The Chirurgeon's Burden

NEWSLETTER FOR AN TIR CHIRURGEONS

ISSUE #4 – October, 2004 Editor: Lianna Stewart, GdS

A Short History of Medicine:

Contributed by: Robert Trinitie the Chickenhearted MC, WoW, etc and so on

"I have an earache..."

2000 BCE: "Here, eat this root."
1000 CE: "That root is heathen. Here, say this prayer."
1850 CE: "Prayer is superstition. Here, drink this potion."
1940 CE: "That potion is snake oil. Here, swallow this pill."
1985 CE: "That pill is ineffective. Here, take this antibiotic."
2002 CE: "That antibiotic is artificial. Here, eat this root"

Recruitment

Contributed by: Caelin on Andrede former Ansteorran KC ER deputy to the Society Chirurgeon

When I became a Chirurgeon, there were 6 (including me) in our Kingdom. I became the Baronial Chirurgeon and became active in the local area. The incoming Kingdom Chirurgeon wanted to get more Chirurgeons and I jumped on the bandwagon. I became her Deputy and worked to make her (and my) goal happen. We had about 50 when she stepped down and I stepped up. About 35 of those were active. When I stepped down there were 85 with 65 active. At our biggest event this year, we had 39 Chirurgeons working and 100 Waterbearers! This is not a "how great a job I did" thing. I just want to put the following in perspective.

First I worked every event I could and made sure my baldric was very visible. I told a million people what the upside-down 2 was and why they might want to wear one. When we got an apprentice I tried to make sure they got to work. I traveled to them if that's what it took. When they made Journeyman, we did it in court. It just takes about 4 minutes to call them in and give them a new baldric. While they walk up, I talk about what the Chirurgeonate is and does and what this person did to earn this recognition. We nearly always get a few apprentices after court.

Next I tried to analyze what kept people from becoming Chirurgeons. I asked everyone who would talk with me; Chirurgeons, fighters, ladies in waiting, and most especially those who had become apprentices and did not continue to Journeyman. Many just decided it was not for them. But of those who were good candidates it came down to one of two issues.

Training was hard to find and it cost too much. The local ARC was charging US $65 for Community First Aid and CPR. And it's gone up since then. And even in the big cities in my Kingdom you were lucky to find a class once a quarter. In the smaller communities, once a year was de rigor.

It took too darn long to apprentice. In addition to some basic training, we required apprentices to work at least three events where they did something beyond trivial. Luckily, the Marshals and the Chirurgeons were preaching safety enough that injuries were down. Unluckily, there were few non-trivial things to treat. Apprentices got the attitude of the vulture who told his companion on the electric line "To hell with this waiting for something to die, I'm going to kill something."

So I began arranging classes taught by AHA and third party groups. I'd ensure a minimum class count and they would put on a special SCA class at special prices. It was still $40-45, but we could arrange them more often and in smaller cities. One of those classes was taught by an ASHI instructor. As we talked, I realized I could run an effective program and ASHI had a quality program with less politics than either ARC or AHA. Along the way I had become an EMT in Texas (I am a computer consultant and CPA), so I talked my EMT instructor into loaning me equipment to get started, took the training courses to become an ASHI instructor, recruited others in the SCA to become instructors, did the paperwork to become a certified Training Center, and began offering courses at SCA events. Eventually, I bought the dummies, AED trainers, Oxygen equipment, etc. from the profits of the training. And we have 14 instructors and 4 instructor trainers now.

We only teach the "Healthcare Provider" or CPR-PRO CPR and BLS First Aid. We felt the people coming out of Community First Aid and CPR were not really prepared. Of course, we did not change the requirements for the Chirurgeonate, but if you wanted to take our courses, that was what we offered. We schedule classes at King's College, at Baronial Colleges, at Roundtable (an event where the officers do the business stuff so we don't have to do it at events), at Gulf War, at Pennsic, and just about anywhere we can get enough for a class. And we do it for $20/person for both classes (we don't need much in the way of profit). Our CPR is

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adult, child, and infant because you never know who will need it. We turn out 100 -120 a year and most of them become Apprentices (we don't require it of anyone).

We built and now offer several other courses: Chirurgeoning 101, Waterbearing 101, Being CIC, Vital Signs, Armor Removal, and Scenarios. This brings me to number 2 above.

To address the time to Journeyman, we decided to offer classes in Scenarios and give credit for all but one of the event evaluations for a good Scenario. We talked with the Society Chirurgeon at the time (Galen) and he agreed. After all, most medical people receive a part of their training this way. We worked out some scenarios based on our experience and stories from this list. The moderator would set the stage, one of the class would be chosen to "lead", and we would set them loose. When they needed something not apparent in the fake victim, like pulse, they could say "I'm checking the pulse" and the moderator would tell them the value. They could use the others in the class to help (bystanders). The moderator could turn the plot on a dime to emphasize something they missed or to make it tougher on really good students. It was popular and helped get evaluations in.

