



Inside

(p. 1)
President's Message
From the Editor
(pgs. 2 - 3)
2011 Specialty Day
Business Meeting
Highlights
(p. 5)
Research Committee
Secretary's Report
(p. 6)
Education Committee
Program Committee
Fellowship Committee
(p. 7)
NEW!
OTA Tip of the Month
Call for Volunteers
(p. 8)
Disaster Management
Committee
(p. 9)
Military Committee
International Relations
Committee
(p. 10)
In Memoriam
(p. 11)
COTA
(p. 12)
From a Fellow's
Perspective
2011 Nominating
Committee
(p. 13)
Classification,
Database & Outcomes
Trauma System
Funding
(p. 14)
Resident Work Hours
(p. 15)
AAOS & OTA Launch
Distracted Driving
Campaigns
(p. 16)
Overseas Program
2011 Calendar
Announcements

FRACTURE *lines*

The Newsletter of the Orthopaedic Trauma Association

Spring 2011



MESSAGE FROM THE PRESIDENT

Andrew N. Pollak, MD

I'm proud to report that our Specialty Day meeting in San Diego represented an outstanding success from the standpoint of program quality and overall participation. While final attendance numbers are not yet available, we were very pleased with the overall level of participation by our own members as well as many other orthopaedic surgeons with interest in trauma care. Specialty Day represents one of our largest gatherings of the year, and it represents our greatest opportunity to showcase the OTA's many accomplishments for the rest of the orthopaedic community.

At the meeting of the Board of Directors, we discussed several topics of great importance to our membership. One dealt with the oversight of trauma fellowships, and another with a consideration of appropriate criteria for voting membership in our association. I think it is valuable for our membership to understand what your board is working on in both of these areas.

We have noted a substantial increase in the number of orthopaedic trauma fellowships nationally, only partially commensurate with the dramatic increase in the number of orthopaedic residents interested in pursuing additional trauma education. While this is clearly good news from the perspective of increased capacity in the workforce to care for injured patients, the OTA Board is in agreement that fellowship program guidelines and criteria are needed to guarantee sufficient educational value will be provided to the entering surgeons. We are considering several options in order to better define base line requirements for fellowships to participate in the OTA match program. Options under consideration include defining basic curriculum expectations and case

CONTINUED ON PAGE 4



FROM THE EDITOR

Lisa K. Cannada, MD

Welcome to the spring edition of the newsletter! Hope those of you who attended the AAOS Meeting in (not so warm or sunny) San Diego had a productive meeting. The OTA Specialty Day and reception were well attended as the Presidential gavel was turned over from Tim Bray to Andrew Pollak.

In this issue, we have several committee reports, a Fellow's Column and an interesting report on Trauma System Funding. A must read is Dave Templeman's contribution on Resident Work Hours. Be sure to look for announcements of meetings and important deadlines and mark your calendars now. Also, the OTA lost a member in a tragic accident. Please see Bill Mills' memorial by Jens Chapman. The summer edition of the newsletter will come out in August. Please feel free to contact me with comments, ideas and news at LCannada@slu.edu. Have a safe and enjoyable spring and summer!

2011 SPECIALTY DAY

Specialty Day at the 2011 AAOS Annual Meeting in San Diego was held on February 19, 2011 at the San Diego Convention Center. It was an exciting day with awards being given. Congratulations to **Rafael Neiman, MD** for winning the Winquist Cup as the outstanding lab at the Comprehensive Fracture Course for Residents! The Bovill Award paper was awarded to **David W. Sanders, MD; Christina A. Tieszer; Canadian Orthopaedic Trauma Society; University of Western Ontario, London, Ontario, Canada** for their study on *Operative versus Nonoperative Treatment of Unstable Lateral Malleolar Fractures: A Randomized, Multicenter Trial*. Topics in the exciting program included: *General Trauma Concepts; International Orthopaedic Care in Haiti, Practical Issues for the Working Traumatologist; Arthroplasty: Indications, Techniques and Case Examples for the Trauma surgeon and a though provoking session on the Business of Orthopaedic Trauma*. The guest speaker was **Rear Admiral Ray Smith** who had everyone motivated after his talk and movie of Navy Seal training!



Rear Admiral Ray Smith, Presidential Guest Speaker with Tim Bray, MD, OTA President.



Rafael Neiman, 2010 Winquist Cup recipient with Tim Bray.



Tim Bray is acknowledged for his outstanding leadership during his presidential term by incoming president, Andrew Pollak.



Tim Bray with a contingent from the Mexican Orthopaedic Society.



Tracy Watson, MD was acknowledged for his leadership in the OTA presidential line and also roasted by Roy Moed, MD.



Members enjoying the reception...

OTA BUSINESS MEETING HIGHLIGHTS – February 19, 2011

James Stannard, OTA Secretary

- **Jeff Smith**, OTA Public Relations Committee Chair, presented the distracted driving public service announcement. The goal is to get these messages out in local communities.
- **Alan Jones**, CFO (2010) reported that:
 - \$300K will be transferred from operations to research
 - The Annual Meeting was a huge financial success
 - Specialty Day is a near break-even event
 - OTA is currently at 4.3 million net of liabilities, with an overall gain of more than \$550k
- The floor was opened to nominations to the Nominating Committee. Nominations included: **Pierre Guy, Bruce Ziran, Bill Obrebsky, Toney Russell, Pete Althausen, Herb Alexander, Brad Henley**, and **Brian Mullis**.
- 27 Active, 4 Allied Health, 8 Associate, 76 Candidate, 42 Community, 5 International, and 5 International Community Members were welcomed to the OTA membership.
- **James Goulet**, Annual Meeting Program Chair presented the Annual Meeting report. There were 672 abstracts received for the 2011 Annual meeting.
- **David Teague**, Education Chair (2010) presented the Education Committee report. He presented the slate of courses, and noted that this year's Fellows Course will not include airfare for fellows, but all other expenses are covered. The 2011 Winkist Cup award was presented to Rafael Neiman, MD.
- **Andy Schmidt** presented the Research Committee report. 26 proposals were received and 7 were funded at \$10,000 each.
- **Larry Webb**, Bylaws Committee Chair reported that there are two amendments regarding OTA membership categories under review. They will be on the docket for the Fall OTA Annual Meeting.
- **Michael Chapman**, COTA Chairman of the Board, provided the COTA report. He noted that 27 applicants submitted for fellowship grants. Ten (10) programs were funded at \$75,000 per year and 13 were funded at \$50,000 per year. He also noted that major contributions were made by Smith & Nephew, Stryker, and Synthes, totaling more than 1.5 million dollars.
- **Tim Bray**, OTA President (2010/2011) recognized those who donated \$1,000 + to the OTA Research Fund. He also thanked those rotating off committee chairmanship. He presented and recognized the new committee chairs. Finally, he thanked those who were rotating off of the BOD, **Tracy Watson, Alan Jones, Brendan Patterson**, and **David Stephen**. He welcomed the new OTA BOD members, **A. Schmidt** (2nd president elect), **D. Hak** (CFO), **D. Teague** (Member at large), and **L. Cannada** (member at large).

