



# FRACTURE *lines*

The Newsletter of the Orthopaedic Trauma Association

Winter 2006

University of Louisville Hospital  
Louisville, Kentucky 40202

## 21<sup>st</sup> Annual OTA meeting

The 21<sup>st</sup> Annual OTA meeting in Ottawa was the largest OTA meeting ever. The meeting boasted 746 orthopaedic surgeons, and 585 allied health professional and industry representatives. Not surprisingly, there was a record attendance by our Canadian colleagues.

Here is a bit of history about this newsletter. The summer of 1995, ten and a half years and 27 issues ago, the “maiden Voyage” of the newsletter launched by Dr. Jeff Anglen at the helm as “editor-in-chief” began its first mission into uncharted territories. The first issue included a Presidential address by Dr. Alan Levine and a description of the upcoming 1995 annual meeting in Tampa. The OTA Residents Basic Fracture Course, then brand new, and OTA Fracture registry (Orthopaedic Trauma Data Base 4.2) were also topics of discussion. Anglen nearly single-handedly created the foundation of the newsletter, and increased discussion, chatter, and dialogue among the membership on research, practice, and clinical issues. The newsletter continued to grow and grow under his leadership and nurturing. In the Fall of 2001, the baton was passed to Craig Roberts, MD who changed the name of the newsletter to “Fracture Lines” as one of his first actions as editor-in-chief. The increasing pace and volume of information affecting the OTA required that the publication frequency of the newsletter be increased to four times per year. The newsletter went all electronic (and paperless) in December 2002, both for cost-saving and tree-saving reasons. In 2004, the newsletter won the Apex award for excellence in a professional newsletter competition. The newsletter is constantly looking for new blood to ensure its continued growth and development.

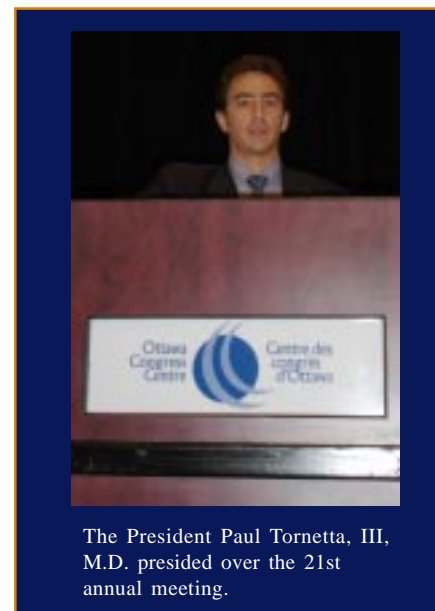
Please have a good look inside this issue for all sorts of interesting information about the John Border Lecture controversy, the results of the questionnaire on computer-assisted surgery, minutes from the Board of Directors meeting and the members meeting, an education committee update, a coding and classification committee update, a memorial tribute to Fred Behrens, MD, the OTA on-call position statement, a research committee report, an article on OTA-sponsored resident education, an article on coordination of orthopaedic trauma submissions to the AAOS, and much, much more.

The OTA Specialty Day in Chicago looks spectacular. An exciting program entitled, “Tips, Tricks, Pearls and Evidence for Managing Common Fractures,” has been organized by the OTA President Paul Tornetta and approved by the 2005 Planning Committee (Peter A. Cole, MD, Bruce G. French, MD, George J. Haidukewych, MD, Ross K. Leighton, MD, William T. Obrebsky, MD, William M. Ricci, David C. Ring, MD, Emil H. Schemitsch, MD, Andrew H. Schmidt, MD, and David C. Templeman, MD).

Please bear in mind the deadline (February 10, 2006) for papers for the 22<sup>nd</sup> Annual OTA meeting in Phoenix is just around the corner. Hope to see you in Chicago at Specialty Day.

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



The President Paul Tornetta, III, M.D. presided over the 21<sup>st</sup> annual meeting.



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# John Border Memorial Lecture Controversy

By Ross Leighton, MD, OTA Program Committee Chair  
Andy Schmidt, MD, OTA Program Committee Co-Chair

In Ottawa, the John Border Memorial Lecture was given by Dr. Robert Meek of Vancouver, who helped pioneer the introduction of modern internal fixation techniques to North America as well as advance the care of the multiply injured patient. In his presentation titled “Delaying Emergency Fracture Care-Fact or Fad,” Dr. Meek gave a contrarian’s viewpoint of the concept of “damage-control orthopaedics.” In his presentation, Dr. Meek first reviewed the proposition advanced in the early 1990’s that reamed femoral nailing caused increased pulmonary damage, noting that this idea was primarily based on the results of one retrospective study published by Dr. Pape and colleagues from Hannover. The results of that study were not confirmed in subsequent studies from many centers in North America and Europe. Dr. Meek then drew a similar conclusion about damage-control orthopaedics, drawing parallels to another retrospective paper on the topic, also by Dr. Pape and colleagues. Since Dr. Meek was very critical of Dr. Pape’s paper and based much of his conclusions on this one particular paper, the Program Committee felt that Dr. Pape should be given the opportunity to respond to Dr. Meek’s comments. Dr. Pape’s counterpoint is given below.

## Comment on the John Border Memorial Lecture 2005 given by Dr. R.N. Meek at the OTA meeting in Ottawa, 2005

Specific issues have been addressed by Dr. Meek during the JOHN BORDER MEMORIAL LECTURE at the Annual Meeting of the Orthopaedic Trauma Association in Ottawa 2005. These dealt particularly with a publication about management changes in multiply injured patients at the Department of Orthopaedic Traumatology in Hannover (Pape et al. J. Orthop. Trauma 2004, reprinted from J. Trauma 2002).

1. During the lecture, Dr. Meek accused us of having used the wrong denominators in a table (table 7) that describes a general improvement in the incidence of complications over the decades. He then summarized that our conclusion regarding a decreased ARDS incidence of patients submitted to DCO was not substantiated by the data provided. We would like to give the following clarifying comments in order to reconfirm that the data provided in the manuscript is sound and does support the conclusion cited above: The ARDS incidence was NOT calculated referring to ALL patients (table 2), as suggested during the lecture. The correct denominators were used and patients were selected as follows: We excluded patients (a) in whom retrograde nailing was performed and (b) those in whom primary fixation was delayed because of severe head trauma.

a. The fracture pattern and the indication for retrograde nails are different from antegrade nails. Retrograde nails in polytrauma patients are usually indicated when a distal fracture location, bilateral

fractures or floating knee injuries are present. Also, the complication rate after retrograde nailing is poorly described. The ARDS incidence in patients who had antegrade nails (n=99 out of 110 in the DCO era) was 15.1 % (15/99).

b. In 13 out of 14 patients with head injuries who received an external fixator, the timing of definitive surgery did not depend on the influence of the orthopaedic surgeon, but was delayed because of the severity of head injury. These cases are irrelevant regarding the incidence of ARDS, thus leaving 55 patients for evaluation. In these, the ARDS incidence was 9.1% (5/55; 9.1%, as indicated in the abstract). A more specific summary will be available in a comment on the publication of the lecture in the Journal of Orthopaedic Trauma. Dr. Meek recalculated data from table 7 from the manuscript, which we had included to demonstrate the general improvement in the rate of complications over time. We do not feel that it is appropriate to recalculate the raw data from manuscripts in this manner. Also, we are disappointed because a portion of the data that lead to the conclusion of a better outcome with DCO was made available to him prior to the lecture. This information, however, was never used: We have calculated the relative risk regarding the development of ARDS using an odds ratio. We thereby have clearly documented that a decrease from 54.6 % (ETC) to 26.4% occurred in the group with primary nailing and a decrease from 97.4 % to 22.1 % occurred when primary external fixation was performed. These numbers are indicated in the discussion of the manuscript, but were not quoted in the lecture.

