

FRACTURE *lines*

The Newsletter of the Orthopaedic Trauma Association

July 2003

University of Louisville Hospital
Louisville, Kentucky 40202

The Dog Days of Summer

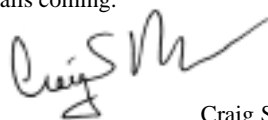
The dog days of summer are here. However, with the leadership of Dr. Marc Swiontkowski, the OTA and its Board of Directors has been working tirelessly. Have a look inside the newsletter and see for yourself.

You will find a draft of an important document by the Goulet Commission on EMTALA and the orthopaedic traumatologist. It represents an incredible amount of work by a group headed by Jim Goulet, M.D., which included Sam Agnew, M.D., Jeff Anglen, M.D., Mark Brinker, M.D., Tim Bray, M.D., Jim Carr, M.D., Jim Nepola, M.D., and Marc Swiontkowski, M.D. This version is a draft and your comments and feedback are being solicited. Please send comments to Jim Goulet, M.D. (jgoulet@umich.edu) or Marc Swiontkowski, M.D. (swion001@umn.edu).

Also inside, the membership committee reports on a new membership category for the community orthopaedic traumatologist. An OTA mentoring program is also introduced by Marc Swiontkowski, M.D., with an appeal for mentors willing to participate. Following the theme of political action from OTA Specialty Day in New Orleans, the results of the member survey on political action are presented. If anyone has the importance of political action figured out, it is Michael Suk, M.D., J.D., M.P.H., who was selected as a White House Intern for 2003-2004. He is currently doing an orthopaedic trauma fellowship at HSS with Dr. Helfet. If you are having a hard time getting your open fracture wounds flapped quickly or if you "fix and flap," you will want to complete the new survey on soft tissue coverage of open fracture wounds.

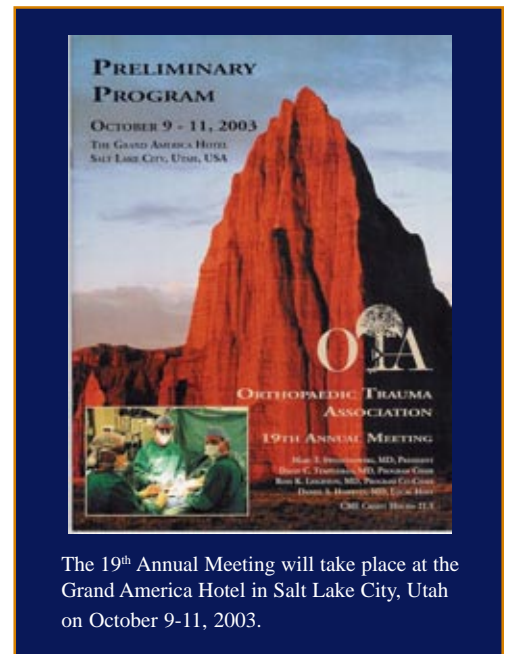
The Salt Lake City Meeting is just around the corner. Local Host Dan Horwitz, M.D., David C. Templeman, M.D., Program Chair, and Ross K. Leighton, M.D., Program Co-Chair, have put together a spectacular two and one-half day meeting beginning at 1:00 pm on Thursday and ending at 4:15 on Saturday with special sessions on the polytrauma patient moderated by Larry B. Bone, M.D., and DVT prophylaxis moderated by Larry X. Webb, M.D. Wednesday, 3:00 pm is the start of the OTA Basic Science Focus Forum organized by Emil Schemitsch, M.D. featuring a Surgical Navigation Workshop, a Symposium on Bone Graft Substitutes, and an additional Thursday morning session of Basic Science Peer-reviewed papers. Please help promote the meeting with your colleagues. Register on-line today!

I look forward to seeing you in Salt Lake City. Please keep your e-mails coming.