minimums, developing an independent accreditation agency for orthopaedic trauma fellowships, and partnering with an existing accreditation agency. Overall, our goal will be to ensure that residents who enter an orthopaedic trauma fellowship program through the OTA match can expect an outstanding educational experience that includes adequate clinical volume combined with expert instruction.

We also continued an ongoing discussion around the categories of membership. Recently, some of the community members who represent the fastest growing segment of our membership have expressed an interest in gaining voting privileges. Community members are orthopaedic traumatologists whose practice is largely devoted to the care of trauma patients but who did not apply for or meet criteria for active voting membership, typically because of not meeting the publication requirements. While solving this issue in a way that meets the goals of many community members to obtain voting privileges in the organization is still a work in progress, the Board is committed to building a membership category structure that allows active participation in the organization by as many orthopaedic surgeons committed to trauma care as possible while promoting the long-term focus on the association's missions of education and research in orthopaedic trauma.

Your Board has also been actively working to address the ever increasing concern that many of you have raised regarding the palpable decrease in resident surgical skills and cognitive abilities that has resulted from the duty hour restrictions initially implemented by the Accreditation Council for Graduate Medical Education in 2003. The OTA Presidential Line, under Jeff Anglen's leadership, authored a letter to the ACGME that was published in the *Journal of Bone and Joint Surgery* in 2009 expressing our concern and cautioning against implementation of further restrictions as had been recommended by the Institute of Medicine. While the ACGME response was, we believe, moderated by the concerns we as well as many others expressed, we continue to believe that the current duty hour restrictions are unsafe for patients because they are preventing residents from maximizing the educational opportunity that their residency presents. In his new role as Chair of the AAOS Board of Specialty Societies (BOS), Dr. Anglen continues to lead efforts address this critical problem. The BOS included a symposium on this issue at the National Orthopaedic Leadership Conference in

Washington, DC on April 8, 2011. Furthermore, the OTA BOD has requested that the BOS pursue a formal AAOS resolution requiring that the AAOS develop and implement a plan to address the problem including, if necessary, working with other medical organizations to support the development of an alternative body to the ACGME that is more focused on the unique challenges of surgical education.

The Board is currently engaged in a process of evaluating our overall governance structure. Our membership has almost tripled in size over the past ten years while our Board and committee structure has remained the same. While we recognize that our current structure has led to development of many successful programs and growth of the organization in multiple areas, we want to be certain that the Board and committee chairs are best positioned to make certain that the organization continues to provide outstanding value to its membership and continues to contribute to the specialty through education and research. We anticipate providing the membership with an update of our plans for governance structure change at the Annual Meeting in October.

As many of you are aware, OTA members who were alumni of the Landstuhl Distinguished Visiting Scholars Program were asked to assist the **USNS Comfort** with its mission to help the victims of the Haitian earthquake in January and February of 2010. Eleven of our members participated in that relief program which was responsible for treatment of 540 patients and over 1,000 operative procedures. The **Comfort** plans a return to Haiti this summer as part of its scheduled Caribbean and Central American humanitarian relief mission. The US Navy has again asked for OTA's assistance in staffing the **Comfort** for this effort, and we are proud that three of our members will be joining Navy medical personnel in this important follow-up activity.

I will keep you updated through this newsletter as to the progress your BOD is making with these and other important OTA projects. Please make certain that your calendars are marked for this year's Annual Meeting in San Antonio from October 12-15. The meeting promises to be another outstanding event like the Baltimore meeting last year. In addition, we plan many new activities including an Advanced Practice Management Symposium, a Case-Based Coding Update, a Media Training Session, an "Own the Bone" Session, and a Guest Nation Program featuring Italy as the 1st OTA Guest Nation. A fantastic Southwestern style outdoor barbeque is planned for the member reception just above the San Antonio River Walk. We look forward to seeing you there.

At the February BOD meeting, the following resident research grants were approved: **2011 OTA Resident Research Grants** (Grant cycle: June 1, 2011 – May 31, 2012).

SECRETARY'S REPORT

James Stannard, MD

Highlights from the February 16, 2011 Board of Directors Meeting

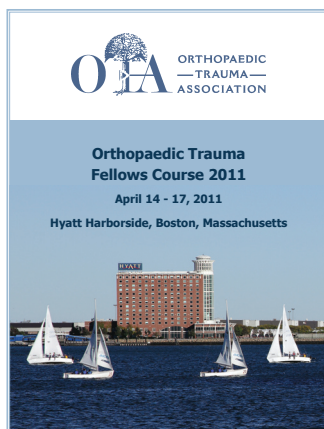
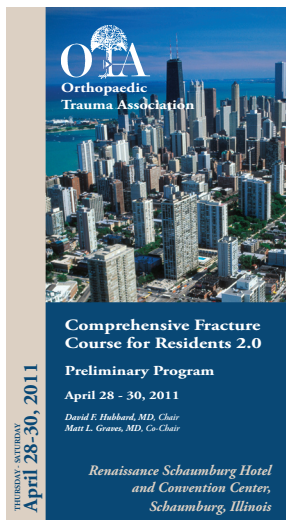
- **Ed Harvey**, Research Committee Chair (2010), provided the research committee report. The committee recommended funding for 7 resident research grants. The Board unanimously approved.
- **Alan Jones** presented an OTA financial report. He recommended transferring \$300,000 from the operations fund to the research fund (which the BOD approved). The Research and Education fund is now approx. \$4.3 million and has grown by \$350,000 from investments. The fund has doubled since 2003. Rick Armiger from Smith Barney was also present, and reviewed the OTA investment portfolio. He noted that we increased our allocation to 70% stocks which paid off in growth. The portfolio performed well above benchmark.
- Gene Wurth, CEO OREF, updated the Board on changes to the designated giving policy. OREF previously offered a 60/40 split (40% to OTA) for OTA designated donations up to \$999, but effective January 1, 2011, the split will be 50/50. (for donations above \$1,000, the first \$500 must go to OREF, remainder can be designated by the donor).
- **Mark Lee**, OTA Fellowship Committee Chair reported the following:
 - There are 85 applicants for 81 positions at 53 sites. (number dropped slightly this year).
 - 91% response rate to a 38 question fellowship survey. Many fellowships do not have any education specific to the fellow, and many do not give performance feedback. Discussion followed regarding fellowship oversight, and ACGME accreditation (subject to be further researched and discussed by the OTA BOD).