2. The second concern addressed changes in the indication of plating versus nailing versus damage control. In the lecture, it was suggested that the indication for nailing was unchanged and that a switch from plating to DCO has occurred. However, this assumption, which derived from the raw demographic data, is inappropriate for the following reasons: The manuscript describes the changes in the management of major fractures over a period of 19 years at one institution (early IM nailing / early total care 1981-1989 ETC; intermediate period 1990-1992 INT; damage control era / primary external fixation 1993-2000 DCO). During the first time period (ETC), the indication for plating based on biomechanical considerations, i.e. the fracture type. It has been documented clinically and experimentally that plating does not cause systemic effects (Bosse JBJS-A 1997, Neudeck J. Trauma 1996). In contrast, both the indications and our understanding of the influence of intramedullary pressures on the inflammatory system have greatly improved. Regarding the indications, the options for interlocking have become much more advanced. Therefore, a wider range of fractures is now eligible for intramedullary fixation. Accordingly, more patients have technically been eligible for IM nailing during the latest time period. Regarding our understanding of the systemic effects of IM nailing, a perioperative burden associated with an inflammatory reaction has been proven. It has been recognized to have clinical relevance regarding unexpected deterioration of the patient’s clinical condition (Wenda Injury 1993, Pell JBJS-B 1993, Christie Tech Orthop 1996, Giannoudis JBJS-B 1999, Smith CORR 2000). It is of note that the first publications dealing with surgical procedures producing stimulation of the inflammatory systems were also not published until the early 1990’s. These studies reflected the availability of techniques to characterize and quantify molecular markers assessing the degree of surgery that induced inflammatory stimuli (Cruickshank Clin Sci 1990, Roumen Ann Surg 1993).

In summary, we do not agree with the main conclusion made by Dr. Meek, that the only time that definitive surgery should be delayed is when soft tissue problems are present. This statement is unjustified since none of the studies cited during the lecture specifically looked at the patients at high risk for developing complications.

The implementation of a staged approach of fracture treatment for severely traumatized patients (damage control orthopaedic surgery, DCO) has become increasingly important over the last decade. Today, most Northern American and European authors agree that damage control is an important strategy for selected patients at high risk of complications (Nowotarski JBJS-A 2000, Scalea J. Trauma 2000, Giannoudis JBJS-B 2003, Olson CORR 2004, Roberts JBJS-A 2005). Some discussion appears to exist as to which patient is eligible for a given degree of definitive initial surgery.

Finally, we would like to point out that there is an ongoing need for a prospective randomized trial that deals with the fracture management of polytrauma patients. This should be undertaken as a multi center approach, such as has been achieved with the LEAP study and other fine projects initiated by members of the OTA.

On behalf of the authors

Sincerely,

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## Coding and Classification Committee

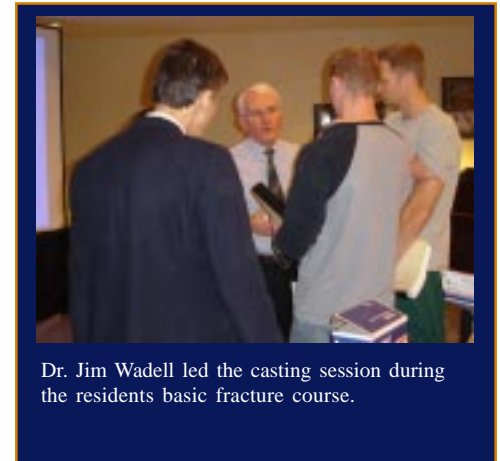
By Larry Marsh, MD

In coding, activity has centered around the AMA's Relative-Value Update Committee's (RUC) meeting that was in late August in Chicago. A subcommittee led by Brad Henley submitted eight codes on behalf of the OTA, and they were surveyed through the AAOS membership. These codes were mostly post-traumatic reconstructive procedures where there was good reason to think that surgeon effort was under valued. Larry Marsh, MD and David Volgas, MD presented the codes supported by Dan Sung, JD, Policy Analyst of the AAOS and Brad Henley, MD, Chair of the AAOS Committee on Coding, Coverage and Reimbursement. The RUC has completed the review and their recommendations will be submitted to CMS. The

OTA codes have fared very well to this point. Four codes (20680 removal of implant deep, 24430 repair of nonunion/malunion humerus without graft, 27465 femoral shortening, 27709 osteotomy tibia and fibula) have been recommended for RVU increases ranging from 10-75%. Based on the survey data, another code (27470 repair nonunion/malunion femur without graft), was recommended for no change and three of the codes (20692 application of multi-plane fixator, 27472 nonunion/malunion femur with graft, and 27720 repair of nonunion tibia without graft) were deferred for CPT review. Ongoing work involves suggesting further trauma codes for CPT revisions or additions.

The committee is working on details of a fracture classification initiative to republish the OTA classification both in a compendium of JOT and electronically on the website. The plan is to work cohesively with efforts of the AO Committee on Classification, so these new publications will provide maximum value for the members of the OTA. Members interested in this classification project should contact Larry Marsh, MD.

The OTA fracture database is offered as a member benefit. Check with the OTA Staff Office for a password [ota@aaos.org](mailto:ota@aaos.org) and then log onto the website to look at this user friendly tool to help members with clinical research projects, research databases, and multi-institutional collaborations which will provide access to past fracture cases for educational purposes.



Dr. Jim Wadell led the casting session during the residents basic fracture course.

## OTA On-Call Position Statement

As part of its stated mission, the *Orthopaedic Trauma Association (OTA)* is committed to excellence in the treatment of patients with musculoskeletal injuries. Recent reports indicate that emergency departments and hospitals are experiencing difficulty finding specialty surgeons including orthopaedic surgeons to provide on-call services.

The OTA believes that orthopaedic surgeons are the most appropriate provider of acute musculoskeletal care. A loss of the availability of this resource in Emergency Departments will negatively impact the quality of musculoskeletal trauma care delivered in the United States.



This access problem is exacerbated by several factors:

Many hospitals do not apply sufficient resources to allow quality care delivery to the trauma patients. Working within such a compromised system provides disincentive to surgeons who attempt to provide such care. In the context of overall rising cost and decreasing reimbursement, the financial burdens associated with provision of on-call services have become difficult for orthopaedic practices to bear. Many uninsured and underinsured patients now use Emergency Departments as a primary source of health care leaving those covering these facilities with a disproportionate burden of providing uncompensated service.

There is a perceived increase in liability associated with the treatment of higher risk problems such as severe trauma which is predisposed toward poorer outcome. This has influenced orthopaedic surgeons to avoid such activity.

The combined effect of these factors as well as others has resulted in decreasing access to orthopaedic surgeons for patients with musculoskeletal injuries. Analysis of these issues suggests that such access is likely to further decrease in the future without changes in the emergency healthcare environment.

The *Orthopaedic Trauma Association* believes that the following principles are paramount in the development of a solution to this developing health care crisis:

1. Orthopaedic surgeons are the best trained caregivers to evaluate and treat patients with significant musculoskeletal injuries.
2. Orthopaedic surgeons, hospitals and legislators share a duty to the community in which they serve to provide timely services to patients with musculoskeletal injury.
3. Musculoskeletal trauma care from a qualified orthopaedic surgeon should be available to individuals with significant injuries 24 hours per day and 7 days per week within their communities. If these responsibilities cannot be met, appropriate need based transfer policies should be established.
4. Access to specialized high-level care from orthopaedic trauma specialists should be available on a primary or referral basis for those patients with severe injuries to the musculoskeletal system that cannot be adequately managed by a non-trauma specialist orthopaedic surgeon.
5. Orthopaedic surgeons have been trained in basic musculoskeletal trauma care and should maintain the skills needed to provide basic musculoskeletal trauma care services (i.e. splinting, fasciotomies, debridement of open wounds and basic internal and external fixation application.)