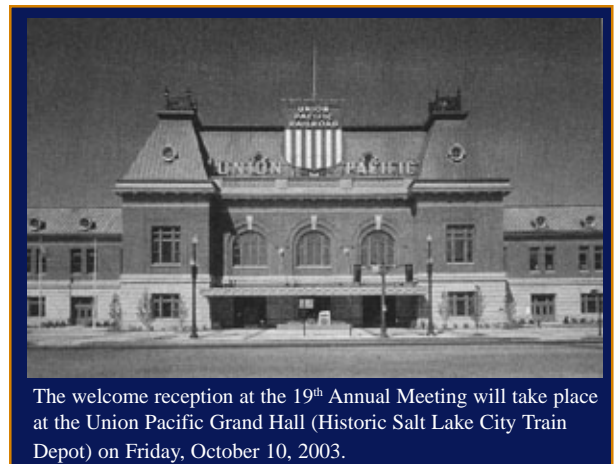


Craig S. Roberts, M.D.
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The Editor's Pen



The 19th Annual Meeting will take place at the Grand America Hotel in Salt Lake City, Utah on October 9-11, 2003.



The welcome reception at the 19th Annual Meeting will take place at the Union Pacific Grand Hall (Historic Salt Lake City Train Depot) on Friday, October 10, 2003.

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DRAFT Document: EMTALA and the Orthopaedic Traumatologist

The following OTA members have contributed to this document: Sam Agnew, Jeff Anglen, Marc Brinker, Tim Bray, Jim Carr, Jim Goulet, Jim Nepola, and Marc Swiontkowski.

A symposium at the October 2002 Orthopaedic Trauma Association focused on recent changes in the economic and legal issues affecting the delivery of emergent orthopaedic care. The symposium participants reviewed recent changes driving emergent orthopaedic care delivery in nonacademic centers. The symposium participants also reviewed the emerging opportunities for orthopaedic surgeons interested in participating in the care of these patients while receiving reasonable remuneration for their work, and having acceptable control over the distribution of their work hours.

Factors changing the delivery of orthopaedic emergency care have included increasing subspecialization of orthopaedic surgeons, with a decrease in the number of generalists taking call. The phenomenon is coupled with a proliferation of ambulatory surgical care centers that have split many orthopaedic surgeons away from large hospital settings where most urgent and emergent care is administered. An increasing number of orthopaedic surgeons have little recent experience in the management of fractures. An increasingly higher percentage of uninsured or underinsured patients are seen through the emergency departments of most hospitals. These patients require a high level of unreimbursed care, and may be associated with considerable potential legal liability. While the potential to “practice-build” by taking call still exists in some communities, many insured patients are directed away from large institutions to other care providers by managed care organizations, taking away another incentive for surgeons to take call. Finally, recent clarifications in EMTALA law have put the responsibility for care of patients seen in hospital emergency departments squarely on the hospitals themselves, rather than on the physicians who have privileges at those hospitals.

The changes noted above have contributed to an increased willingness by progressive hospital management teams to find creative solutions to orthopaedic trauma problems, and a willingness to pay for implementation of these solutions. The participants in this OTA symposium were asked to draft a document to be used to establish a framework for hospitals and orthopaedic trauma surgeons interested in working together to solve these problems. The document which follows is the product of work from members of the symposium committee. The document is intended to complement the AAOS compendium “EMTALA and the Orthopaedic Surgeon”, produced through the efforts of the AAOS Board of Councilors and available to AAOS members at the Academy website.

Orthopaedic trauma care in the community hospital: A fundamental framework for physicians and hospitals to deliver responsible and cost effective care

Establishment of an orthopaedic trauma system at a community hospital or academic health center can be envisioned as consisting of two complementary components: a hospital / surgeon component, and a surgeon/operating environment component. The surgeon/operating environment component is defined by the relationship of the orthopaedic trauma service to other orthopedic surgeons, to general surgery trauma surgeons, and to other medical professionals providing care to injured patients. Within most community hospitals, one orthopaedic trauma surgeon can be designated to handle most or all of the subspecialty level traumatology orthopedic injuries presenting to the facility, if patient flow is properly organized. This document assumes that the community hospital meets ACS or state-determined trauma center designation, and does not attempt to address situations that may arise at community hospitals that have not met such designations.

Five practice models have emerged for the delivery of orthopaedic trauma from fellowship-trained orthopaedic traumatologists. Three of these models are long-standing; two models are relatively recent developments. The newer models have in response to recent developments in the health care market and practice environment. The existing models include the following:

1. **Academic Practice Model.** This is the model most familiar to orthopaedic surgeons with fellowship training in orthopaedic trauma. OR access, workload and reimbursement relative to others in the department are the key issues leading to early exit from academic orthopaedic trauma practices for many surgeons.
2. **Solo Practice Model.** Relatively rare for orthopaedic trauma. This type of practice has worked best in locations with high reimbursement rates.
3. **Private Group Model.** Experience depends on inter-group dynamics, subject to disproportionate workloads, after-hours surgery, and payment disagreements between partners. The orthopaedic trauma specialist in this setting should not have other responsibilities in terms of office practice and a reasonable baseline salary guarantee. The private group must value the function the OTS provides to the whole for this model to work.

