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Western Trauma Association: Past, Present and Future—1989 Presidential Address

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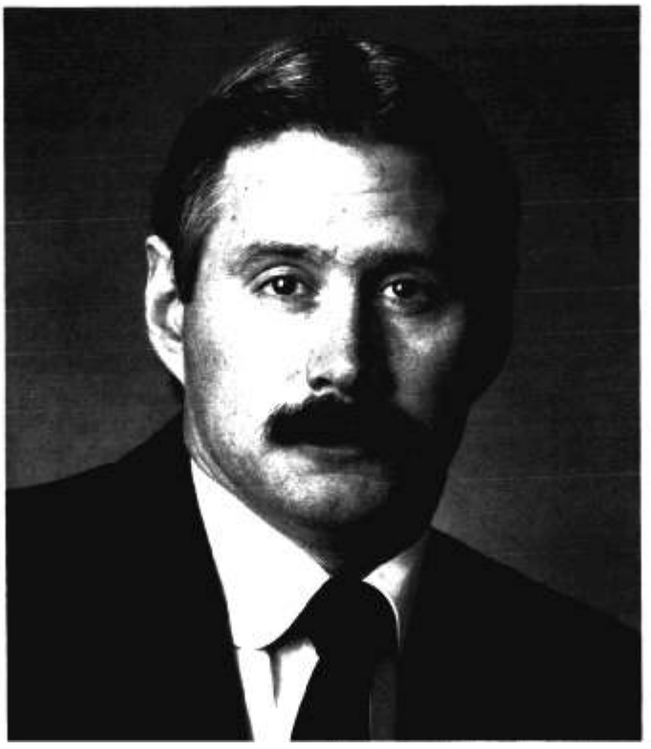

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The Western Trauma Association (W.T.A.) is completing its second decade as a viable, functional, and self-sustaining regional trauma society; it may be an appropriate time to reflect on how we were conceived, to what extent we have developed, and in what direction we need to proceed (Fig. 1). During these 20 years the enormous socioeconomic impact of trauma in this country has finally been recognized, and has culminated in a nationwide effort to develop organized trauma systems in which patient care, education, and research can be optimized (3, 5, 13). The American Association for the Surgery of Trauma (A.A.S.T.) (9), the Committee on Trauma (C.O.T.) of the American College of Surgeons (2, 4, 10), the American College of Emergency Physicians (11), and the American Trauma Society (12) have provided leadership from a national perspective, but there is now a growing need to accomplish these goals at the grass roots level. The W.T.A. has evolved into a society which has been uniquely effective in this mission. The purpose of this review is to provide a basis for additional maturation of the W.T.A. as well as to describe an experience that may prove useful for other groups aspiring to fulfill a similar role. The analysis has been divided into the past or infancy (1970–1979), the present or adolescence (1980–1989), and the future or adulthood (1990----).

THE PAST (1970–1979)

The founding members of the W.T.A. were Robert G. Volz (Orthopedic Surgery, Denver), Peter V. Teal (Orthopedic Surgery, Billings), William R. Hamsa, Jr. (Orthopedic Surgery, Omaha), and Douglas A. McKinnon (Plastic Surgery, Denver); the first three served as presidents in that order. Peter Teal and Bob Volz, who had grown up together in Nebraska, accomplished most of the spadework which led to the incorporation of the W.T.A. in Colorado 16 December, 1970. The purpose as stated in the Articles, was to: " . . . exchange educational and scientific ideals and principles at the highest level, in the diagnosis and management of traumatic conditions . . . " . The initial Board was expanded to include representatives from Wyoming and Minnesota. Several operational principles were agreed upon: 1) members must be Board certified; the membership would be interdisciplinary and not dominated by any particular specialty; 2) there would be wide geographic representation to avoid provincialism; the original membership would be 50 and gradually expanded to a limit of 100; 3) members must be active participants, submitting an abstract as well as attending at least every third meeting; and 4) a special effort would be made to include spouses and families. The latter goal was in part fulfilled by providing a spouses' breakfast each day, dedicating an afternoon session to nonmedical topics of interest to spouses and families, and conducting the scientific program in the early mornings and late afternoons, leaving the balance of the day for skiing and other outdoor activities with the families.

The first Annual Meeting was held in Vail February 4–6, 1971 (room rates were $25.00, double occupancy). Early membership was predominantly from private practice groups, and consisted of roughly one third orthopedic surgeons, one third general surgeons, and one third other specialties. At the 1973 meeting, there were 51 members presenting 17 papers over 3 days. The meeting was lengthened to 5 days in 1976, and at the 1979 session in Snowmass 31 papers were presented. Membership had grown to 74: 19 were orthopedists, 21 general surgeons, and 34 represented other specialties. The Bylaws had

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been formalized, but did not change substantively from their original description.

This infancy period was remarkably stable due to the foresight of the founding members and continued incorporation of active participants who were dedicated to the goals of the Association. The other presidents serving during these critical years were Arthur M. McGuire, Lynn Ketchum, Frederic C. Chang, Glen D. Nelson, and Gerald D. Nelson.