In support of these principles, we support adoption of the following specific guidelines with regard to provision of emergency musculoskeletal trauma services:

1. Emergency care for injuries to the musculoskeletal system should be provided by a properly trained orthopaedic surgeon prepared to consider both the acute as well as the long term reconstructive and rehabilitative needs associated with musculoskeletal injury.
2. Meaningful liability reform is necessary to reduce physicians risk associated with the delivery of emergent care and prevent attendant insurance costs from driving orthopaedic surgeons away from providing necessary emergency musculoskeletal care.
3. The financial burden for provision of emergency musculoskeletal services on-call should be borne jointly by hospitals, the public and physicians. The challenges associated with disruption in medical practice and lifestyle are borne by the physicians alone. Therefore orthopaedic surgeons must be compensated for their on-call services. Payment for such services should reflect the work and liability risk associated with these services.
4. Hospitals need to provide adequate resources both in terms of personnel and facilities to ensure that provision of emergency musculoskeletal trauma care can be accomplished in a safe and timely fashion regardless of the time of the day at which that care is needed. Non-emergent conditions requiring surgery should be addressed during regular working hours when regular staffing and ancillary help is available. Emergency conditions should be addressed surgically within a medically appropriate timeframe. The responsibility for determination of the distinction between urgent and emergent conditions must rest with the treating orthopaedic surgeon, as he or she is best capable of combining information about the individual patient's condition, the treatment options for that condition and the available evidence in the medical literature.
5. Hospitals without continuous availability of musculoskeletal trauma specialists should develop transfer agreements with centers where such specialists practice to allow for the appropriate transfer of patients with musculoskeletal injuries whose complexity exceeds the capability of the initial treating institution. Such transfers should always be based on complexity of injury and the best interest of the injured patient's musculoskeletal condition. Such transfers should never be based on an injured patient's ability (or lack thereof) to pay for such services. Transfers other than those prearranged by standing hospital agreements should be communicated from the consulting orthopaedic surgeon to the receiving orthopaedic surgeon after an appropriate evaluation (history and physical exam) by the referring physician.
6. All orthopaedic surgeons should make themselves available to their hospital's on-call list during the active years of their practice at that institution. In providing emergency depart-

ment coverage, hospitals should not impose an undue burden on orthopaedic surgeons offering such coverage. Hospitals and orthopaedic staff should negotiate an appropriate amount of on-call coverage that is not burdensome to either party.

7. Hospital systems MUST provide necessary facilities, equipment, and ancillary services necessary to provide emergent care to those with musculoskeletal injury. A general scheme of these elements may be seen in the OTA optimum resource guidelines, which are the minimum standard. <http://www.ota.org/downloads/05EMTALA.pdf>
8. The *Orthopaedic Trauma Association* calls on the American Academy of Orthopaedic Surgeons (AAOS), the American Board of Orthopaedic Surgeons (ABOS), the American Orthopaedic Association (AOA), and all specialty societies to work toward mechanisms to assure the sufficient participation of their membership on-call lists at their institutions including evidence of such participation as a qualification for membership and certification.
9. AAOS and the ABOS must monitor the orthopaedic workforce to insure availability and distribution of orthopaedic surgeons to meet the needs of the nation's Emergency Departments.

James V. Nepola, MD  
Health Policy Committee Chairman  
Orthopaedic Trauma Association

Paul Tornetta, III, MD, President  
Orthopaedic Trauma Association

December 2, 2005

## OTA Offers New Research Grants By Ted Miclau, MD, Research Committee Chair

At the October 2005 OTA Board Meeting, the Board of Directors approved a restructured research grant program, including the addition of one multi-year Clinical Research Grant and five Resident Research Grants to be awarded annually. The Clinical Research Grant will be for an amount up to \$50,000/year (3-year funding cycle) and solicited through a request for proposals (RFP) in the following areas: Treatment of Femoral Neck Fractures in Elderly Patients; Timing of Non-Life or Limb-Saving Orthopaedic Surgery in the Multiply Injured Patient; and DVT Prophylaxis in Extremity Fractures. Resident Research Grants will be awarded for up to \$10,000/year (1-year funding cycle). In addition, the amount for a Clinical Research grant (previously up to 25,000/year for 2 years) was increased to \$40,000/year (2-year funding cycle). The amount available for a Basic Re-

search Grant will remain at \$25,000/year (1-year funding cycle).

Additional information on the grant awards and application process can be found on the OTA website. Some additional details on the grants are listed below:

### Deadlines for research grants for 2007:

- April 1<sup>st</sup>: Pre-proposal Applications (available on the OTA website beginning January 10<sup>th</sup>) due for OTA RFP-directed Clinical Research Grants, and Clinical and Basic Research Grants.
- August 1<sup>st</sup>: Invited full-grant submissions are due.

### Resident Research Grants:

Applications will be accepted twice during 2006.

- February 1<sup>st</sup> (June 1<sup>st</sup>, 2006 Award)
- August 1<sup>st</sup> (January 1<sup>st</sup>, 2007 Award)

Note: Resident grant applications will not require full pre-proposals, but will be abbreviated, full submissions.

The OTA would also like to congratulate the 2006 OTA Research Grant Recipients and their corporate grant sponsors:

**Principal Investigator:** Mohit Bhandari, MD

**Amount Funded:** \$50,000

**Co-Investigator:** Emil H. Schemitsch, MD  
(two years)

**Grant Title:** Fluid Irrigation Techniques in Patients with Open Fracture Wounds: A Multi-Center Blinded Randomized Controlled Trial (F.L.O.W.). A Pilot Study.

**Grant Funded by:** OTA/DePuy, a Johnson & Johnson Company

**Principal Investigator:** Michael J. Gardner, MD

**Amount Funded:** \$25,000

**Co-Investigator:** Joseph M. Lane, MD

**Grant Title:** The Role of Parathyroid Hormone in the Mechanosensitivity of Fracture Healing

**Grant Funded by:** OTA/Stryker

**Principal Investigator:** David J. Hak, MD, MBA

**Amount Funded:** \$25,000

**Grant Title:** Investigation of Stem Cells in the Management of Atrophic Nonunions

**Grant Funded by:** OTA/Medtronic

**Principal Investigator:** Thomas F. Higgins, MD

**Amount Funded:** \$25,000

**Co-Investigator:** Brian D. Johnson, MD

**Grant Title:** Effect of IGF-1 and Range of Motion on Articular Cartilage After Fracture

**Grant Funded by:** OTA/EBI

**Principal Investigator:** Sanjeev Kakar, MD

**Amount Funded:** \$25,000

**Co-Investigator:** Paul Tornetta, III, MD

**Grant Title:** Anabolic Mechanisms of PTH

During Fracture Repair

**Grant Funded by: OTA/Zimmer**

**Principal Investigator:** Melvin P. Rosenwasser, MD

**Amount Funded:** \$50,000

**Co-Investigator:** Brian W. Su, MD

**Grant Title:** A Prospective, Randomized, Double-Blind, Placebo-Controlled Study of the Effects of Risedronate (Actonel®) on Fracture Healing in Elderly Patients with Intertrochanteric Hip Fractures

**Grant Funded by: OTA/Smith & Nephew**

**Principal Investigator:** Emil H. Schemitsch, MD

**Amount Funded:** \$49,000

**Co-Investigator:** Michael D. McKee, MD

(2-years)

**Grant Title:** A Prospective Randomized Trial Investigating the Effect of a Novel Reamer-Irrigator-Aspirator on the Incidence of Fat Embolism and Respiratory Function During Intramedullary Nailing of Femoral Shaft Fractures.