Two relatively new practice models have emerged, each with strengths and weaknesses. The model successfully chosen may depend largely on the level of involvement and enthusiasm of general orthopaedic surgeons within the community to participate orthopaedic trauma care. The specific needs and “personalities” of the community, the community hospital, and the orthopaedic trauma surgeon interested in delivering care to patients at this hospital will also be important factors in determining which model would best fit.

4. **Hospital Based Model.** In this model, the orthopaedic trauma surgeon is directly employed by the hospital, with a variable relationship to local orthopedic surgeons. This

system offers a guaranteed salary, and support from the hospital for medical liability insurance, office support, billing, physician assistant etc. Due to the payer mix for most community trauma, the hospital must be committed to supporting the surgeon even if the professional fees cannot fully fund the whole practice. This provision is particularly critical for a single orthopaedic trauma surgeon. The surgeon will generally find it useful to outsource functions such as physician billing when using this model in most hospital settings. Careful attention to practice management is required to allow such a system to function effectively. Poor practice management is the most common cause of failure with this model. Obtaining off-duty coverage is often a challenge in this model.

- 5. Hospital Based/ Private Group Hybrid Model.** This model folds the orthopaedic surgeon into a group practice already present, and adds hospital salary support. Such a model uses the practice mechanics set up by the group, and adds provisions including built in call coverage by the partners. Pitfalls of this situation might include uneven workloads within the group, and possibly reimbursement issues if the hospital fails to provide sufficient support. Off duty coverage may still be an issue in this model.

Within all of these systems, a host of challenges must be addressed. These challenges have been most effectively addressed by establishment of a direct relationship between the hospital chief administrator and the orthopaedic trauma surgeon seeking partnership with the hospital in addressing the trauma needs of the community. The position that evolves will be unique to the needs of the hospital and the community, and constant adjustments are expected as the system evolves to meet these needs. The parties involved must anticipate that problems will arise, and that these problems must be effectively addressed to allow a continued productive relationship between the hospital and the orthopaedic trauma surgeon. As many issues as possible should be addressed prior to signing employment contracts or starting employment in order to maximize effectiveness of the negotiations. These challenges include:

- 1. FUNDING FOR ON-CALL COVERAGE:** For any community or rural trauma system to function adequately, the hospital must make a substantial financial commitment to orthopaedic trauma coverage. Without such a commitment, systems ultimately fail. Financial support may come in the form of directly hiring a hospital orthopaedic traumatologist, or by paying for emergent services provided by community orthopaedic physicians. A responsible approach that has emerged in many hospitals employing community orthopaedic surgeons to provide services has focused on covering office overhead expenses incurred while the orthopaedic surgeon covers the trauma service. For example, if office overhead cost is determined to be 200 dollars/hour/physician, a \$1600 stipend would be established to cover an 8 hour call coverage period. Considerable variation between communities exists. A similar calculation is made for payment to an orthopaedic traumatologist providing daytime care if his/her responsibility has been directed to hospital needs, giving up the opportunity to

establish a traditional private practice and the revenue associated with such a practice. The issues for Academic Health Centers are no different and salary support for the orthopaedic trauma surgeon is requisite.

All patient surgical/care related billings in successful systems have been placed in the province of the physicians rather than with the hospital. A monthly stipend is provided for each physician. All trauma program financial/ billing records should be accessible to physicians so that they can help and actively participate in the planning and budget process.

- 2. ACCESS TO OPERATING ROOMS:** Access to the operating room must be provided to allow urgent but non-emergent care delivery, and to allow follow-up in-patient care of orthopaedic trauma patients. Cancellation of elective cases to care for under-reimbursed trauma problems is a poor alternative to provision of such a priority room, disadvantaging equally the hospital and the orthopaedic surgeons providing urgent care. This need varies with program size and with the number and length of time of operative cases. A priority room may be required three to five days per week in an average community hospital. Provision of such a room allows all trauma services to priority schedule in-house patients; if the time is not used, the room opens up to all community surgeons. One trauma room should be immediately available at all times, and a trauma crew available 24/7/365.