- A motion was made and seconded for voluntary contracture of fellowship programs. After discussion, the motion was tabled, and it was agreed a specific letter would require further discussion/review.
- A second motion was made for a two-year BOD mandated "no growth" policy for fellowships. There was no second for the motion, and it was therefore denied.
- A Practice Management Committee Report was presented including a motion which was unanimously passed to include additional education at the OTA Annual Meeting on advanced practice management and case based coding.
- **Craig Roberts**, PR Committee Chair (2010) presented a Public Relations Committee report. A motion was made and approved to provide funding for a professional media trainer at the OTA Annual Meeting (approx. cost \$5,500).
- **Larry Webb** presented the bylaws committee report, which included **2 proposed bylaws amendments**.
 - The first proposal involves the current membership structure, including membership requirements and voting privileges. It was determined that the proposal required further discussion.
 - The second proposal was regarding the candidate membership class. A motion was passed to amend the bylaws to make the candidate membership class inclusive of those participating in US and Canadian residency programs (and omitting those participating in a country outside the US or Canada).
Note: the bylaws amendment will allow residents to apply during residency, or within 36 months of completing residency. It will be presented to the membership for vote at the October 2011 business meeting.
- Governance Consultant, Dr. Eric Lister discussed OTA Governance & Leadership. A proposal to assist the OTA with best practices for governance of the organization will be developed, and discussed at an OTA Board retreat in summer 2011.

EDUCATION COMMITTEE

William Ricci, MD, Chair

The Education Committee is hard at work with new initiatives as well as some updates. The Comprehensive Fracture Course for Residents 2.0 is soon to be launched (April 28-30, Schaumburg IL). **David Hubbard** and **Matt Graves** will co-chair this newly formatted course which will be based on small group modules. Modules will be primarily case-based, and will have about 20 residents per 6 faculty members. Mini-lectures, video technique demonstrations and hands-on labs will augment the learning experience. This will be a premier educational opportunity for junior level residents. Many OTA members are sending their residents and taking advantage of tuition and travel scholarships made available by generous support from industry sponsors.



This year's OTA Fellows Course took place in Boston, April 14-17 and was chaired by **Paul Tornetta**. This unique educational opportunity utilizes fellow case presentations as a spring-board for discussion among co-fellows and senior level faculty. Another important goal of the course is to connect current fellows with OTA leaders.

The Core Curriculum, 3rd Edition update is in full swing. **Tom Higgins** is leading this substantial effort. Completion is targeted for summer 2011. The completely updated version will be available on the web.

Finally, the Education Committee would like to recognize the outgoing chair, **Dave Teague**, for his expert leadership, extreme hard work, and selfless devotion. Luckily, Dave has agreed to stay on for a while as a counselor while the new team gets up to speed with the many facets of this Committee's charge.

PROGRAM COMMITTEE

James Goulet, MD, Chair

There were 617 abstracts received for the 2011 OTA Annual Meeting. The committee will be reviewing these applications and putting an exciting program together. Look for the preliminary program in June! There will be several pre-meeting events including the Basic Science Fracture Forum, Masters Level Trauma Coding course, International Trauma Care Forum, and Young Practitioners Forum, as well as several new sessions as Dr. Pollak announced in his Presidential Report.

Don't forget to mark your calendars now for the **27th OTA Annual Meeting** October 12 - 15, 2011; San Antonio, TX.



FELLOWSHIP COMMITTEE

Mark Lee, MD, Chair

The OTA completed the first fully online Match this year through SFMatch with all materials and notifications distributed electronically. No major technical problems were reported. SFMatch distributed 82 completed applications, and 64 positions were filled. SFMatch distributed approximately 17 applications per applicant.

A post-fellowship training survey was distributed to fellows who completed training within the last five years. The survey included questions regarding training, job market, etc. The response rate was excellent with overall optimism for post training career opportunities and satisfaction with training. We will distribute this data to all participants in the near future.

All fellows are asked to remember to log their surgical cases. We have provided a useful template for fellowship case reporting. These will be requested prior to the end of your training.

SFMatch agreed to waive the fee for military applicants who are not deemed eligible for fellowship training and must re-apply or withdraw.

After a successful fellowship focus session at the OTA Annual Meeting in Baltimore, we sought further feedback from the current fellowship training class at the Fellows Course in Boston in April which will be used to further assess and improve the program.

NEW! OTA TIP OF THE MONTH

Watch the OTA website for “Tip of Month” articles. Each article will include “pearl’s of wisdom” from an OTA Past President!

Title: **Surgeon’s Diary**
by **Peter Trafton, MD**
(Presidential Term: 1993 – 1994)

Howard Rosen, the legendary AO surgical educator and mentor, told me about this years ago. To the extent that I’ve followed his suggestion, it has proven well worth the invested time and effort.



A surgeon can learn a lot from a single operation. Reviewing, analyzing, and, yes, remembering the lessons are all improved by recording them in a private diary. The process focuses us on performance, and upon retaining what we’ve learned. Howard stressed that such a diary allows the surgeon to record, for personal use and review, observations that might not appear in the patient’s medical record: things less satisfactory than planned, surprise discoveries, problems encountered, attempted solutions, how well they worked – or didn’t. The reduction or fixation that was accepted, but led later to second thoughts; perhaps regrets. The solution not conceived of until the operation was finished. The trick that jumped into your mind, or maybe was suggested by your resident or scrub tech, and turned out to be the magic answer. The instrument that worked so well, or perhaps failed to. The equipment not requested, and so on.

Such details are most vivid soon after an operation, or as the surgeon mentally replays a difficult procedure, trying to figure out how problems could have been anticipated, and/or surmounted. Howard Rosen, like all good surgeons, believed in self-improvement. He understood and communicated the value of incorporating effective improvement efforts into his daily work and life.