**Grant Funded by: OTA/AO North America**

**Principal Investigator:** Douglas E. Stull, MD

**Amount Funded:** \$49,218

**Co-Investigator:** Michael J. Bosse, MD

**Grant Title:** Radiation Prophylaxis for Post-Traumatic Heterotopic Ossification of the Elbow

**Grant Funded by: OTA/Synthes**

**Total: \$298,218**

## OTA Sponsored Resident Education: Far from “Basic”

By William M. Ricci, MD

Education is a core purpose of the Orthopaedic Trauma Association. The OTA became formally involved in resident education with the inaugural OTA Resident Course in 1995 chaired by Robert Winkquist, MD. Since then, this course has been refined under the direction of Dave Templeman, MD and Jeff Anglen, MD. This year the reins were handed to Kevin Pugh, MD. The course, attended by 120 residents, was a great success which Dr. Pugh modestly attributed to “the enthusiastic support of the membership, the hard work of the planning committee, and the OTA staff.” This year’s faculty included over 70 orthopaedic trauma surgeons with over 600 years of combined experience. The quality of the instruction was truly unsurpassed. Dr. Pugh pointed out that this course serves multiple purposes, “the

course is essential as it allows us to fulfill our education mission, to put a human face on what is thought to be a tough specialty, to market the OTA to potential new members, and to recruit future trauma surgeons to our fellowship programs.” Dr. Pugh reminded us, “It is never too early to volunteer to help next year.” If interested, contact the OTA Staff Office [ota@aaos.org](mailto:ota@aaos.org).

This year’s Winkquist Cup winner, awarded to the highest rated lab, was the Calcaneus Fractures Section 2 lab led by David J. Stephen, MD. Congratulations! They scored a perfect 5.0 and comments were accordingly complimentary: “One of the best labs”, “Excellent lab,” and “Best of the conference.”

Despite the success of this course, the Education Committee, chaired by Michael Baumgartner, MD, has made one significant change; the name. With sections and labs devoted to general topics such as “Fracture Healing,” “Surgical Fixation,” “Casting and Functional Bracing,” “Problems in Fracture Care,” as well as anatomically focused topics including long bone, hand, foot, and spine injuries, it is obvious that this course is “far from basic.” It is a pleasure to announce its new name, the “**Orthopaedic Trauma Association’s Resident Comprehensive Fracture Course.**” The committee felt that this name better reflects this course’s scope.

Dr. Baumgartner summarized the Education Committee’s efforts on resident education by stating that, “The OTA’s strategy to influence resident education goes much beyond two courses, as evidenced by the available lecture series on the web, the bibliography, the OKU Trauma 3, resident membership, etc. Our plan to reorganize the web content for improved access and linking to other sites will be rolled out within the next 12 months, and represents a needed step in a continuing effort to make the OTA site a user friendly guide and resource for the best possible care of the trauma patient.



Are we having fun yet? A teaching moment during the OTA residents course with Cliff Jones, MD and residents Scott Klein and Sean Rocha.

Education, as one of the core missions of the OTA, and resident education in particular, is one of the focus issues of OTA President, Paul Tornetta, III, MD who stated that “The OTA is uniquely positioned to provide the best, most comprehensive, and most unbiased resident education programs.” With the help of the membership and industry partners, we hope to further the OTA’s leadership role in this critically important mission of the organization.” Indeed, surveys of course participants indicate how absolutely essential members are to a resident’s decision to attend the OTA resident course. In an informal survey given at the 2005 meeting, 50% note the recommendation of their “trauma mentor” or residency director as the primary factor in

choosing to attend.

Now is a perfect opportunity for members to support another OTA sponsored resident course. The second **Residents Advanced Trauma Techniques Course**, formerly known as the Residents Regional Course, will be held at the Sheraton Buckhead Hotel Atlanta, Atlanta Georgia, May 5 and 6, 2006. Michael Stover, MD should be congratulated for his efforts to pioneer this additional educational offering, as last year's inaugural course was a tremendous success. He is joined this year by me as co-chair. The course focus, as the name implies, is on current techniques of fracture care. Although faculty was preferentially selected from members regional to Atlanta to reduce travel costs, the 14 faculty are all seasoned presenters. To maximize the educational benefit for the participants, each speaker was asked to speak only on subjects in which they have particular expertise. Presenters will provide practical technical solutions to common, as well as controversial problems. Also, this year case discussion sessions are expanded to meet the request of last year's participants. Educational grants to defray registration costs, generously provided by industry sponsors, should be available on a first-come first-served basis through the OTA office. Syllabus and registration information are available on the OTA web site, and other promotional materials can be provided upon request. However, as the survey says, member recommendation is by far the most important factor in making the course successful. We hope to see your residents in Atlanta.

## Alfred F. Behrens, MD In Memoriam

Dr. Alfred F. Behrens, 64, chairman of orthopaedics at UMDNJ, died on Wednesday, November 16, 2005. Dr. Behrens was Professor and Chairman of the Department of Orthopaedics at the University of Medicine and Dentistry of New Jersey-New Jersey Medical School for the past 13 years. Previously, he was a Professor at Case Western Reserve University in Cleveland and had worked at St. Paul-Ramsey Medical Center in Minnesota and as an Assistant Professor in the Department of Orthopaedic Surgery at the University of Minnesota. Dr. Behrens was a member of the American Academy of Orthopaedic Surgeons and the American Orthopaedic Association and the Orthopaedic Trauma Association. He served in advisory positions for the Center for Disease Control and the National Institute of Health. In addition, he advised on orthopaedic publications, including the *Journal of Orthopaedic Research*, the *Journal of Ortho-*



*paedic Trauma*, and the *Journal of Bone and Joint Surgery*. Dr. Behrens studied at the University of Bordeaux in France, Westminster Medical School in the United Kingdom and the University of Zurich in Switzerland, where he earned his medical degree. He completed a master's degree in experimental surgery and his orthopaedic residency at McGill University in Montreal. Born in Europe, he lived in Switzerland, Canada, Minnesota, and Ohio before moving to Madison more than 13 years ago. Surviving are his wife, Valerie's sons, Thomas, Mark and Erik; his mother, Lydia Behrens, and a sister, Sylvia Bieri.

## Calendar of events for 2006

- February 1<sup>st</sup> is the Kenneth Johnson Fellowship Award deadline and Resident Research Application deadline.
- February 10<sup>th</sup> is the 22<sup>nd</sup> annual meeting abstract deadline. Submit online: [www.ota.org](http://www.ota.org).
- February 20<sup>th</sup> ICL Symposia topics for 2007 due in staff office.
- March 25<sup>th</sup> OTA Business Meeting and Specialty Day Meeting: Tips, Tricks, Pearls and Evidence for Managing Common Fractures in Chicago, Illinois. Program Chair: OTA President 05-06: Paul Tornetta III, MD.
- April 1<sup>st</sup> Pre-Proposal Research grant deadline.
- April 27-30<sup>th</sup> AAOS/OTA 6<sup>th</sup> Comprehensive Trauma Course: Current Management Concepts, Surgical Techniques & Practices in St. Augustine, Florida. Course Directors: Christopher T. Born, MD and Michael R. Baumgaertner, MD.
- May 5-6<sup>th</sup> in Atlanta, Georgia, Residents Advanced Trauma Techniques Course, Co-Chairs: Michael D. Stover, MD and William M. Ricci, MD.
- July 1<sup>st</sup> Membership Application deadline.
- August 1<sup>st</sup> Full Research Proposal due; Resident Research Applications due (2<sup>nd</sup> opportunity).
- September 5<sup>th</sup> register and obtain hotel room for the OTA annual meeting in Phoenix, Arizona.
- October 5-7<sup>th</sup> OTA 22<sup>nd</sup> Annual Scientific Meeting at the Arizona Biltmore Hotel.
- October 4<sup>th</sup> Basic Science Focus Forum and Pre-Meeting Events. OTA President 06-07: Michael J. Bosse, MD, Chair: Ross K. Leighton, MD, Co-Chair: Andrew H. Schmidt, MD, Local Host: Michael J. Brennan, MD.
- October 4-7<sup>th</sup> Residents Comprehensive Fracture Course in Phoenix, Arizona, Chair: Kevin J. Pugh, MD.