- 3. PERSONNEL SUPPORT:** A hospital based, orthopaedic liaison nurse is provided to help the orthopaedic trauma service with scheduling, trauma registry, complaints, quality assurance, scheduling, and other orthopaedic trauma needs that predictably arise. The nurse is provided with office space and support staff as part of the budget of the trauma program directed to orthopaedics. A full time nurse is not required for the orthopaedic component of care at most community hospitals. A busy community hospital might be expected to require 30% - 50% of the time/space needs of a nurse specifically for orthopaedic trauma issues. Trained orthopaedic radiology technicians must be available 24/7 in proportion to the volume of surgery involved. A minimum of one physicians' assistant is also generally required for each orthopaedic trauma surgeon. Residents and orthopaedic fellows play part of this role in many Academic Health Centers.

- 4. STATE TRAUMA SYSTEM INVOLVEMENT:** This responsibility is most often directed to the general surgery/trauma program director. Some community and academic orthopaedic trauma surgeons can be helpful in this regard if they have direct relationships with local and state legislators with an interest in health care within their communities.

- 5. OR EQUIPMENT:** An orthopaedic liaison in the operating room is directly responsible for all orthopaedic equipment, including trauma implants. Although desirable, most community programs are simply too small to have specialty trained trauma personnel in the OR; larger hospitals should provide this type of support.

DRAFT Document cont.

One benefit of an orthopaedic trauma program is voluntary participation in cost containment for the OR. Orthopaedic trauma surgeons are expected to work with hospital administrators to limit the number of trauma implants to optimize staff familiarity and cost, and to minimize implant inventory.

An appropriate number of image intensifiers must be available to the OR at all times.

6. **TRANSFER AGREEMENTS:** Rural hospitals with no orthopaedic surgeons on staff have full and easy access for transfer of all orthopaedic cases, including trauma patients. Patients that fulfill pre-specified trauma criteria are automatically transferred to the trauma center. In cases of isolated orthopaedic injuries, orthopaedic staff at hospitals requesting patient transfers must examine the patient and speak directly to the orthopaedic surgeon on call at the trauma hospital to explain why the patient needs to be transferred. The emergency department is not empowered to accept isolated orthopaedic trauma patients. This policy tends to eliminate the inappropriate transfers for reasons other than patient care needs.

7. **EMTALA:** A 24-hour voice mail number is provided in the orthopaedic trauma office specifically designed to report problems concerning transfers, or to report on requested referrals that are not accepted. Such an ongoing program is designed to collect data on transfer issues, as well as to develop an improved transfer program.

8. **COVERAGE FOR OFF DUTY HOURS:** Specific agreements should be made in advance to determine frequency of call by the orthopaedic trauma specialist. Both of these provisions are critical for the hospital-based model. Ideally coverage is provided by another hospital based orthopaedic trauma surgeon. Other possibilities include other orthopedic surgeons at the hospital, and area orthopedic surgeons looking to moonlight.

Requirements for Successful Orthopaedic Trauma Services in Community Hospitals and Academic Health Centers

1. Emergency OR access 24/7/365 days a year
2. OR availability to the orthopaedic trauma service Monday – Saturday 7 a.m. – 5 p.m. The orthopaedic trauma surgeon may give up the room to other services if no cases are scheduled by 12 midnight the night before.
3. Orthopaedic OR nurse staff be responsible for organizing implants, instruments and OR tables, etc.
4. 1 PA/ortho trauma surgeon FTE
5. Reliable, functioning image intensifiers in adequate numbers to match orthopaedic trauma surgery volumes – well trained radiology techs assigned to the OR in corresponding numbers.
6. Funded call support coverage at a suggested rate of \$200/hr.
7. Available implant systems for intramedullary nailing, external fixation, small, mini, and large fragment plating systems, specialized plating systems, and arthroscopy equipment.
8. Support for research coordinator assigned to orthopaedic trauma research in Level I and Level II centers which corresponds to the patient volumes for orthopaedic trauma service.
9. Support for orthopaedic trauma surgeon CME – travel and course fees
10. Clinic facilities to follow patients after discharge with adequate x-ray capacity, nurse staffing, and wheelchair/stretchers access.
11. Commitment from Emergency Room MD leadership to increase orthopaedic injury triage capabilities – capability to send x-ray images electronically to the orthopaedic surgeon covering call.