Times have changed since Howard told us about the surgeon’s diary. Now we must respect Protected Health Information, according to HIPAA privacy and security rules. My electronic diary must comply – but digital technology simplifies legible recording, retrieval of information, and inclusion of images. These all contribute to our improving surgical knowledge & skills.

CALL FOR VOLUNTEERS

The OTA needs members to become involved with the American College of Surgeons (ACS) Committee on Trauma (COT) orthopaedic specialty section. The COT is responsible for a host of trauma efforts nationally and internationally, from ATLS courses and the National Trauma Data Bank (NTDB) to verification of trauma centers by the Verification Review Committee (VRC) of the COT. We currently have eight orthopaedic representatives on the COT, and the COT Membership Committee is asking the OTA for suitable names to consider for an additional spot.

Willing volunteers must be Fellows in the ACS (FACS). If you are not currently FACS yet have an interest in working on the COT in the future, please speak with your local FACS colleagues to begin the process so that you will be eligible for COT membership in the next year or two. COT membership carries with it responsibility to attend at least one of the two yearly meetings of the COT. One is a spring meeting typically mid-March and the other is associated with the annual ACS Clinical Congress meeting typically in October. The meetings seldom conflict with our AAOS and OTA meetings, but are often close on the calendar. Additionally, committee work for the COT is expected of all members, and ranges from Education to Disaster Preparedness to ATLS to VRC.

Over the recent years, the orthopaedic specialty group has made important contributions to the COT on behalf of the OTA and orthopaedic constituencies. The group is now recognized as an important partner of the COT and an extension of the OTA. Although we do not control appointments to the COT, our recommendations typically carry forward successfully. The initial appointment is for three years with an opportunity for a single reappointment for a second three year term. Please notify [Kathleen Caswell](#) if you would like to be nominated to membership to the COT. If you have questions about the opportunity, the home office can connect you with the current orthopaedic members who can provide you details of the work and expectations. Contact the OTA at ota@aaos.org if you are interested.

DISASTER MANAGEMENT COMMITTEE

Christopher T. Born, MD, Chair

AAOS/OTA Haiti Relief and Disaster Preparedness Project Team, Co Chair

At the Disaster Committee meeting in San Diego, **Dr. Kaye Wilkins** noted that the **Société Haitian Orthopédie Traumatologie (SHOT)** has begun to work with Dr. Andy Pollak's Orthopaedic Trauma Care Specialist (OTCS) program in Haiti. This is a component of the orthopaedic education rebuilding program there. In late January, Drs. **Andy Pollak** and **Bill DeLong**, and a number of other OTA members held a 2 day orthopaedic trauma conference at the University of Notre Dame du Haiti (UNDH) with over 30 residents and practicing surgeons in attendance. (Report in this newsletter with pictures). Logistical support for OTCS will be through the Catholic relief Services (CRS) while the University Of Maryland School Of Medicine will help with planning, operations and evaluations. Funding is being sought from the CDC, USAID and the private sector. The plan is to build a 2 year residency program focused on orthopaedic trauma care for appropriately trained Haitian physicians. Partners in Health (PIH) will be working with the University Hospital to re-establish a formal five year residency in orthopaedic surgery.

SOMOS President, CDR Matthew T. Provencher, MD reported that "Combat Extremity Surgical Course" (CESC) taught to military surgeons prior to deployment will be modified for civilians interested in participating in disaster response. It will become a key component of the educational program being developed by the AAOS/OTA Disaster Preparedness Project Team (PT) with the first course being given at the SOMOS annual meeting in December, 2011 in San Diego. For this program to be a success qualified faculty will need to be recruited. The SOMOS Core Curriculum and Critical Skills List are derived from the CESC objectives and are presented as part of the **Orthopaedic Disaster Preparedness and Trauma Care Tool Box** initiative presented in conjunction with the Wheelless' On-line Textbook of Orthopaedics. <http://www.wheelsonline.com/ortho/12821>.

The Disaster Preparedness Project Team has continued to work on the development of a disaster response program for the OTA and AAOS. At this time, there are two training and certification pathways being considered for those interested in this type of work. Immediate Phase Responders would consist of two Types. Type I would be trauma trained responders and Type II would be general orthopaedic responders. The second pathway would be for



Chris Born and Mark McAndrew reducing a fracture at the Gheskio Field Hospital, Port-au-Prince.

Sustaining Volunteers (Responder Type III) who would work with pre-identified programs/NGOs for longer term care of populations in need following a disaster. All three responder types would have educational requirements such as the SOMOS course or other programs that have been identified. Work is ongoing to define these programs and to determine how members interested in disaster response might be identified, educated, credentialed and tracked in a database as a Type I/II/III responder.

A significant breakthrough was made at the Extremity War Injuries VI Symposium in the credentialing of civilian orthopaedic surgeons to work either with the military or with HHS/ National Disaster Medical System (NDMS) when Dr. Warren Lockette (Deputy Assistant Secretary of Defense for Clinical and Program Policy) expressed significant interest in promoting a process that would allow for a common credentialing pathway that might be used by both DOD and HHS/NDMS. A conference call on March 14 brought together many of the stakeholders from the federal departments involved as well as the OTA and AAOS. A project team of representatives is in the process of being formed.

The Pilot Registration Program for the NDMS Multi-Specialty Expansion Team (MSET) registration that has been championed by **Dr. Bruce Browner** is in the process of undergoing an evaluation. MSET is being created to augment disaster response with a cadre of qualified, specialized medical professionals. Dr. Browner will be attending the NDMS Summit in May to review the results of a survey that has been sent to participants.



The Military Committee promotes collaboration between civilian and military orthopaedic trauma surgeons in the areas of patient care and research. The USNS (United States Naval Ship) Comfort recently set sail for Central and South America for a Humanitarian Mission where they will be visiting Haiti. **CAPT William Todd** (OTA Member, Bethesda, MD) is the current Director of Surgical Services on the ship and in that capacity is responsible for all the surgical care on the ship. Last year he coordinated the OTA members joining the crew for the Haiti mission. This year's trip will be an opportunity to get follow up on some of the patients he and many of the OTA members operated on in Haiti. The OTA members who have been selected to participate in this year's mission are **David Teague**, **Roman Hayda** and **Marc Swiontkowski**.