# Coordination of Orthopaedic Trauma Submissions to AAOS Annual Meeting

By Ken Koval, MD and the Education Committee

In an effort to coordinate submission of Trauma related Instructional Course Lectures (ICLs) to the AAOS Annual meeting, we are going to try to centralize submission of ICL proposals through the Education Committee of the OTA. The goal of this process is to try to avoid duplication of proposals, increase OTA membership involvement at the AAOS annual meeting, and insure a wide spectrum of offerings.

For submissions to the 2007 AAOS annual meeting, the Education Committee is going to try the following procedure: Members should submit ICL topic proposals to the OTA Staff Office [ota@aaos.org](mailto:ota@aaos.org) by Monday, February 20th. The proposal should define the topic and anticipated lecture titles, but should not list specific speakers. The Education Committee will have a conference call to review the proposals and rank highly those that would best serve the mission of the OTA. \*Moderators (not members of the Committee) would be

selected. This committee may also rank additional topics not proposed by OTA membership. The selected Moderator will be encouraged to choose Faculty from the OTA membership, but will not be forced to do so. It will be up to the Moderators to choose the Faculty, fill out the AAOS application and make the sample handout (if needed). The completed application will be submitted to the OTA at least ten days before the AAOS deadline, so the Education Committee can ensure that the applications are properly submitted and the faculty fairly selected. The OTA office will send in the application to the AAOS as OTA sponsored ICLs.

Again, the goal of this process is to try to increase OTA membership involvement at the AAOS annual meeting. This process will be a work in progress for the 2007 AAOS. Of course, OTA members can also submit ICL proposals directly to the AAOS, but these proposals will not have the opportunity to be labeled as OTA sponsored ICLs.

## ORTHOPAEDIC TRAUMA ASSOCIATION BOARD OF DIRECTORS MINUTES

October 19, 2005  
By Robert Probe, MD

### Presidents Report Paul Tornetta, III, MD

- Project Teams Appointed – Since the last meeting of the BOD Dr. Tornetta felt as though two issues have arisen which require further study by the OTA. Two ad hoc committees

have been formed to address these issues.

1. Guidelines for Timing of Emergent vs Urgent Procedures - Chair: Larry Bone
  - Several groups including practicing Orthopaedist, the College of Surgeons, the AAOS and the OTA would appreciate evidence based direction in timing care provided to victims of orthopaedic trauma. The charge of this committee is to address this issue considering the influence of the multiple variables present within the trauma patient. These variables include polytrauma, head injury, open fractures, pediatric fractures, spine fractures, foot trauma and pelvic trauma. Committee members will review progress to date. The OTA looks forward to evidence based guidelines and identification of areas of need for further research.
2. Hospital Quality Metrics - Chair: Steve Olson
  - With “pay-for-performance” on the horizon and public dissemination of quality metrics becoming increasingly available, Dr. Tornetta felt as though the OTA should investigate its potential role as a defining leader in establishing metrics for Trauma Quality. This subject is projected to be an issue of significant discussion at the March 22 BOD meeting. In the interim, this committee will investigate feasibility of OTA development of metrics and oversight for this process with probable partnership with the NQF.
  - Dr. Tornetta related the historic success of industry sponsorship of OTA related educational events. Drs. Baumgaertner and Tornetta plan to meet with representatives of six leading Orthopaedic Trauma companies 10/20/05 to explore options to further this relationship.
  - Kathryn Cramer Memorial Funds – As of Aug 31, 2005, \$5000 in donations had been received by the OTA in honor of Kathy Cramer. The Board discussed appropriate means of utilizing existing and future funds to memorialize this significant OTA contributor. While all supported this concept, the challenge of providing appropriate avenues of recognition for other past and future deceased leaders was discussed. Consideration will be given to pooling of resources to create and sustain support for a worthy cause. Future discussion is planned.
  - Research AAOS Capital Hill Days – 2004 was the inaugural year for this Academy initiative. The opportunity to place physicians and patient before representatives and senators was felt to be a hugely successful initiative. Plans are being made to repeat this in 2006 with two OTA physician representatives and patients. Dr. Pollak has agreed to participate. Other physicians and patient volunteers are being sought. Contact the Staff Office if interested [ota@aaos.org](mailto:ota@aaos.org).



The view from the podium at the Resident's Fracture Course



## Report of the CFO

### Alan Jones, MD

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#### General Fund

- General Fund Balance Sheet (August 31, 2005) \$774,000
- 2005 Budgeted Revenue of \$1,332,000 and Budgeted Operating Cost of \$1,324,000
- Actual 2005 through August 31st is \$584,000 revenue with \$505,000 cost.
- Early attendance indicators for the annual meeting are high suggesting potential for increase over budgeted revenue.

#### Research Fund

- With transfer of \$200,000 from the General Fund, the Research fund is at \$2,994,000
- Income continues to outpace expenditures. The need to increase the number of quality grant applications was expressed to show production for donations.
- Directed Orthopaedic Research Grants – This concept was introduced to become responsive to the interest of potential donors and modeled after similar statute within OREF. Proposed structure included: (see agenda book page 37 for details).
  - Directed portion must be matched with unrestricted portion
  - Unrestricted portion must equal prior year's contribution
  - No ownership of results and no control of reporting
  - Projects to be awarded based on request for proposal response and administered through the research committee
  - Motion to establish this option as outlined made, seconded and passed unanimously.

## Expansion of the Research Mission of the OTA - Discussion led by Dr. Tornetta

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- Discussion was initiated by a report of the Research Committee Chair; Dr. Miclau. This year eight grant applications were funded for a total amount of 298K. This year's cycle included 45 pre-proposals of which 21 were invited to provide full submission. Unusually, only 13 of those invited to submit full proposals followed through with complete submission. All four of the repeat

submissions were funded based on improvements in the proposal.

- In conference call in conjunction with Dr. Marsh, the following language was adopted for proposals of clinical research projects.

*“Clinical studies which require a research database should utilize the OTA database. Log-on and passwords for members are available through the OTA office.”*
- Several initiatives of the research committee were presented and discussed. These included:
  - Written reviews of pre-proposals and full grants provided to authors
  - Continued sponsorship of members to OREF grant seminars (Steve Olson & Mike Stover)
  - Grant writing seminar in conjunction with the annual meeting (led by Dr. Miclau)
  - Research mentorship program
  - Initiation of biannual reviews
  - The Board congratulated and endorsed all of these existing and inchoate initiatives.
- General Discussion was carried out focusing on two topics intended to evolve research:
  - Encouragement and development of young investigators
- Unanimous support of concept that OTA should be involved in developing young investigators
- Specific recommendations to be researched include:
- Extend invitation to attend OTA and other grant writing seminars to those young investigators submitting OTA grant applications
- Assign mentors to worthy projects at the pre-proposal level
- Make statisticians and trialists available for consultation and support
- Foundation for Orthopaedic Trauma committed \$50,000 annually for three years to fund Resident Research – These resources will be distributed in 5 grants of up to \$10,000 beginning with the 2007 distribution year. Proposals to be evaluated with the existing research committee structure. A motion was made, seconded and passed unanimously to create this category of research grant as outlined.
  - Establishing grant levels that would lead to multi-centered clinical work of sufficient quality to lead to higher levels of funding from other agencies