In exchange for those resources provided by the hospital, the orthopaedic trauma surgeon director will provide:

1. QA direction and leadership
2. Responsibility for call schedule coverage
3. Commitment to limit variation in orthopaedic implant use
4. CME leadership for OR nursing, staff MD's, floor nurses, and clinic staff
5. Regular review of fiscal impact of the service with hospital Administration

Membership Committee Update: New Membership Category

by William T. Obremsky, M.D., M.P.H.

Patients with severe multiple injuries are usually treated in level I trauma centers, but over 90% of musculoskeletal injuries receive definitive diagnosis and treatment in community orthopaedic surgeon offices and community hospitals. The Orthopaedic Trauma Association has created a new member classification to encourage more community orthopedic surgeons to join. Orthopaedic Surgeons who meet the following requirements are eligible for associate membership in the OTA:

- Board certification
- Membership and in good standing of the American Academy of Orthopaedic Surgeons or American Osteopathic Association or Canadian Orthopaedic Association
- Majority of practice related to injuries of the soft tissue and bony musculoskeletal system.
- Licensed to practice medicine
- Citizenship in United States or Canada

These requirements are exactly the same as for active membership (please see www.ota.org for full details), with the exception that there is **no authorship** requirement.

Benefits of membership include:

- Subscription to *The Journal of Orthopaedic Trauma*
- Subscription to OTA newsletter "Fracture Lines"
- Access to OTA website to obtain opinions/advice on difficult cases
- Use of OTA Web-based or PC-based Database
- Reduced registration fee for the OTA meeting
- Access to OTA research funding
- Board funded member social events

Applications are available on the OTA website or please contact Sharon Moore (smoore@aaos.org) at the Orthopaedic Trauma Association. This is a reminder for 2004 applicants that the deadline is JULY 1. The full application is available in the preliminary program for the 2003 Annual Meeting. During this next year encourage your colleagues to join. The OTA staff office has received the following number of applications for 2003: Active (6), Associate to Active (17), Associate (7), Associate/Community (18), International (6), Resident (15), and Research (1) for a total of 70 applications.

Orthopaedic Trauma Association Board of Directors Conference Call

Abbreviated Minutes - April 9, 2003

by Robert A. Probe, M.D.

Minutes

Minutes from the February 2003 meeting, New Orleans of the Board of Directors were unanimously approved as written.

OTA Mentoring Program

The concept of a mentoring program for young OTA members was proposed by Dr. Swiontkowski. Members eligible for this service would be those within 10 years of completing training. The intent is to provide career guidance to young Traumatologist. Discussion centered on the qualifications of mentors. As different young surgeons may have differing needs and expectations, a database of mentor volunteers was suggested. This database would be accessible through the Members Only section of the web page.

The obligation of the mentors would include:

- Answering e-mails from mentee within 1 week
- Responding to phone calls within 2 days
- Offering clinical and career advice
- Serving as an advocate for career advancement for the individual proportional to their interests, talents and energies
- Meeting with the mentee at the annual OTA meeting and AAOS/OTA specialty day on an informal basis

Additions to Existing Committee Structure

A proposal was put forward by President Swiontkowski to consider creation of six new committees: Strategic Planning + Board Development Committee, Evaluation Committee, Finance and Audit Committee, Fundraising Committee, Public Relations and Branding Committee and a Past President Liaison Committee.

Modifications to include clarification of "senior member" as it appeared in several committees and the addition of the immediate past CFO on the Finance and Audit Committee were made.

This motion received unanimous approval by the Board. The initial proposal of Dr. Swiontkowski will be modified and forwarded to the Bylaws Committee. It is anticipated that this proposal will be forwarded to the membership prior to the Salt Lake City Meeting and considered for Bylaws change at that time.

Research Fund Management

CFO Pollak put forward the idea of commissioning the services of professional management for the research endowment. Historically the fund has performed well but as the size of the fund increases it is felt that other opportunities for sage investment may be possible from a professional firm. A proposal was made to create an ad hoc exploratory committee to research these opportunities. Volunteers to be on this committee include Drs. Andy Pollak, David Templeman and Doug Dirschl. Dr. Pollack will invite Dr. Brad Henley to participate as well. Plans will be made to convene this group via conference call.

Leadership in Voluntary Organizations

Dr. Swiontkowski proposed that the OTA consider having members of the Board of Directors and possibly select committee Chairs attend an 8-hour program produced by Glenn Tecker of Tecker Consulting. The program is entitled "Leadership in Voluntary Organizations: Best governance practices in a professional association."