In January, the sixth iteration of the Extremity War Injuries Symposium was held in Washington, DC. OTA members were again very involved, the Co-Chairs **CAPT (R) Mike Bosse** and **COL James Ficke** put on an excellent program that focused on Data-Driven Progress in Combat Casualty Care. The highlight of the conference was the work being done at Brooke Army Medical Center with the Intrepid Dynamic Exoskeletal Orthosis (I-DEO) in the rehabilitation of lower extremity limb salvage. This was the first year that Axial Skeletal Injuries were discussed and several interesting talks were given on spine and lumbosacral injuries were presented. In addition, **Drs. William Todd** and **Andy Pollak** lead the session on "Disaster Relief Progress". Talks on the continued work of the AAOS/OTA Disaster Project Team, the NDMS experience in Haiti, federal surgical platform deployment in Haiti and the development of the OTCS were well received. A morning session with Lt. Gen Charles Green, MD (Air Force Surgeon General) attended by OTA military leadership from the three service branches, SOMOS and other OTA members, helped to further identify barriers to credentialing. General Green appeared to be committed to help with NDMS and legal follow-up as well as promoting the ideas of standardized equipment sets between the three services.

OTA members continue to participate in the Distinguished Visiting Scholar Program (DVSP) at Landstuhl Regional Medical Center in Germany. With

the surge in Afghanistan underway increased casualty rates are being seen. If you are interested in participating please send a CV and letter of interest to ota@aaos.org or hiller@aaos.org.

INTERNATIONAL RELATIONS COMMITTEE

William Delong, MD, Chair

The 2nd annual "International Trauma Care Forum" took place on October 13, 2010 in Baltimore, MD at the 2010 Annual OTA Meeting. There were 23 papers accepted for presentation from six different countries. The topics that were particularly unique included "Delayed Open Reduction Internal Fixation of Proximal Humerus Fractures" and "Fibular Head Osteotomy: A New Approach for the Treatment of Lateral or Posterolateral Tibial Plateau Fractures." The highlight of the Forum was the Keynote Speakers from Haiti. They represented The Societie Haitian Orthopaedic Traumatology (SHOT). Dr. Hans Larsen, President of SHOT, delivered a moving account of the local response to the devastating earthquake. Dr. Bernard Nau, Secretary General of SHOT, gave a spirited account of how their organization was trying to prepare for future orthopaedic needs. Both presentations were moving and set the tone for the rest of the meeting. There were sessions on upper and lower extremity topics as well as spine and pelvic fracture issues. All the presentations were well received. The audience included 100 participants which was felt to be significant for a pre-meeting session of the OTA.

At the request of **Dr. Timothy Bray**, President, the OTA International Committee developed a "Guest Nation" program with the inaugural session scheduled for the OTA meeting in October of 2011. The first guest nation was chosen at the Board of Directors meeting and will be Italy. The Guest Nation session will last for one hour from 4PM to 5PM at the end of the International Orthopaedic Trauma Care Forum. A topic for this session will be chosen by mutual agreement with the International Committee and the Guest Nations' Orthopaedic Trauma Society. Two members from the OTA and two members from

CONTINUED ON PAGE 10

the Guest Nation will present the selected topics. We will invite the Guest Nations Ambassador to the US to our meeting and pay for round trip transportation from Washington, D.C. to the meeting. They will be "Special Guests" at the International Reception which follows the Guest Nation Forum. OTA President, Andrew Pollak, will formally greet and recognize the Guest Nations representatives and Ambassador.

The International Committee of the OTA partnered with Dr. Pollak and the University of Maryland to provide a Trauma Update Course for Practicing Surgeons, residents and medical students at The University of Notre Dame de Haiti. This took place on January 28 - 29, 2011. The course was funded by Catholic Relief Services. There were about 45 participants that were enthusiastically engaged in the didactic and hands on portion of the symposium. AO supplied the saw bones and provided instruments for the hands on lab sessions. The faculty included **Drs. Bill De Long, Andrew Fury, Andy Pollak, Spence Reid, Saqib Rehman and Marcus Sciandini**. This was meant to be the kick-off event for the two year fracture surgeon residency program planned for Haiti and the University of Notre Dame. For political reasons, the start of this program will be delayed, but the committee looks forward to supporting the startup and continued success of this most important effort. There are still 700,000 Haitians living in tents and many people that need orthopaedic care. This program will help provide the surgeons of the future in a more streamline fashion to help facilitate providing the needed care. Following is a picture from the course.



IN MEMORIAM

Dear Friends and Colleagues,
It is with profound sadness that I share the news that our very dear friend and colleague **Bill Mills** passed away March 15 in Anchorage, Alaska surrounded by his closest family after sustaining grave injuries following a ski accident.



Bill graduated from residency at Harborview in 1995 and following completion of his tour of duty with the Navy returned to join us as faculty in the Department of Orthopaedic Surgery and Sports Medicine at Harborview Medical Center in 1998 as attending on our Trauma Service. He rejoined his extensive family in Anchorage in 2004 but remained very active in the WWAMI program as Clinical Professor and has remained a vigorous supporter of Harborview Medical Center throughout. His legacy in the Orthopaedic Trauma world is substantial – he changed the perspectives of surgical treatment of knee dislocations and contributed to numerous other major articles pertaining to Orthopaedic polytrauma management. Most importantly Bill personified what it takes to be a great doctor. Superbly skilled surgeon that we was (he fixed my knee) he was universally popular for his infectious energy, his thoughtful yet magnetic personality and the unique gift of easily connecting with anybody he came in contact with. As a partner he was a pure delight to work with – the smile you see on his photo was seemingly ever-present regardless of the circumstances or hours of the night. Aside from his family, the wilderness and open expanses of Alaska were Bill's major source of happiness and spiritual home. He leaves behind his wife Carey with their three young children Isabella (15), Jackson (13) and Isiah (11) as well as a large extended loving family.

Bill will live on in probably more than a hundred of fortunate patients through his gift of organ donation, also in his legions of surgical patients who benefitted from his skills and in the countless students, residents, fellows and colleagues who were witness to his gift of teaching, which he enjoyed so much. From our end I will commit efforts of our Department to preserve the genuine inspirations provided by this wonderful colleague for many generations to come.

