Letters to the Editor

To the Editor:
The present-day concept of triage in a major disaster depending on the urgency of the treatment required was first conceived of in the Boer War. The management of large scale casualties whether in war or in a civilian accident was often uncompensated because of a lack of resources or technology. Dividing casualties into those requiring immediate attention, urgent treatment, delayed treatment, and no treatment was appropriate and worked well. As medical science improved, so changed the criteria for dividing casualties into these four categories. Planning for civilian disasters was modest as the awareness of the need for such planning was low. This classification has served well until now.

In the nineteen-seventies and nineteen-eighties, several important changes occurred. First, the diagnosis and management of head injuries and burns improved very significantly. Secondly, media attention to civilian disaster, caused an upsurge in planning. Third, most civilian disasters are well compensated because of abundance of medical facilities. Finally, there is criticism of the secondary transfer of burns or head injuries from district general hospitals to larger facilities that have these services.

As a result of these changes, some disaster planners for the last three years have wondered whether it is time for a new triage classification to be adopted for general use. This new means of assessing triage would employ the acronym "WENTS": Walking wounded; Extensive burns; Neurosurgical; Trunk—including pelvis, abdomen and chest injury, smoke inhalation; and Skeletal—including minor head injury.

The use of WENTS would allow the medical supervisor of a wartime or civilian disaster to coordinate triage so as to make use of the latest improvements in medical management of traumatic injury when determining the type and nature of treatment required by disaster victims.

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To the Editor:
I just read the article by Schwartz, Jacobs, and Lee on the "Role of the Physician in a Helicopter Emergency Medical Service," along with the comments by Benson and Thomas. What I found most interesting is the fact that this question comes up at all.

As a general rule, our society has made the reasonable decision that people who have medical problems ought to be cared for by physicians. This is true even for people with trivial illnesses. For example, if I develop a sore throat, I would not approach a nurse, paramedic, or respiratory therapist—I would go to a physician's office. In fact, a non-physician who undertook to treat me for my sore throat would be in violation of the law.

On the other hand, in a situation (helicopter emergency medical services) where the patients are extremely ill and often unstable, we spend a lot of time belaboring a question, the answer of which should be intuitively obvious. Specifically, it's intuitively obvious that the "best" team for such work would include a properly trained and experienced physician in preference to a team consisting only of properly trained and experienced non-physicians. I submit that in every instance where prehospital care teams sent to care for critically ill patients do not include a physician, the decision to omit the physician is made for economic and not for medical reasons.

I suppose that the point of such (subjective, not very meaningful) studies is to help console ourselves by trying to show that even though economic considerations prevent our providing the "best," what we can provide seems to be "adequate."

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