The AOA has engaged this individual previously and Dr. Swiontkowski has attended the program.

Alternatives were discussed including commissioning this individual for an OTA specific program vs. attending a course tentatively scheduled for 4/2/04 in Rosemont. Ten positions are currently reserved for the 2004 course. After discussion the latter option seemed preferable. The projected cost is \$4000 plus travel.

Several Board members spoke in support and after motion and seconding the concept was approved by unanimous vote. Invitations will go out to BOD and the OTA staff. Depending on response and available positions, invitations may be extended to Committee Chairs.

Open-Ended Interviews

Dr. Swiontkowski proposed a questionnaire technique designed to gain insight into deficiencies in the annual meeting. A proposal was made to query six prior attendees who have stopped coming to the annual meeting. This information will be used in planning future meetings to meet the needs of the OTA body. The suggestion was made also to query surgeons who should be OTA members who are not. This would include recognized trauma surgeons and recently graduated fellows. The lack of a complete listing of current trauma fellows was cited as a potential difficulty in contacting these individuals. The OTA staff has agreed to attempt the creation of such a list.

Without formal vote, the idea of gaining information via an open-ended query of these individuals was supported by the BOD. Dr. Swiontkowski would like to receive names of individuals known to Board Members who might provide this type of feedback. Dr. Swiontkowski will coordinate interviews with the OTA staff.

Educational Relationship with AAOS

James Beaty, M.D., Chair of the Academy's Committee on Education, has set about contacting the subspecialty societies with the purpose of improving synergy. David Templeman has had significant experience in Chairing dual sponsored courses and has found the relationship in the Marco Island and Sante Fe courses to work well. Nancy Franzon pointed out that OTA profits are restricted by attendee caps that are sometimes unrealistic. Dr. Swiontkowski will respond to Dr. Beaty with affirmation of our interest in continued joint ventures.

Specialty Day

A draft agenda for the 2004 Trauma Specialty Day was circulated by Dr. Swiontkowski. The BOD endorsed the schedule and speakers as suggested.

Salt Lake City Annual Meeting

David Templeman, M.D., provided an update on planning for the 2003 Annual Meeting. The program committee reviewed 392 abstracts (down from 420 in 2002) accepting 69 for podium presentations (18% acceptance). 114 posters were accepted. The program committee will finalize symposiums and break outs in the near future. Discussion was provided on the feasibility of having another combined meeting with ISFR. It was the sense of the group that ISFR would have interest in this, as Toronto was a highly successful meeting for them. Pricing of the meeting was discussed and it was felt that a goal of revenue neutral should be sought for ISFR members to attend the OTA. This was felt to be in the range of \$375. OTA members would hopefully be able to attend ISFR free of charge. Contact will be made with Emil Schemitsch to convey this decision of the BOD.

Goulet Task Force Document

The final document was not available for review at the time of the meeting; however, it has been received in the OTA office. This will be forwarded to the BOD for comment.

OTA Mentoring Program

by Marc Swiontkowski, M.D.

The OTA Board of Directors has unanimously approved the development of an OTA mentoring program. The goal of the program is to provide career guidance to young traumatologists who are within 10 years of residency/fellowship training. Your obligation as a mentor would include:

- Answer e-mail messages within 1 week
- Respond to phone calls within 2 days
- Offer clinical and career advice

- Serve as an advocate for career advancement for the individual proportional to their interests, talents and energies
- Meet with the mentee at the annual OTA meeting and AAOS/OTA specialty day on an informal basis

All OTA members who can fulfill the above obligations and are interested in serving as an orthopaedic trauma mentor should consider completing the application.

Once all applications are collected and reviewed, a mentor database will be created and posted on the OTA website. The database will allow young trauma surgeons to search the database for a mentor with the clinical and research experience that best matches their interests.