In loving memory of a true friend and a good man -

Jens R. Chapman

Fellowship Grants Awarded 2011-2012

Please note that COTA Orthopaedic Trauma Fellowship Program Grants have been made available because of the generosity of three donor companies in supporting quality education to enhance future patient care. COTA is grateful to *Smith Nephew, Stryker, and Synthes*, companies whose leadership has recognized the merit of the blinded selection process by non-conflicted orthopaedic trauma surgeons.

COTA is pleased to announce that the following listed twenty-three (23) Orthopaedic Trauma Fellowship Programs will receive grants totaling \$1.4 Million by a blinded review process at the February 17, 2011 COTA Board meeting:



Allegheny General Hospital, Drexel University School of Medicine, Pittsburgh, PA, *Daniel Altman, MD*
Carolinas Medical Center Orthopaedic Trauma Fellowship, Charlotte, NC, *James F. Kellam, MD*
Denver Health Orthopaedic Trauma Fellowship, Denver, CO, *David Hak, MD*
Georgia Orthopaedic Trauma Institute, Macon, GA, *Lawrence X. Webb, MD*
Harborview Medical Center, University of Washington, Seattle, WA, *David P. Barei, MD*
Hospital for Special Surgery, New York, NY, *David L. Helfet, MD*
Massachusetts General Hospital, Boston, MA, *Mark Vrahas, MD*
R Adams Cowley Shock Trauma Center, University of Maryland, Baltimore, MD, *Robert O'Toole, MD*
Regions Trauma Center, University of Minnesota, Minneapolis, MN, *Peter A. Cole, MD*
Reno Orthopaedic Trauma Fellowship, Reno NV, *Timothy Bray, MD*
Saint Louis University Orthopaedic Trauma Fellowship, St. Louis, MO, *J. Tracy Watson, MD*
San Diego Trauma Fellowship, University of California San Diego, CA, *Jeffrey M. Smith, MD*
Sonoran Orthopaedic Trauma Fellowship, Scottsdale, AZ, *Anthony S. Rhorer, MD*
Tampa General Hospital Orthopaedic Trauma Service, Tampa, FL, *H. Claude Sagi, MD*
University of Alabama, Birmingham, AL, *Rena L. Stewart, MD*
University California, Davis, Sacramento, CA, *Mark A. Lee, MD*
University of California, San Francisco Orthopaedic Trauma Institute, San Francisco, CA, *Theodore Miclau, MD*
University of Miami, Jackson Memorial Orthopaedic Trauma, Miami, FL, *Gregory Zych, DO*
University of Tennessee, Campbell Clinic Orthopaedic Trauma, Memphis, TN, *Edward Perez, MD*
University of Texas Health Science Center, Orthopaedic Trauma, Houston, TX, *Milan Sen, MD*
Vanderbilt Orthopaedic Institute, Division of Orthopaedic Trauma, Nashville, TN, *William Obrebskey, MD*
Wake Forest University Health Sciences Orthopaedic Trauma, Winston-Salem, NC, *Eben Carroll, MD*
Washington University School of Medicine, Orthopaedic Trauma Institute, St Louis, MO, *William Ricci, MD*

The COTA Board convened for its second business meeting at the annual American Academy of Orthopaedic Surgeons on February 17, 2011. The COTA Board includes **Michael Chapman, MD**, Chair; **Brendan Patterson, MD**, President; **Bruce Browner, MD**, Secretary; **Larry Bone, MD**, Treasurer; **Mark Richardson, MD**, Vice-Chair; and **Maureen Finnegan, MD**, Member-at-Large. Nancy Franzon serves as the Executive Director.

Status Report: Eight months down, four to go. I find myself again wondering where the time has gone. A year of trauma fellowship can be an exceptionally challenging, often enjoyable, sometimes painful, frequently tiring, but totally worth-it experience, for those of us passionate about it. I went into it lacking confidence in my skills and decision-making, and now feel so much more prepared for the "real world" of a clinical trauma practice. The learning curve can be steep and intense, but as the year progresses, you realize you have the tools, and have developed the confidence and skills to handle previously unseen injuries.

Speaking with fellows over the course of the year, I have realized that there is a wide spectrum of experiences one can have in a fellowship. The decision regarding which fellowship program one should pursue is probably more complex than I realized when I was applying. Some programs don't require their fellows to take call at all. Many fellows don't do independent staff call. Some programs allow progress from intense instruction to independent operating over the course of the year. Others require staff to be present and involved in every case from start to finish. Some fellows have very limited clinic experience, while others run their own clinics. For some, there are limited physician extenders and/or residents, so all of the day-to-day patient care work must be done by the fellow. Some fellows can pick and choose exactly what cases they want to do, while others have some choice, but also sometimes have to just get the work done. Some allow dedicated time for research pursuits, while others have to find the time outside of their regular schedule. Some have the time and access to moonlighting opportunities. This can be a big deal if you have debts to pay or families to support. I believe most of us don't get training in billing and coding as part of our fellowship, so if you do, take advantage of it.

With all of this diversity in training, there is no right or wrong way to do it. The trick to all of it is to determine what kind of experience you want, and seek out the best combination of program traits to match your needs. Much of this comes from speaking to the current fellows at each program. Then you have to leave it to the match. If you feel like you are not getting what you need out of your fellowship, ask if anything can be changed to better prepare you for the practice you plan to engage in. Trauma is a dynamic

and unpredictable subspecialty, and your fellowship can be dynamic and flexible as well. If you are lacking in exposure to some areas, attend courses to broaden your experience. For me, some of the most useful information gained at courses is from the small group sessions with a variety of traumatologists, discussing specific cases in detail from presentation to post-operative course. You learn that there are multiple ways to accomplish a goal, and pick up excellent tips, tricks and techniques that you might not otherwise get exposure to. The wisdom of their experience is immeasurable.

I am privileged to have found a program that, I feel, is preparing me for the complete work experience, and not just developing my operating skills. There are many injuries that I haven't had the opportunity to treat yet, and as the year winds down, I will try to focus on the areas where my exposure has been limited. I have experienced an incredible increase in confidence, skill, and decision-making independence over the course of this year, which is exactly what I needed. Real life begins soon...are you ready?

2011 NOMINATING COMMITTEE

POSITION NOMINATIONS

Tim Bray, MD, Chair, Immediate Past President

The 2011 Nominating Committee will recommend a slate of candidates to be voted upon by the members at the October Business Meeting held October 13, 2011 in San Antonio, TX. Please send suggestions for open positions to: hiller@aaos.org or ota@aaos.org. Positions to be filled include: 2nd President Elect, Secretary, 1 Member-at-Large position, and 2 Members for the Membership Committee.