We also watched for those who worked hard for the benefit of the population and made sure they were put in for awards they deserved. Some had worked for years as Chirurgeons or Waterbearers and did not have an AoA. They did not work for awards, but they sure smiled when they got them.

Finally, my successor as KC has done a wonderful job of building a team out of us. He has Chirurgeon social time at Gulf War and many events. Sometimes a pot luck supper, sometimes he serves breakfast for all the Chirurgeons who can get up in time. We have had a torchlight tournament for the heavy fighters where the fighter had to be sponsored by a Chirurgeon or Waterbearer. The Marshals were all also Chirurgeons and the List Mistresses were Chirurgeons. The fighters really enjoyed it including the King, Queen, Prince, and Princess. We had a Chirurgeon sponsored Iron Chef competition with nice prizes. The food served the nobles and my wedding party (I paid for the food, not the SCA). The current and a former Queen were among the judges. It was wonderful and we all had fun.

My advice is to find out what is preventing people from becoming Chirurgeons in your area (it sounds like training) and be creative in finding what you can do to bypass the problems. Do PR whenever possible. Reward people for their work publicly. Build a team.

Sports Concussions: New Guidelines Issued

By Jeanie Lerche Davis

Sept. 29, 2004 – Tighter rules on team sports have cut injuries dramatically. To further protect athletes, a team of experts has issued a study and guidelines regarding concussions. "

As sports become more of a fixture in the lives of Americans, a burden of responsibility falls on the shoulders of the various organizations, coaches, parents, clinicians, officials, and researchers to provide an environment that minimizes the risk of injury," writes researcher Kevin M. Guskiewicz, PhD, with the University of North Carolina at Chapel Hill. His report appears in this month's Journal of Athletic Training.

The guidelines from Guskiewicz's report are based on the latest studies, and are intended to provide trainers, coaches, doctors, and parents with recommendations on preventing and handling concussions.

Among the guidelines:

Defining Concussion – The term "ding" should not be used to describe a sport-related concussion as it generally diminishes the seriousness of the injury. If an athlete shows signs of a concussion after contact to the head, the athlete has, at the very least, sustained a mild concussion. Signs of concussion include: changing levels of consciousness, balance problems, memory and concentration difficulties, headache, ringing in the ears, and nausea.

Making the Return-to-Play Decision – With sports that have a high risk of concussion, athletes may need brain (cognitive) and balance (postural-stability) tests before playing to establish their baseline functioning. These cognitive screening tests are similar to monumental status exams, which measure immediate memory, orientation, concentration, and delayed recall. If an athlete is injured, the time of the initial injury should be recorded. The athlete should be monitored for injury symptoms afterward, and symptoms should be noted in writing. Officials should monitor the athlete's vital signs and

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level of consciousness every five minutes after a concussion, until condition improves. The athlete should also be monitored over the next few days, looking for signs of delayed injury as well as recovery.

Determining Seriousness of Concussion – After an injury, cognitive and balance testing is recommended to determine injury severity and whether the athlete is ready to return to play. Once the athlete is symptom-free, another round of testing should show normal results for that player.

Referral to a Doctor – On the day of injury, an athlete with a concussion should be referred to a doctor if he or she lost consciousness or experienced amnesia lasting longer than 15 minutes. A team approach should be used in making return-to-play decisions after concussion. This approach should involve input from the athletic trainer, physician, athlete, and others involved.

Disqualifying Athletes who have symptoms of injury – Athletes who have symptoms of injury, both at rest and after exertion for at least 20 minutes should be disqualified from returning to participate in a sport on the day of the injury. Athletes who lose consciousness or have amnesia should be disqualified from playing on the day of injury. Athletes with a history of three or more concussions and experiencing slowed recovery, temporary or permanent disqualification from contact sports may be indicted.

Special Considerations for Young Athletes – Because damage to the maturing brain of a young athlete can be catastrophic, even greater caution should be used with athletes under age 18. An athlete with a concussion should be instructed to avoid taking medications, unless it's acetaminophen or other drugs that are prescribed by a doctor. Any athlete with a concussion should be instructed to rest, but complete bed rest is not recommended. The athlete should resume normal activities of daily living as he or she is able, while avoiding activities that could make symptoms worse. The athletic trainer should enforce the standard use of helmets for protecting against catastrophic head injuries and reducing the severity of concussions. The athletic trainer should enforce the standard use of mouth guards for protection against dental injuries -- even though there is no scientific evidence that they will reduce concussion injuries.

SOURCES: Guskiewicz, K. Journal of Athletic Training, Sept. 2004: vol 39, pp 280-297.
News release, National Athletic Trainers' Association.

Proper procedure for severed limbs/digits

Submitted by: Signore Antonio di Rienzo,
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Wrap it in a cool damp swab (preferably sterile, but hey...)
Put it in a plastic bag Write the patients name and date of birth on the bag in indelible ink.
Put the plastic bag in a bag of ice water.
Transport to hospital with the patient.