Orthopaedic Trauma Association

6300 North River Road, Suite 727 • Rosemont, Illinois 60018-4226
Phone: (847) 698-1631 • Fax: (847) 823-0536 • Website: www.ota.org

OTA Mentoring Application

Name:
Note: If the address information currently on-file with the OTA office is current, you may leave the following 6 lines blank. If you're unsure, check the members only page of the OTA website: www.ota.org
Address:
City:
State:
Zip:
Phone:
Fax:
E-mail:

Qualifications/Areas of interest
How many years have you been an OTA member (10 year minimum requirement):
years in practice:
Areas of clinical interest:
Areas of research interest:
Publications of interest (please list a maximum of 10):
Committee positions held:
Local:
National:
Briefly state what you can offer the mentee:

Please return your application by e-mail to: franzone@aaos.org

Or by fax to number below

Orthopaedic Trauma Association
6300 North River Road, Suite 727 • Rosemont, Illinois 60018-4226
Phone: (847) 698-1631 • Fax: (847) 823-0536 • Website: www.ota.org

Results of Prior OTA Survey Political Action and Medical Societies

55 total questionnaires returned – please note that some individuals did not answer all questions

- 1) How many times have you contacted a senator or representative to address a political concern relevant to the practice of orthopaedic surgery?
 - a. Never 15 (27%)
 - b. 1-2 12 (22%)
 - c. 3-5 15 (27%)
 - d. 6-10 8 (15%)
 - e. 11 or more 5 (9%)

- 2) Please select the choice which most approximates your contributions to Political Action Committees:
 - a. Contribute regularly through financial contributions 14 (26%)
 - b. Contribute regularly through time and support 3 (5%)
 - c. Contribute occasionally through financial contributions 19 (35%)
 - d. Contribute occasionally through time and support 4 (7%)
 - e. Never contribute financially 4 (7%)
 - f. Never contribute with time and support 11 (20%)

- 3) Please circle the organizations for which you are a member and then rate their political effectiveness (1=lowest; 5=highest)
 - a. AMA 26 (47%) [1] 1 (4%) [2] 4 (15%) [3] 12 (46%) [4] 7 (27%) [5] 2 (8%)
 - b. AAOS 48 (87%) [1] 1 (2%) [2] 3 (6%) [3] 20 (42%) [4] 17 (35%) [5] 7 (15%)
 - c. OTA 48 (87%) [1] 9 (19%) [2] 20 (42%) [3] 11 (23%) [4] 7 (14%) [5] 1 (2%)
 - d. ACS 19 (35%) [1] 2 (10%) [2] 3 (16%) [3] 7 (37%) [4] 7 (37%) [5] 0 (0%)
 - e. State Med. Soc. 36 (65%) [1] 1 (3%) [2] 10 (28%) [3] 6 (17%) [4] 12 (33%) [5] 7 (19%)
 - f. State Ortho. Soc. 37 (67%) [1] 8 (22%) [2] 10 (27%) [3] 7 (19%) [4] 7 (19%) [5] 5 (13%)
 - g. Local Med. Soc. 24 (44%) [1] 11 (46%) [2] 6 (25%) [3] 3 (13%) [4] 1 (4%) [5] 3 (12%)
 - h. Local Ortho. Soc. 15 (27%) [1] 10 (67%) [2] 4 (27%) [3] 0 (0%) [4] 1 (6%) [5] 0 (0%)
 - i. Reg. Med. Soc. 7 (13%) [1] 2 (29%) [2] 2 (29%) [3] 3 (42%) [4] 0 (0%) [5] 0 (0%)
 - j. Reg. Ortho. Soc. 14 (25%) [1] 7 (50%) [2] 4 (29%) [3] 1 (7%) [4] 1 (7%) [5] 1 (7%)

- 4) Do you think there are sociopolitical issues that could be more actively addressed by the OTA?
 - a. No 11 (21%)
 - b. Yes 41 (79%)

Here are some selected responses which were added to positive responses to question #4:

1. I think OTA could better address trauma standards of practice issues, promote the specialty more, etc.
2. Medicare reimbursement.
3. Access to quality trauma care.
4. Malpractice reform.
5. RVUs to more adequately represent practice of trauma surgery.
6. Rationale Trauma System Development, nationally. Advocating for trauma patient and trauma, not just the trauma doctor. I am strongly involved at state regulatory level but do not waste my time at national level because the thrust (AMA, AAOS) appears to be “the doctor” and not “the patient” and this is a losing political tactic!
7. I think the OTA is too small a group to be effective. I have tried to serve as a liaison for our OTA group through BOC executive committee. I recommend we try to establish a more permanent link through one or more board members interested in communicating with and educating. . .
8. Poor reimbursement by government for care of uninsured/underinsured patients.
9. Better working conditions.
10. Trauma care for rural areas.
11. Poor reimbursement.
12. Trauma funding.
13. Trauma resource utilization and health insurance requirements for high-risk activities.
14. Trauma Center funding.
15. Money for management of multiple trauma, trauma centers, geriatric fx, pediatric trauma, and many issues.

