The Chirurgeon's Burden

Newsletter For An Tir Chirurgeons

ISSUE #10 – August, 2006 Editor: Lianna Stewart, MC, GdS

Your Kingdom Chirurgeon Speaks!

Greetings, all!

As the Kingdom Chirurgeon is involved in studying now here is a copy of her final KWACs report in case you missed it. Appears a good time was had by most.

55 treated, several hospital referrals by private vehicle due to response time in cases where high level care wasn't the issue, one transfer to ambulance where situation was emergent and ongoing care was essential. We were very lucky, at the time of that event the local EMS were having a social time at the fire station and we did not lose the time for them to gather; response time 22 minutes. During the emergent situation we had family screened for their privacy in the intake area, treatment station 3 in the warm room was where the patient went down so we were able to effectively screen him from family and public while our team worked on him, good transfer to a treatment table and ongoing treatment and smooth transfer from there to the ambulance. Only difficulties came from one of the ACT kits had been opened and items not returned to expected locations, and our modern EMT was unfamiliar w/ NATO litter used, which caused slight delay in logrolling patient onto it. Team worked together very well in difficult situation, showing the advantages of both training together and the layout and resources set up. Transfer to ambulance team was the smoothest I've ever participated in, showing the effectiveness of pre-event coordination w/ local EMS.

Final setup was 20x40 vinyl pavilion, still very hard to heat. During KWCS it was front 20x10 intake and 2 treatment stations, back 20x10 was Advanced Care Team (operating as WA EMT, etc, not chirurgeon) area w/ advanced supplies and 2 2'x6' treatment tables set up w/ blanket padding under 3' wide plastic tarp roll so we could pull up new barrier as needed. Center 20x20 was classroom space and storage around the edges. After KWCS we gradually shifted to final config for last weekend w/ expected high numbers. This was the center split into 2 more 10x20 zones; one storage and one hangout / warm room with a 3rd treatment station in the warm room. There were 2 more tables holding equipment in the ACT zone that could have been turned into treatment tables at need; they were not needed. Total attendance including daytrips was appx 1700 not the 3000 plus expected. Only one treatment table at a time was in use though on packdown Monday there was very little time between 2 patients. 2-3 times all 3 treatment stations were in use at one time.

is- and very proud of my people!

THLord Tvorimir Danilov, MC, GdS, JdL, WOAW
Kingdom Chirurgeon, An Tir

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Hand Sanitation for Camping Chirurgeons

By Lianna Stewart

Semmelweis demonstrated many years ago that cleaning hands between patients lessened the carrying of germs from one to the next. The chirurgeon at a campsite often has no, or limited, access to soap and water. Providing quality first aid while preventing subsequent infections is the goal of the chirurgeon.

Health care professionals advocate the use of soap and water as the most simple and effective primary means of hand sanitation. At larger events where running water, maybe even hot and cold water, are provided, the chirurgeon washes hands between patients. However, most Society for Creative Anachronism (SCA) events are held in locations outdoor without an outside source of clean water. It is possible to bring a large water container and soap to chirurgeon point. Rarely is this provided. In order to accomplish basic cleanliness, a chirurgeon must find alternative means to cleanliness.

Most chirurgeons find the use of protective gloves to be a tool which serves several purposes. Gloves protect both the chirurgeon and the patient from the resident germs which each carry. Changing gloves between patients and, if needed, in the middle of cleaning or bandaging a wound, allows the least possible germ transfer. However, even with excellent technique used in donning or removing gloves, contamination is possible. Further care needs to be considered in hand sanitation for the most optimal outcome for patient and first aid provider.

Following glove disposal the chirurgeon should either wash their hands with soap and water or clean by other means. Since water is often unavailable, some use hand wipes. These come in slightly moistened sheets in either individual packets or in boxes containing many. Unfortunately, studies have established that hand hygiene wipes have very little effectiveness thereby making them relatively useless for hand sanitation. (Larson, Navarra, Weinstein)

The most widely advocated substitute for hand washing is the alcohol-based hand sanitizer. Studies show that healthcare professionals spend ten seconds cleaning their hands with alcohol-based hand rubs between patients. This decreases microbial transmission between 50 to 75 percent. (Hitti) One of the advantages of the alcohol rubs is that germs are destroyed by the contact so mutation is not possible. Therefore, resistant microbes do not grow. Anti-bacterial hand rubs, on the other hand, have been proven ineffective as they don't break down microbes effectively. (Larson) Alcohol rubs can be purchased in both tiny and large bottles. A tiny bottle can be carried in a belt first aid kit and replenished when the chirurgeon returns to a larger kit. This allows for greater portability. Alcohol-based hand rubs are an effective means of hand sanitation.

It is impossible in a dirty, dusty, hot field or park to provide a sterile environment for first aid. The chirurgeon must utilize the tools that are most available. If soap and water is readily available, then washing and gloving are an appropriate proven time-honored means of hand sanitation. In the more common event sites, however, the combination of gloves and an alcohol-based hand rub are the most practical deterrent for chirurgeons.

References:

Aiello, Allison E., et. al. "Antibacterial Cleaning Products and Drug Resistence." http://dscape.com/viewarticle/513525_print.

Hitti, Miranda. "Which Hand Washing Cleansers Fight Germs Best?" http://www.webmed.com/content/Article/102/106515.

Larson, Elaine. "Hygiene of the Skin: When is Clean Too Clean?" http://www.medscape.com/viewarticle/414394.

Pittet, Didier MD, MS. "Hand Washing and Skin Antisepsis-Herein Lies the Rub". http://medscape.com.