- All Board members were in agreement with the concept.
- Discussion points:
  - Dollar amount
  - Length of grant
  - Defining project topics
  - Need for annual review
- After significant discussion, a motion was made, seconded and unanimously adopted to:
  - Create a new category of multi-centered clinical research grants funded up to \$50,000 per year for up to three years.
  - Areas of project interest would be defined by the Board and RFP's extended to membership.
  - Project specifics and protocols would be defined by the applicant.
  - Applications would follow protocols similar to those existing for single-center grants.
  - Continued funding beyond the first year would be dependent upon satisfactory annual review by the research committee.
  - Fund Development Committee to explore opportunity for further support of the research mission
    - Foundations that support medical research
    - Patients
    - Non-traditional industry
  - Question was posed regarding expansion of the research committee to 11 members to accommodate some the growth and increased scope of responsibility assumed by the committee. Chairman Miclau suggested that he felt the existing committee had the necessary work capacity. Should this situation change he would request expansion through the Board of Directors.
- and Dr. William Schwab, President elect of the AAST.
- Activity of the OTA is occurring in parallel to Task Forces created by both the AOA and AAOS. OTA Board representatives are present on both of these task forces.
- The Board of Directors of the OTA expressed unanimous concern over the quality of Orthopaedic Trauma care that would be provided by acute care surgeons. The ability for these surgeons to develop a curriculum in Orthopaedics that would provide sufficient experience to provide safe quality care seemed doubtful.
- Dr. Swiontkowski outlined the lengthy process that would be required to achieve recognition by the ABMS. Requisite steps would include:
  - Demonstrate the uniqueness of this body of knowledge
  - Define a curriculum
  - Create training centers and define scholarly work
  - ABMS assembly must pass
  - Final approval from the 22 member boards including the ABOS and the ABNS
  - CAQ in hand surgery took eight years to go through this process
  - Potentially helpful to align ourselves in opposition with ABNS
- The point was made that hospitals could grant privileges without sanctioned Specialty Board Certification.
- Dr. Tornetta plans to perform a study examining the percentage of urgent orthopaedic procedures which could be performed by a non-orthopaedic acute care surgeon. This will be a repeat a study performed by General Surgery authors. OTA members potentially interested in participation should contact Dr. Tornetta.
- Discussion was carried out regarding the concept of gauging the desire of general surgery residents in providing orthopaedic care through a questionnaire. After some discussion this was felt not to be advisable as results would do little to support the OTA position.
- Board members felt as though the operations by military front line providers should be taken into consideration as position statements are drafted.

## The ACS Proposed Acute Care Surgeon Discussion led by Dr. Tornetta

- The continued efforts of Dr Steven Shackford to promulgate the concept of an acute care surgeon as proposed in his editorial article in Journal of Trauma (2005, pg 663) were discussed. Dr. Tornetta has had discussions with Dr. Shackford which have essentially come to an agreement to disagree. Future meetings are planned with Drs. Tornetta and Bosse of the OTA, Dr. Shackford,

## Membership Committee John Gorczyca, MD

The Membership Committee has reviewed and recommended the following slate of 76 new Members:

15	Active
3	Associate to Active
1	Community to Active
6	Associate
25	Community
22	Resident
4	International

At the time of the Board Meeting applications were incomplete on four individuals each lacking a letter of recommendation. A motion was made, seconded and unanimously passed to accept the list as submitted including those with deficient applications if there deficiencies were corrected promptly.

Other action:

- Total membership for 2006 is 651; voting members total 354.
- Recommendation to remove “Orthopaedic Transactions” as a qualifying publication was made. This was moved, seconded and unanimously passed.
- The dilemma of dealing with Orthopaedic Fellows was presented. This category intermediate between Resident and Associate/Community does not appear to be addressed with the description of the current membership categories. This received discussion and consensus was built around the concept of “candidate” member as used by the AAOS. Bylaw language based on the recommendation to extend eligibility to five years beyond the completion of residency will be drafted by Dr. Olson and presented to the Board of Directors for consideration.
- Additional bylaws change will be the waiving of dues for any category of membership for those in active duty military during any portion of a membership year. Motion to support this change was made, seconded and unanimously approved.

## Health Policy Committee Report

### Jim Nepola, MD

- “On-Call Position Statement” – Jim Nepola has created a draft, four page document outlining the position of the OTA with regard to provisions for delivering emergent orthopaedic care. This document will be forwarded to Board members for comment and revision via email.
- Request has been made to the OTA by Dr. Robb on behalf of the William Tipton Endowment Committee to support their goal of creating a William W. Tipton Leadership award endowed at \$150,000. After discussion, motion was made, seconded and unanimously approved to support this effort with a \$2,500 contribution.
- Request was made to the OTA by John Dormans on behalf of Health Volunteers Overseas (HVO) Orthopaedics Overseas to support their humanitarian and international outreach efforts. While the entire Board commended their work there appeared to potential for conflict with donations of a not-for-profit to another not-for-profit. Bob Ostrum volunteered to serve as liaison to this group and explore opportunity for collaboration.

## Quality Metric

### Steve Olson, MD

- Background:
  - Definition: Quality Metric - A mechanism to quantify the quality of a selected aspect of care by comparing the process of care to a measurable criterion.
  - “To Err Is Human” report by the Institute of Health in April 2000 brought attention to the incidence of medical errors
- Major initiatives in USA that have developed since
  - IHI 100,000 Lives
  - Leapfrog group
  - SCIP
  - NSQIP
- Reasons for OTA to become involved
  - Improve patient care
  - Bring attention to Orthopaedic Trauma
- Strategy to be explored
  - Partner with NQF
  - Develop quality indicator
  - No small undertaking
- A validated metric used for quality reporting would likely require 30 months
- Estimated cost of \$750,000
- Lesser goals could be accomplished at less cost
- Plan to research the issue:
- Web-based forum to garner OTA member input
- Create ad-hoc committee to assist with preliminary literature review for aspects of Orthopaedic Trauma to focus on for quality metrics
- Ask one or several leaders in evidence based literature to help with this preliminary step
- Report to Board at AAOS 2006.

## Committee Reports

- The Board was asked to pre-read committee reports submitted from these groups: These reports were contained on pages 93 thru 110 in the Board Agenda Book.
  - Coding and Classification: Larry Marsh
  - Education Committee: Mike Baumgaertner
  - Evaluation Committee: David Templeman
  - Fellowship and Career Choices: Tracy Watson
  - Fund Development Committee: Bruce Heppenstall
  - International Committee: Charles Court-Brown
  - Mass Casualty Response Committee: Chris Born
  - Newsletter Committee Report: Craig Roberts
  - Website Report: Jeff Anglen
  - Orthobiologic Committee Report: William DeLong
- Motion was made, seconded and unanimously accepted to accept these reports as submitted.



## Congratulations to New Members: The 2005 New Member List

### ACTIVE

Daphne M Beingessner, MD  
Gary E Benedetti, MD  
Gregory K Berry, MD  
David Casey, MD  
Wade Gofton, MD  
Keith Alan Heier, MD  
David Joseph Jacofsky, MD  
Michael Langworthy, MD  
Eric Lindvall, MD  
Michael Todd Mazurek, MD  
Timothy McConnell, MD  
Matthew Mormino, MD  
Brad A Petrisor, MD  
Rudy Reindl, MD  
Timothy Weber, MD

### ASSOCIATE TO ACTIVE

Theodore Toan Le, MD  
Mark Lee, MD  
Heather Vallier, MD

### COMMUNITY TO ACTIVE

Stuart Gold, MD

### ASSOCIATE

Enes M Kanlic, MD  
Arvind Nana, MD  
Jeffrey Richmond, MD  
Howard S Richter, MD  
Steven H Ryder, MD  
Franklin D Shuler, MD, PhD

### COMMUNITY

Scott Beck, MD  
Julius Brecht, MD  
David Brokaw, MD  
Kenneth Cobbs, MD  
Thomas Csencsitz, MD  
Richard Gehlert, MD  
Patricio Grob, DO  
Benjamin M Hicks, MD  
Gary Steven Jones, MD

