NURSES IN THE OLIVE GREEN : WHAT NEXT?

Dear Editor,

Military Nursing Service (MNS) officers form one of the important components of paramedical staff in the Army Medical set up. Recently changes have been made in the routine working dress of the Nursing Officers from traditional white to olive green shirt and pant. The exact cause of this change is not known, but the new pattern of dress seems to lack elegance and working comfort compared to traditional white. Most of the young nursing officers do not appear to be satisfied with the change.

The olive green shirt and pant is not able to hide the disproportionate bulges in the obese persons and looks ugly on some of them. This has a detrimental effect on the typical charm of the Army uniform. Moreover, due to lack of adequate Army training their pattern of wearing the head gear is below the desired standards and their reluctance to salute senior officers, adversely affects the decorum of service.

The previous pattern of olive green one piece skirt was still better compared to the shirt and pant, as it could maintain their identity without affecting the rank. Moreover, it looked more sober in obese persons. With the present uniform, most of the patients find it difficult to differentiate between the lady medical officer and a nursing officer which may at times lead to embarrassing situations. Though MNS offers best career opportunity for nurses in India, unfortunately, over the years, 'nursing' component of their nomenclature seems to be taking a back seat and more stress is being laid on the 'officer' component. They have started equating themselves with the medical officers and tend to exercise authority over the medical officers, especially the junior ones.

Though status of the nursing officers has been clarified time and again, but an ambiguity remains. With the gradual change in attitudinal profile, a junior AMC officer may find it difficult to extract work out of a senior ranking MNS officer.

There is a tendency to palm off routine nursing procedures like sponging, catheterisation etc and get it done through the less trained para medical staff. In a survey of attitudinal profile of MNS officers, Goel et al also found more authoritarian attitude and a greater negative attitude towards authority [1]. This seems to be an alarming trend. Disciplinary cases pertaining to the nursing officers (both reported and unreported) are on the rise and their immunity from most of the Army Acts/Rules adds to the problem. All these factors may have a deteriorating effect on the image of the MNS. The role of Principal Matron and senior nursing officers in bigger hospitals also needs to be redefined. There is reluctance to do the basic job and thus causing a loss of technical manpower.

The aim of this article should not be construed in a negative way. The idea is to enrich the discussion on this important subject. Solicited response/comments from the editorial board/appropriate authorities will be appreciated.

References

1. Goel DS, Kumari R, Saldanha D, Kaushik A and Gupta L. Attitudinal profile of Military Nursing Service Officers. *MJAFI* 2000;56:140-2.

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POLYTRAUMA : OCCASIONAL DILEMMA FOR THE SINGLE SURGEON

Dear Editor,

A 20 year old serving soldier was heli-evacuated to this Field Ambulance with history of having sustained multiple splinter injuries during enemy shelling. He was in a state of shock but was conscious. A quick evaluation revealed that he had the following injuries :

a. An Acute Abdomen with entry wound in the lower right abdomen.

b. A compound comminuted supracondylar fracture of the right humerus bleeding profusely, multiple splinters in the elbow joint and an absent radial pulsation with mild discolouration of the right hand.

c. A wound over the right iliac crest with fracture right iliac crest and profuse bleeding.

d. Splinter injuries in the forehead, which were bone deep.

e. Splinter injury in the left upper thigh with splinter seen on X-ray but distal pulsations palpable and no fracture.

In a forward centre with limited investigative and blood transfusion facilities and a lone surgeon, it is occasionally difficult to decide which wound to tackle first and that which would be the best for the patient's survival.

In this case the patient was first resuscitated with IV fluids and hemacel and a decision was taken to control bleeding from the right iliac crest wound which was obvious and visible. The right elbow and brachial artery were explored next.

The brachial artery was found to be compressed by the proximal end of the severely shattered humerus but intact. An arterial branch which was bleeding was controlled, the brachial artery released and the fracture reduced so that radial pulse was palpable. Next an

exploratory laparotomy was done. It revealed multiple small intestinal perforations. There was no major vessel injury or mesenteric haematoma. Resection anastomosis was performed. Wound debridement of the other wounds was done. The patient behaved throughout the surgery and did not 'crash'. Post operative recovery was uneventful and he was transferred to the next referral centre on the 6th post operative day once he was having a normal diet and was ambulant.

It is usually as a single young surgeon that one faces the situation of handling polytrauma with no one to consult or fall back upon. It is very important to keep calm and relaxed so that a quick decision that is best for the patient's benefit is made. The logic followed here was that the wounds in iliac crest and the elbow were obvious and profusely bleeding and hence were tackled first. Also the right forearm was at risk because of an absent radial pulse. The patient started to settle down once the bleeding was controlled. The management of acute vascular trauma often presents a major challenge to the trauma surgeon who is frequently confronted with a life or limb threatening situation or both. Angiography provides the definitive diagnosis and its value in the management of arterial trauma is well recognized. However, in the presence of focal trauma to lower extremity or to the upper extremity at brachial artery or distal levels as in this case, the injury can be accurately diagnosed and localized by clinical examination and angiography may only delay surgery. Principles of repair include use of lateral suture, vein patch angioplasty, end to end anastomosis and interposition graft.

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