary means to carry it out. We believe this is an important issue that has important social-healthcare repercussions, which is why it should be treated with decisiveness.

In well-structured organized healthcare institutions, the mortality rate profile of trauma patients shows a very characteristic pattern. Fifty per cent of deaths occur in the setting of the accident, and 80% of those who die at the hospital, do so within the first 24–48 h following the extremely serious lesions they sustained that are almost incompatible with survival.[10] Barely 2.5% can be considered avoidable deaths, meaning that, from the point of view of healthcare, mortality rate may have been reduced to its lowest, since, in order to achieve just marginal improvements, the investment required would be disproportionate. Without having to abandon the ambition to reduce mortality rate in the healthcare setting, other ways should be explored in order to show a more favorable cost-effective ratio. In this sense, there is no doubt that promoting prevention is the most effective alternative on this regard.

Prevention of trauma is a task shared by many administrations but, in Spain, the effort made in this area by the healthcare institutions cannot be compared to the one made by other administrations, leaving the impression that some organizations are more sensitive than others when it comes to carrying out their respective responsibilities.

The reduction of the accident rate in Spain has to do with several factors, among which we should mention how the Spanish road infrastructure has changed, and how safe vehicles have become during the last two decades, added to the various educational campaigns that have been carried out in the news media. The legal system has operated significant changes too by passing effective pieces of legislations in order to persecute or punish risky behavioral patterns that may jeopardize safety on the road, at work, at home, etc. We could go on and on listing the number of prevention achievements, but should never lose focus on what is considered primary prevention, and here healthcare institutions have had little to say. Healthcare institutions should and must invest in secondary prevention, which is the sole responsibility of healthcare personnel and, also, an inseparable aspect of their activity. We should admit that we have not been up to the challenge on this regard.[8] In the healthcare setting, an extraordinary effort has been made in order to improve the care of trauma patients without cutting any investments aimed at the recovery of patients,[11] but there is something we have not controlled here, which is the ''revolving door'', so to speak, that recurrence means; thus, today, after the trauma patient has recovered, we recommend wishing him well although, unfortunately, what we are really mean to say is... see you next time!

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