Alan H Klein, MD  
Thomas Lange, MD  
Bruce Levy, MD  
Mark Olson, MD  
Mitchell Rothenberg, MD  
Anthony Gerard Sanzone, MD  
Andrew T Saterbak, MD  
Robert Schutt, Jr, MD  
Cary Schwartzbach, MD  
Milan Sen, MD  
Andrew Trenholm, MD  
Rajendra Prasad Tripathi, MD  
Walter Virkus, MD  
Philip Wilcox, MD  
John D Wyrick, MD  
Paulo Lourenco, MD

### RESIDENT

Matthew R Craig, MD  
Justine Marion Crowley, DO  
Bradley R Dart, MD  
Jason Evans, MD  
John C. P. Floyd, MD  
Robert Gaines, MD  
Michael Gardner, MD  
Stuart Trent Guthrie, M.D.  
Amir Jahangir, MD  
Michael S Kain, MD  
Steve C Lochow, MD  
Rakesh, Mashru, MD  
Samir Mehta, MD  
Christopher Mutty, MD  
Saam Morshed, MD, MPH  
Robert Nathaniel Reddix, MD  
Jeff Eric Schulman, MD  
Judith A Siegel, MD  
Scott Andrew Swanson, MD  
Henock Wolde-Semait, M.D.  
Boris A Zelle, MD  
Navid Ziran, MD

### INTERNATIONAL

Sudhir Shankar Babhulkar, MD  
Federico A Bonnelly, MD  
Jan Paul M Frolke, MD, PhD  
Tobias Hufner, MD

# Members Business Meeting

## Friday, October 21, 2005

By Robert Probe, MD

### CFO Report - Alan Jones

- Record attendance at annual meeting should close out 2005 books on a positive note.
- The research fund has almost reached \$3,000,000.
- Multi-centered multiyear trials were endorsed by the Board of Directors and will consume greater amounts of the research fund. In light of this, there continues to be need to search for continued and expanded funding sources. The newly established "Fund Development Committee" will pursue this goal.

### Steve Olson - Bylaws proposed

- Change in Presidential line from three to five years with the addition of a second Past-President and a second President-Elect
- Education committee increase by two people with nonvoting resident member
- Evaluation committee creation.
- **Motion made, seconded and passed to accept all three proposals as previously written and distributed.**

### Membership - John Gorczyca, MD

- Charles Court-Brown recognized for ad-hoc international contributions
- 80 applications. 74 approved. Of the remaining, 4 were awaiting letters of recommendation and 2 were fellows prior to Board Certifications.
- 34 members have yet to pay 2005 dues. These individuals will be contacted, and provided the option of continued membership support or loss of privilege.
- Brief discussion of proposed Candidate membership category to include:
  - Resident
  - Fellows
- International Growth
  - 2 letters an obstacle
  - Reception planned with strategic outcome to increase international interest and membership
- Allied Health
  - First year
  - Discounted membership will be proposed because of limited response
  - Membership was asked to identify allied health professionals involved in Orthopaedic Trauma and encourage application.
- Community Membership
  - Letters of recommendation a problem for some applicants. Strategies such as interviews will be considered to remove this barrier to membership.

- Members reminded that on-line applications are available as they direct potential new members.
- Fellowship Director Encourage fellows to apply to OTA. Anticipated bylaw change will make them eligible for "candidate membership" during next year's application cycle.

### Ted Miclau, MD – Research

- Grant Writing seminar attended by 30 people. Focused on clinical research. Felt to be largely successful.
- OREF seminar attendance OTA secured 2 positions. Eight people interested. Plan to continue this program. Notify the OTA office if you are interested in future attendance.
- Mentorship program has shown limited success. Renewed focus from participants and mentors is encouraged.
- Grant application process modifications:
  - Provide pre-proposal and full grant reviews with written critique and suggestions
  - Two funding cycles (OTA, AAOS) to fast-track resubmission request
- Directed topic Research Grant opportunity endorsed by the Board of Directors
  - Donors may now direct money to fund projects in specific areas.
  - Donors of these types of funds must also contribute matching funds to the general fund
  - RFPs targeted to directed gifts will be developed by the research committee and communicated to membership
- New Grants
  - Clinical study (1 grant, 3 years, \$50K/yr)
    - Topic solicited by RFP
    - Standard pre-proposal/grant cycle
    - Subsequent year funding predicated on satisfactory annual review
  - Additional clinical study in 2006 (250K)
    - Directed topic donation from Medtronic
    - RFP for Clinical Research on rhBMP-2
    - Standard proposal cycle
  - Resident
    - 5 grants for 10K per year
    - Grant application is through the OTA Research Committee

### Larry Marsh, MD – Coding and Classification

- Coding - presented 8 codes to RUC. Reconstructive codes in humerus, femur and tibia. 2 tabled. 6 received modest increases.
- Classification - Should OTA be doing anything in terms of reworking existing coding? Perhaps in concert with worth by the AO's initiative? Please forward thoughts on this issue to Larry Marsh.
- Database - demonstration provided by Mike Sirkin. OTA member use remains limited. This database will be suggested as a common method of data collection for OTA funded clinical research.

## Mike Baumgaertner, MD – Education

- o OTA educational courses overall were revenue positive thanks generous corporate supporters of many of these events. The first resident's regional course chaired by Mike Stover was a large success. Bill Ricci and Mike Stover will repeat this next year in Atlanta.
- o The regional update course in St. Louis Update Course chaired by David Teague and Bill Ricci was also highly rated by participants.
- o This year's annual meeting Residents Course going well under leadership of Kevin Pugh.
- o Chris Born, Paul Tornetta, and Kathy Cramer ran a successful joint venture course with the AAOS
- o Early phases of exploring a more organized method of delivering resident education.
- o OKU 3 is out. Early sales are encouraging. OTA anticipates significant revenue as a result of our contributions.
- o Resident slide series - David Teague is working on updating lectures and will contact previous authors on a rotating schedule. Goals are to update 30% annually.
- o Steve Kottmier will redesign education on our web-site. Plans are to integrate multiple offerings in anatomic based format with links that allow for simplified navigation.
- o Ken Koval will form a subcommittee of the education committee to coordinate ICL submission for the AAOS annual meeting.

## Tracy Watson – Fellowship and Career Choice

- o Trauma as a career video distributed - Thanks to Jeff Smith for his exhaustive work.
- o Fellowship fair - slow increase in numbers over recent years
- o Upgrade of website based application process in the works
- o Creation of standards for fellowships in the works

## Jim Nepola - Health Policy

- o AAST/COT Acute Care Specialty Initiative
  - o Proposal for General Surgeon hospitalist to perform acute care surgery in Trauma Patients
  - o Proposals by leadership within the AAST are inclusive of I&D, External Fixation and Fasciotomies
  - o Creation of this subspecialty is not supported by the Board of Directors of the OTA
  - o OTA response signed and endorsed by the OTA Presidential line to be published in the Journal of Trauma.
- o On-Call Position Statement
  - o Parameters of responsibility currently being drafted
  - o Overriding theme is that there is dual responsibility from physicians and hospitals.
  - o Legal support with regard to liability reform is also a critical component.
  - o Final position statement to AAOS Project Team on Call with hopeful creation of a position statement

from AAOS

- o Transfer Criteria and Procedure Principles
  - o Transfers are increased to higher level Centers
  - o Parameters defining proper criteria and procedure for transfer needed
  - o Position Statement by 2006 AAOS from a team led by Jim Goulet

## Doug Dirschl reporting for Dr. Sander's - Nominating Committee Report

- President elect - Jeff Anglen
- 2<sup>nd</sup> President elect - Tracy Watson
- Secretary Robert Probe (to begin 2<sup>nd</sup> three year term)
- Member at large Sean Nork
- Member at large - Bill Ricci
- Membership
  - o Chair - David Karges
  - o Dan Horwitz
  - o Madhav Karunakar

## Education Committee Update By Michael R. Baumgaertner

The Education Committee oversaw numerous projects during 2005. A great deal of credit and appreciation is due to all the OTA members who donated their time and expertise toward the educational mission of our Association. A brief summary follows.