New Survey Logistics of Coverage of Open Tibia Fractures

By Jeffrey M. Smith, M.D. and David Volgas, M.D.

A patient presents with an open IIIB tibia fracture without specification to proximal or distal. There is an approximately 3 x 3 cm area of exposed bone anteriorly with moderate contamination.

- 1) Who would typically provide definitive coverage for this wound, if it were your patient?
 - a) orthopaedic traumatologist
 - b) orthopaedic hand surgeon
 - c) general orthopaedic surgeon
 - d) plastic surgeon

- 2) In what time frame would this wound typically be covered?
 - a) less than 24 hours
 - b) 24 - 72 hours
 - c) 3 - 6 days
 - d) more than 6 - 7 days

- 3) What types of wound coverage would you personally consider performing yourself?
 - a) free flap
 - b) local rotational flap
 - c) fasciocutaneous flap
 - d) b) and c), but not a)
 - e) all

- 4) Which technique would you use to temporize the wound until definitive coverage can be done?
 - a) bead pouch
 - b) wound VAC device
 - c) daily dressing changes
 - d) other

- 5) What is the greatest determinant of whether a free flap will be performed at your institution within 3-6 days of injury?
 - a) any distal 1/3 wounds
 - b) microvascular surgeon availability
 - c) operating room availability
 - d) other (please specify)

- 6) If a 1 - 2 day cadaver course were available covering simple flap and soft tissue coverage, would you attend?
 - a) definitely
 - b) possibly
 - c) not likely
 - d) no

Please respond to:

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“The OTA does not endorse these technical points and formally disclaims any responsibility for their use.”

Announcements

- The Coding, Classification, and Outcome Committee expects to launch the web-based trauma registry database in September. In addition, **a users meeting is planned to view and review the database with the committee, Thursday, October 9th, following the afternoon session of the annual meeting 5:45-6:45 p.m. at the Grand America Hotel, Milano Room in Salt Lake City.** Please e-mail the OTA staff office if you would like to attend. franzone@aaos.org
- Registration is now open for the 19th Annual Meeting in Salt Lake City. If you have already registered, please share the brochure with a colleague.
- Reserve your hotel room before Labor Day at the Grand America Hotel in Salt Lake City—one of the most beautiful hotels in the US and mention OTA to get the conference rate of \$151 per night. Please call 800-621-4505.
- Kudos to Drs. Kenneth Egol and Michael Archdeacon who were the first to register online for the Annual Meeting!
- Congratulations to the 2003-2004 OTA Nominating committee: Toney Russell, M.D. (Chairman), Thomas Einhorn, M.D., David Hak, M.D., Arthur Malkani, M.D., and Jim Nepola, M.D.
- Hats off to Michael Suk, M.D., J.D., M.P.H., who was selected as a 2003-2004 White House Fellow. Dr. Suk is currently an orthopaedic trauma fellow at the Hospital for Special Surgery with Dr. David Helfet.
- Congratulations to Marc Swiontkowski, M.D., who was chosen as second president-elect for the American Orthopaedic Association. His Presidential term will run from June 2005-June 2006.
- Congratulations to Ken Koval, M.D., who was recently elected to the United States Bone and Joint Decade Board.
- Congratulations to Drs. Cramer and Tornetta who organized a successful AAOS/OTA Course in April 2003 with 173 registrants.
- The OTA is planning an OTA Fracture Management and Orthopaedic Emergency Course for January 16-18, 2004, in San Diego at the Hotel Del Coronado. Please alert your colleagues about this outstanding opportunity for orthopaedic trauma education.
- OTA committee appointments will change with the March 2004 Specialty Day Members Business Meeting. There will also be new committees formed if the bylaw changes are approved at the October 10th OTA Members Business meeting. Please contact the OTA office via e-mail or fax if you are interested in serving on a committee.
- The Gerhard Künscher Society recently announced a competition for the best scientific work about the operative or non-operative treatment of fractures, the biology of bone, and biomechanics of fracture healing. The prize is \$5000 (Euros). The deadline is June 30, 2003. Please contact Professor Vilmos Vécsei (e-mail: vilmos.vecsei@akh.wien.ac.at).

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