Don't forget to vote for the 2011 Nominating Committee! OTA Active, Research and Senior members will receive an electronic ballot by email in May to select 4 members from the following list of nominees: *A. Herb Alexander, MD, Peter Althausen, MD, Pierre Guy, MD, MBA, M. Bradford Henley, MD, MBA, Brian H. Mullis, MD, William T. Obrebskey, MD, Thomas A. Russell, MD, Bruce H. Ziran, MD.*

CLASSIFICATION, DATABASE AND OUTCOMES COMMITTEE

Larry Marsh, MD, Chair

The OTA Classification of open fractures continues to be an area of high committee interest and effort. The six open fracture videos that we prepared have been used at several residencies and surgeon meeting formats to test observer reliability of the new classification. We reviewed the data at our meeting in San Diego and were pleased to find high observer reliability for all components of the classification. We made a couple of relatively small wording changes and we will prepare this data and these modifications for publication. Each of our three group categories equate reasonably well to mild, moderate and severe and in our next publication we will discuss the advantages and disadvantages of an overall three group summary classification. **Cliff Jones** is leading a project on the LEAP database to assess the effect of the classification on outcomes, arguably the most important function of any classification.

The MFA project to obtain normative data on 43 and 11 continues to progress. **Doug Lundy** and **Julie Agel** are leading this project. We need to double our current enrollment. Two new centers have been approached and more are up and running than in the past. We hope that within a year we could be at a finish point and decide whether to expand to other codes.

Tom DeCoster presented advantages of expanding classification modules on the AAOS OKO site where we currently have three modules. An open fracture module using the videos would be a good project and Andy Evans is working on a 43 module. Please contact Tom if you would be interested in a fracture classification project. The use of the OTA database continues to dramatically grow. Julie Agel presented the data to the committee. The database is a no cost member benefit.

Finally **Craig Roberts** was welcomed as the new committee chair. L. Marsh will continue as a non-voting presidential appointment. The committee is proud of the accomplishments in the area of Classification, Database and Outcomes over the last six years.

TRAUMA SYSTEM FUNDING

Hassan R. Mir, MD

Trauma systems have been developed over the past few decades in several states and have improved patient access to timely care. The importance of trauma systems that expedite patient transport and care cannot be overstated. However, there is a great deal of variability in the funding available to support their continued development and implementation.

According to a report in the September 2010 Bulletin of the American College of Surgeons (ACS), there are 42 states that have established statewide trauma systems. Only 24 of these had some form of state funding in place at that time, with a variety of ways that they collect and allocate funds. Some of the ways that states are funding their systems include fines and fees on moving violations, fees on motor vehicle registration, fees on license plates, fees on driver's license renewal, taxation on cigarettes, fees from criminal penalties, and from state general revenue funds. As far as 2011 state legislation is concerned, the ACS is currently tracking 6 state bills that address trauma funding. The advocacy section on the ACS web portal (www.efacs.org) should be accessed for updated information on the bills that are currently being tracked. There is a specific section for bills related to trauma funding in addition to information on all of the state and federal legislation that the ACS is following. Do you know where your state stands on the matter?

In 2010, the Patient Protection and Affordable Care Act (PPACA) (P.L. 111-148) authorized a total of \$224 million in federal funding for trauma and emergency medical services programs and activities. The PPACA reauthorized the National Trauma Center Stabilization Act (NTCSA) and provides two grant programs. The Trauma Care Center Grants (\$100 million) are for trauma centers to allow them operating funds to maintain their core missions, to compensate them for losses from uncompensated care, and to provide emergency awards to centers at risk of closure. The Trauma Service Availability Grants (\$100 million) would be channeled through the states and used for a number of activities to address shortfalls in trauma services and improve access to and the availability of these essential lifesaving services. In addition, the PPACA reauthorizes the Trauma Care Systems Planning and Development

CONTINUED ON PAGE 14

Act (TCSP) and incorporates a new Regionalization of Emergency Care Pilot Program. The PPACA authorizes \$24 million for all grant programs provided under the TCSP to support state development of trauma systems. Half of this funding (\$12 million) is intended to be designated for implementation of the Regionalization of Emergency Care Pilot Program to design, implement, and evaluate innovative models of regionalized emergency care systems. However, as with previous Congressional Acts that have authorized federal funding of trauma systems, the House and Senate Appropriations Committees must choose to fund the programs during the appropriations process.

The Access to America's Orthopaedic Services Act (S. 1548/ H.R. 1021) was introduced on February 12, 2009 by Representative Gene Green (D-TX) and Representative **Michael Burgess, MD** (R-TX) in the U. S. House of Representatives, and on July 30, 2009 by Senator Benjamin Cardin (D-MD) and Senator Richard Burr (R-NC) in the U.S. Senate. The legislation addresses the need to educate Congress and the public on the burden of musculoskeletal diseases and conditions. One of the many provisions of H.R. 1021 requires the Secretary of the Department of Health and Human Services (HHS) to issue a report to Congress on the orthopaedic implications of model trauma networks, trauma rehabilitation, and integration into the community, paying particular attention to access to specialty care for patients with orthopaedic-related conditions, outcomes for trauma victims, and access to post-acute rehabilitative services. Please refer to the American Academy of Orthopaedic Surgeons (AAOS) government relations website (<http://www.aaos.org/Govern/Govern.asp>) for updates on state and federal health policy activities by the AAOS.

Orthopaedic surgeons should be involved in the implementation and improvement of trauma systems. Federal and state funding is necessary to improve the current model, and orthopaedic surgeons must advocate on behalf of the specialty and their patients to try to secure funding to ensure the success of trauma systems. I encourage you to get involved!

In July of 2003, the ACGME, which governs some 9,000 programs, enacted the first set of resident work hour standards, and the primary effect was to establish the 80 hour resident work week. The stated goal was "to promote high quality learning and safe care in teaching institutions." The OTA presidential line, led by Jeff Anglen, MD, was active in responding to these restrictions: **The Institute of Medicine Report on Resident Duty Hours Part I: The Orthopaedic Trauma Association Response to the Report Jeffrey O. Anglen, MD¹, Michael J. Bosse, MD², Timothy J. Bray, MD³, Andrew N. Pollak, MD⁴, David C. Templeman, MD⁵, Paul Tornetta, III, MD⁶ and J. Tracy Watson, MD** (*The Journal of Bone and Joint Surgery (American)*. 2009;91:720-722). This paper conveyed that there is a lack of significant data to prove that restricted working hours would improve the quality and outcomes of care. We also expressed concerns regarding reducing the access to trauma care, decreasing the residents clinical experience in trauma care and problems associated with 'handovers' of patient care.