Weinstein, Robert A. MD. "Antimicrobial Resistence: Pushing Back the Tide with Gloves, Hand Hygiene, and Antibiotic Cycling". http://medscape.com.

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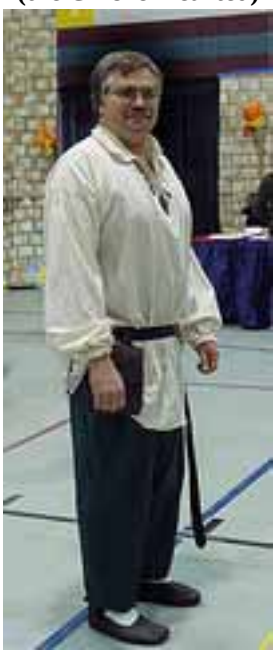
Chirurgeon's Spotlight

Robert Trinitie
(the Chickenhearted)



AoA in AS 19, Torse (AoA+) AS 25, , WoaW AS 27, Goute AS 34. There are a few other local and baronial level awards in there too.

Robert became a chirurgeon in 1983 in the principality of Calontir in the defunct shire of Thousand Hills. This was in the days before things had gotten as formal as they are now. They didn't have too many chirurgeons, so the apprentices often worked unsupervised. (Ed. note: Anyone remember those days?)

The KC often relied on talking to other people who were present at the event. Sometimes that even involved talking to the patient. Robert thinks he apprenticed for two events. He even got to serve as a CIC at his first one. He said, "I arrived at gate to pay my fees and asked a question:" "Who's the CIC?" The Autocrat replied: "Um... I think you are." Ask him about that story sometime. It was an "interesting" day.

Robert was a journeyman from 1984 or 85 until 1990 when he was given his masters (now called MENTOR) baldric by the Calontir KC. Actually; it was mailed to him because they were planning on surprising him with it at an event. Then he moved to An Tir in 1991 before they could pull it off. (Robert: I Guess I'm always running away from courts!)

His move to An Tir as a MC created some controversy since An Tir had no master chirurgeons at the time. (Anyone who wants to hear a funny story about that, talk to Brenna or Mir.) Things got settled out a "few" months later. During Brenna's stint as KC, An Tir got three native MC's of their own. It was nice not being the sole MC, and a foreign import to boot.

Robert started out as a "basic first aider" in the days where basic first aid wasn't too far off from the modern ARC first responder course. He soon became a volunteer instructor with the ARC. Later on he upgraded his certifications to ARC first responder.

Personal comment: "I kinda like the new Red Cross's 2005 take on basic First aid. It looks a lot more like it did 20 years ago. It seems to have a lot less of "check the ABC's and call 911, "They'll be here in a few minutes" type of training. I'm currently withholding comment on the new CPR program pending more info and experience with it."

The Salerno Book of Health

The Medieval Physician in His Office.

RISE earely in the morne, and ſtraight remember,
With water cold to waſh your hands and eyes,
In gentle faſhion retching euery member,
And to refreſh your braine when as you riſe,
In heat, in cold, in *Iuly* and *December*.
Both comb your head, and rub your teeth likewiſe:
If bled you haue, keep coole, if bath' keepe warme:
If din'd, to ſtand or walke will do no harme
Three things preſerue the ſight, *Graſſe*, *Glaſſe*, & *foũtains*,
At Eue'n ſprings, at morning viſit mountains.

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Pain Assessment in the Nonverbal Patient

By Lianna Stewart

The ethical principles of doing no harm and a duty to benefit others are important in attempting to assess a patients level of pain. The chirurgeon with a patient who is either unconscious or an infant/toddler may find getting a pain gauge difficult. The chirurgeon must use other means than the preferable "verbal report". Some of the ways to gauge pain include:

- Observe for potential causes of pain (obviously broken bones, wounds, chronic illnesses).
- Observe behaviors. This may or may not be accurate. Going to sleep doesn't mean that pain is non-existent or lessening. Grimacing and other facial expressions, body movements, mental status changes, moaning, groaning, rubbing a body part, crying or flinching are behaviors which can indicate pain.
- Reports from family or friends of activity or behavior changes.
- Physiologic factors (changes in heart rate, blood pressure, or respiratory rate) are inaccurate pain indicators.

Since pain is defined as "whatever the experiencing person states it is" (McCaffery, 1968) then we, as chirurgeons, must observe what is happening to our patients and relieve pain to the best of our ability

Methods to reduce or relieve pain which the chirurgeon CAN use:

- Change in position (if further damage is not created).
- Ice or heat (generally ice is recommended immediately following an injury).
- Cool a burn.
- Hydrate for hyperthermia.
- Warmth (slowly) for hypothermia.
- Immobilize.

Remember—as first aid providers, we DON'T use pharmaceuticals. Leave those to the professionals.

From the President's Report of the SCA Inc.'s July, 2006 Board meeting

Society Chirurgeon:

Dr. Hart-Carlock asked that the Board put out a call for her successor in office. She also asked that the Board review some potential alternate titles for the Chirurgeonate ranks. By consensus, Chairman Williams ruled that the following titles be instituted as the new title series for the Chirurgeon's office: Chirurgeon-in-Training, Chirurgeon, and Mentor Chirurgeon.

By consensus, Chairman directed the Society Chirurgeon to amend all Chirurgeon paperwork to reflect the new title series, and to provide copies of the aforementioned paperwork to the Vice President of Operations by October 1, 2006.

Dr. Hart-Carlock commended THLd Tvorimir Danilov for organizing and running the Known World Chirurgeon Symposium.