- I. Committee Expansion: The Board approved our request to add two more voting members to the committee, and Dr. Tornetta selected Stephen Kottmeier and Mohit Bhandari to join committee members Dave Teague and Ken Koval. Kevin Pugh, Bill Ricci, Michael Stover, and Chris Born serve in their capacity as OTA course chairs.
- II. OKU Trauma Update3: Published by the AAOS in July, this volume has been very well received and is selling at a pace much better than previous editions. More than 80 OTA member/authors were guided by section editors Anglen, Schemitsch, Schmidt, Stover, Chapman, Teague, Reilly, and Koval. This is an excellent text for both Senior Residents and practicing orthopaedists. The OTA



can earn upwards of \$100,000 in royalties if orders remain strong.

III. Core Curriculum Lecture Syllabus Update: Dave Teague is coordinating the three year rolling update process to keep the syllabus current and representing state of the art care. Volunteers to edit, revise and update the author rewrites include Anglen, Benedetti, Bono, Cannada, Capo, Dickson, Frick, Hayda, Lee, Ostrum Rabin, Reilly, Ruch, Sanders, Schmidt, Shea, Sirkin, Starr, Stover and Templeman,. More than 30% of the original lectures will be revised by Specialty Day at the 2006 AAOS meeting. If you have still not volunteered to support this effort, but would like to, don't hesitate to contact Dave Teague (via OTA office).

IV. OTA 2005 Courses: Four courses were sponsored by the OTA last year. More than 425 participants enrolled, all but one event "sold out," and an overall slightly positive economic balance sheet was achieved.

- a. The first annual Spring Advanced Trauma Techniques Course took place in Chicago in April Chaired by Mike Stover, and supported by generous industry scholarships and unrestricted educational grants. Bill Ricci and Mike Stover will Chair this year's course in Atlanta, May 5 & 6<sup>th</sup>.
- b. Chris Born, Paul Tornetta & the late Kathy Cramer chaired the AAOS/ OTA Annual Trauma course that took place in Miami in April 2005. This year's course will occur April 27-30<sup>th</sup> at the Renaissance Golf Resort, at St. Augustine, FL. The OTA assumes 50% of the financial risk of the meeting, but equally splits profits with the AAOS. Chris Born will Chair, Mike Baungertner, Co-Chair.



- c. The OTA's own annual fracture update course took place in St. Louis, May 13 & 14, chaired by Dave Teague and Bill Ricci. The course was highlighted by small group discussion and with an emphasis on common fracture treatment pitfalls.
- d. The Resident Basic Fracture Course that occurs during the annual meeting is now chaired by Kevin Pugh and coordinated by section leaders France, Gorczyca, Hak, Morgan, Prokuski, Reilly and Ricci. (see the article by Ricci for details of the resident courses and their new, more accurate titles).

- V. Website Education: Steve Kottmeier has initiated a redesign of the way our content is organized and linked. The new format will allow individuals to search by topic rather than the current "venue" based design. It will allow us to progressively link to more useful sites and resources. Expect to see the new format by the AAOS meeting, and continuously more linked content in the months to come.
- VI. Ken Koval has been charged by the Education Committee and President Tornetta to coordinate and optimize the submission of Instructional Course Lectures (and ultimately Symposia) for the Annual AAOS meeting. The goal is to insure that a wide spectrum of clinically relevant courses are available annually as well as to increase the participation of the OTA membership serving as faculty. See the related article by Dr. Koval. The program will be trialed on a volunteer basis when submitting proposals for the 2007 AAOS meeting.

## Announcements

- The OTA membership and OTA board of directors have approved an OTA position statement regarding taking call! This has been sent to AOA and AAOS-and is available on the OTA web site.
- Annual Meeting 2005 recorded highest ever attendance with 746 physicians registered plus 115 residents at the course. Twenty-one countries were represented at the meeting and evaluations are showing a very favorable response to the meeting. Congratulations to all whose tireless efforts made this an outstanding scientific educational event. Also the link to the abstracts is: <http://www.hwbf.org/ota/am/ota05/ota05cov.htm>
- The 2006 OTA Annual Meeting promises to be another outstanding meeting to be held in Phoenix at the Arizona Biltmore Hotel, October 5-7.
- Abstract applications are NOW on the OTA web site [http://www.ota.org/abstracts/submit/submit\\_abstr.html](http://www.ota.org/abstracts/submit/submit_abstr.html) and are due February 10, 2006.
- Jeff Anglen, MD and Mike Bosse, MD have been interviewed for multiple radio stations regarding their experiences with rescue efforts following Hurricane Katrina.
- Don't forget to make your year-end contribution to OTA Research Fund through OREF or directly to OTA.
- Here is the link to Paul Tornetta's presidential address, "Question Everything" <http://www.ota.org/education/presaddress.htm>
- The OTA Board of Directors recently approved the addition of 5-\$10,000 in Resident Research Grants. Applications will be accepted through **February 1st** for June 2006 awards, and August 1st for January 2007 awards. Details and an on-line application are available on the OTA website. Please pass this opportunity on to your residents. Resident Grant Application: [http://www.ota.org/proposal\\_resident/preproposal\\_resident.htm](http://www.ota.org/proposal_resident/preproposal_resident.htm). Grant Information: [http://www.ota.org/Research/grants\\_available.htm](http://www.ota.org/Research/grants_available.htm).
- OTA Reception will be in the "Newsroom" on the second floor of Phil Stefani's, 437 Rush. With the Wrigley Building as a start, your best mode of traveling would be to walk. There is a piazza right next to the Wrigley Building (North of the building) with a statue at the end. Walk through the piazza (West), towards the statue. You will come to a staircase that will take you downstairs to the corner of Rush and Hubbard. This walk will take you less than two minutes.
- **Calendar of events for 2006:**
- February 1<sup>st</sup> is the Kenneth Johnson Fellowship Award deadline and Resident Research Application deadline.
- February 10<sup>th</sup> is the 22<sup>nd</sup> annual meeting abstract deadline. Submit online: [www.ota.org](http://www.ota.org).
- February 20<sup>th</sup> ICL Symposia topics for 2007 due in staff office.
- March 25<sup>th</sup> OTA Specialty Day Meeting: Tips, Tricks, Pearls and Evidence for Managing Common Fractures in Chicago, Illinois. Program Chair: OTA President 05-06: Paul Tornetta III, MD.
- April 1<sup>st</sup> Pre-Proposal Research grant deadline.
- April 27-30<sup>th</sup> AAOS/OTA 6<sup>th</sup> Comprehensive Trauma Course: Current Management Concepts, Surgical Techniques & Practices in St. Augustine, Florida. Course Directors: Christopher T. Born, MD and Michael R. Baumgaertner, MD.
- May 5-6<sup>th</sup> in Atlanta, Georgia, Residents Advanced Trauma Techniques Course, Co-Chairs: Michael D. Stover, MD and William M. Ricci, MD.
- July 1<sup>st</sup> Membership Application deadline.
- August 1<sup>st</sup> Full Research Proposal due; Resident Research Applications due (2<sup>nd</sup> opportunity).
- September 5<sup>th</sup> register and obtain hotel room for the OTA annual meeting Arizona Biltmore.
- October 5-7<sup>th</sup> OTA 22<sup>nd</sup> Annual Scientific Meeting in Phoenix Arizona.
- October 4<sup>th</sup> Basic Science Focus Forum and Pre-Meeting Events. OTA President 06-07: Michael J. Bosse, MD, Chair: Ross K. Leighton, MD, Co-Chair: Andrew H. Schmidt, MD, Local Host: Michael J. Brennan, MD.
- October 4-7<sup>th</sup> Residents Comprehensive Fracture Course in Phoenix, Arizona, Chair: Kevin J. Pugh, MD.

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