OTA's concerns are shared by many of the medical specialties, educators, and the public. These concerns are:

1. The adoption of a 'shift mentality' in the care of patients by the current generation of residents;
2. A focus on complying with hours restrictions with less regard to improving the safety of patient care and the quality of the educational experience; and
3. Persistent concerns that the 24 hour + 4 hour rule still left residents susceptible to fatigue induced errors.

In the medical legal forum, cases have cited problems in patient hand-offs, supervision of residents, and 'general communication issues.' As a result of these observations and the interpretation of them by the ACGME there are new recommendations on duty hours from the ACGME Task Force set to be placed July 2011.

First, the rationale of the guidelines is stated to focus on the process with which "residents gain of experience and demonstrate growth in their ability to care for patients, they assume roles of greater

CONTINUED ON PAGE 16

THE AAOS AND OTA LAUNCH DISTRACTED DRIVING CAMPAIGN

Washington DC – On April 6, 2011, the American Academy of Orthopaedic Surgeons (AAOS) and the Orthopaedic Trauma Association (OTA) announced their increased commitment to end the distracted driving problem in America; released the startling results of a national poll on the habits of American drivers; and formally launched a new PSA campaign and interactive Web site. This national initiative, made possible, in part, with support from the [Auto Alliance](#), encourages drivers to “decide to drive” and includes a new multimedia public service advertising (PSA) campaign, interactive Web site, school curriculum, print public service poster contest and materials to help surgeons talk to their patients about distracted driving.

As part of the effort to launch this campaign, Andy Pollak, OTA President and Aaron Brookens, patient spokesperson, joined Fox 5 News in DC to talk about the campaign. See it here: [Pollak/Brookens Interview](#).

News of this PSA has been picked up by press throughout the US, including this New York Times Article.



THE AAOS-HARRIS INTERACTIVE SURVEY RESULTS:

The survey found that there is a disconnect between what American drivers report observing on the road and what they report practicing behind the wheel.

- Of the more than 1,500 driving-age adults surveyed, NONE of them reported their own driving as unsafe. In fact, 83 percent claim to drive safely. And, yet they believe only 10 percent of other drivers drive “safely.”
- Although drivers are aware that distracted driving compromises the ability of others to drive safely, one in five (20%) agree that they are a good enough driver that they can do other things while driving without compromising [their driving ability].
- Among those who self-reported distracted driving behaviors overall, 30-44 year olds seem to be the worst offenders having more likely admitted to eating or drinking, talking on a cell phone or reaching in the back seat of the car while driving.
- Many drivers that have experienced a near-accident due to their own distracted driving behavior say they will continue the behavior that caused them to swerve or slam on the breaks to avoid an accident.
- The results showed that 94 percent of drivers in America believe that distracted driving is a problem in the U.S. and 89 percent believe it is a problem within their own communities.

Additional details and download can be found at www.decidetodrive.org.

“Froggy” TV PSA – A dramatic, nationally distributed TV PSA showing, in reverse, a crash caused when a mother reaches into the back seat of her car to grab a toy.

“Spoken Word” Radio PSA

[Order PSA materials](#)

RESIDENT WORK HOURS

CONTINUED FROM PG. 14

independence.” Key to this is are new requirements for faculty and senior level supervision. Likely to have the greatest impact is the 16 hour work restriction place on residents in the PGY-1 year. “PGY-1 residents should have 10 hours and must have 8 hours free of duty between scheduled duty periods.” In addition to the new hour restrictions will be the requirement that faculty or senior supervision is physically present or available (ie. In house). Senior supervision is specifically defined for each specialty and for orthopedics *appears* to designate orthopedic PGY-4 and PGY-5 residents.

In a letter to the Board of Specialty Societies your OTA Presidential Line has requested the following – directly taken from our letter:

- “We request that the BOS consider the following:
 - 1) Establish a consensus among specialty societies detailing specific points of concern regarding restrictions to resident work hours, and the long-term ramifications of such restrictions.
 - 2) Develop a formal position statement on behalf of the Specialty Societies, and submit the statement to the AAOS for adoption as an AAOS Resolution at the Fall 2011 AAOS Meeting.

The link to the ACGME website is: http://www.acgme.org/acWebsite/dutyHours/dh_index.asp

VOLUNTEERS NEEDED FOR ORTHOPAEDICS OVERSEAS PROGRAM IN GHANA

Read more about this program, and OTA Past President, **Peter Trafton's** involvement as program director for HVO's Orthopaedic site in Ghana, via this link provided compliments of **RRY Publications/Orthopaedics This Week. Bringing Advanced Orthopaedics to Africa** (page 12).

For volunteer details please contact:
Andrea Moody at HVO: a.moody@hvousa.org.

2011 CALENDAR

OTA Comprehensive Fracture Course for Residents (2.0)
April 28 - 30, 2011
Schaumburg, Illinois

**** Scholarships Available ****



OTA 27th Annual Meeting
October 12 - 15, 2011 • San Antonio, Texas

OTA Comprehensive Fracture Course for Residents
October 12 - 15, 2011 • San Antonio, Texas

ANNOUNCEMENTS

- **Jeff Anglen**, past president of the OTA, began his year as President of the Board of Specialty Societies. He succeeded **M. Bradford Henley** as BOS President, who was also a Past President of the OTA! Congratulations on the strong leadership tradition!
- **2011/2012 Fellowship Match:**
All OTA Fellowship Programs planning to participate in the next match, must enroll and pay the match participation fee by **May 27th**. If you have not received instructions from SFMatch and wish to participate, please contact the OTA Business Office.
- **OTA 2010 Annual Report** now on-line.
- **OTA Membership Application Deadline: November 1st**
Please encourage your colleagues to join!
 - Benefits of Membership
 - On-line Application
 - Requirements for Members

Orthopaedic Trauma Association

6300 N. River Road, Suite 727, Rosemont, IL 60018-4226
Phone: (847)698-1631 Fax: (847)823-0536
e-mail: ota@aaos.org Home Page: <http://www.ota.org>