THE PRESENT (1980–1989)

The most significant change over the next decade was the insinuation of active members from major academic trauma centers, and specifically their influence on the scientific program. In 1979, three (10%) of the 31 presentations were from such centers; whereas in 1985, 14 (41%) of the 34 papers were given by trauma surgeons from the Denver General Hospital, Ben Taub General Hospital in Houston, and Kings County Hospital in Brooklyn. This trend has continued and, in 1988, nearly two thirds of the program originated from general surgeons representing designated trauma centers with accredited surgical residency training programs. Additionally, there were regular contributions from academic orthopedic institutions, most notably the Mayo Clinic and George Washington University. Collectively, these groups changed the program to a more traditional academic format with 10-minute papers and critical but very constructive discussion.

The improved quality of the scientific exchange ultimately led to the publication of selected papers in the *Journal of Trauma* (6). A Publication Committee was formalized and chaired by W.T.A. members who were also serving on the editorial board of the *Journal.* Four manuscripts were published in 1985 and the number has increased progressively to 14 in 1988 (6–8). The opportunity for peer-reviewed publication, in turn, increased the number of submitted abstracts, necessitating a Program Committee for their careful review and selection. The goal of preserving an interdisciplinary scientific program has been emphasized by ensuring broad specialty representation on these important steering committees. Finally, the change to traditional academic style has provided residents and fellows a unique chance to present their preliminary data to a critical audience. This constructive review has frequently matured evolving concepts to a level that has made the studies competitive for national meetings. In fact, a substantial number of papers given at the A.A.S.T. over the past 5 years had preliminary presentations to the W.T.A. at a formative stage.

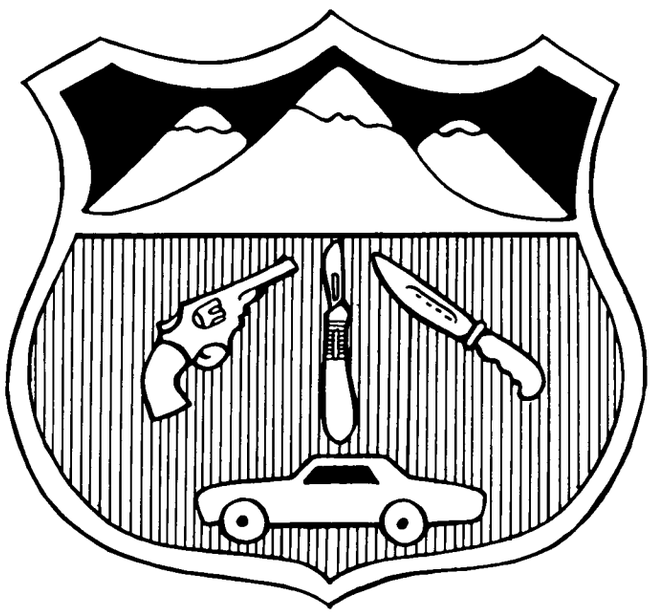

FIG. 1. Logo of the Western Trauma Association, founded 1970.

Perhaps one of the most gratifying accomplishments of the W.T.A. has been multicenter collaboration in clinical research. The first such endeavor detailed the outcome following major liver trauma drawn from an experience of 1,335 hepatic injuries in six different centers (1). The current multicenter effort has addressed the controversial issue of nonoperative management for documented splenic rupture in adults as well as children. Subject content for the afternoon session, dedicated to nonmedical topics, changed from invited guests' presentations to W.T.A. members sharing their unique travel experiences. "Inside Afghanistan, 1985" by John McGill was certainly one of the most provocative. Another important milestone has been recognition of the W.T.A. as an effective regional trauma society by the American Association for the Surgery of Trauma—the national academic trauma society. The W.T.A. president serves as the official liaison to the A.A.S.T., and submits a formal status report to the A.A.S.T. annually.

This adolescent period was marked by rapid development with the obligatory growing pains in changing from a relatively uniform group dominated by private surgeons into a diverse group of medical specialists inspired by academic surgeons to enhance the quality of the scientific program. The presidents serving during this maturing time were Kevin G. Ryan, David S. Bradford, Erick R. Ratzer, William R. Olsen, Earl G. Young, Robert B. Rutherford, Rudolph A. Klassen, Robert J. Neviaser, and Robert C. Edmondson.

THE FUTURE (1990-----)

The major challenge in the immediate future will be to maintain specialty balance in the W.T.A. proceedings. The most conspicuous deficiency is in orthopedic surgery; this specialty contributed nearly one third of the earlier program material but was represented in only 16% at the 1988 meeting. The educational dialogue between orthopedic and trauma surgery is particularly important at regional societies because of its decline at a national level. The latter is partly due to the emergence

of the Orthopedic Trauma Association with its own journal. Moreover, it is essential to provide such a forum for neurosurgery, plastic surgery, urology, interventional radiology, and emergency medicine, who are equally fragmented and isolated because of their specialty societies. Trauma management is clearly a team effort. But to be effective contributors, the other specialties must submit abstracts of comparable scientific value and interest. I believe the senior W.T.A. members of these under-represented specialties must take an aggressive role in recruiting their younger academic colleagues and supporting their active participation. The current senior residents and fellows are the best resource for membership. An annual resident award for scientific work, sustained by a self-perpetuating fund, should be developed to attract these future leaders of the W.T.A. At the same time, the W.T.A. should not be viewed as academically competitive with the A.A.S.T. but rather a learning experience to allow individuals as well as concepts to develop into national level quality.

An equally important objective for the future is to maintain the active role of private physicians in the W.T.A. program. A regional society should capitalize on the unique opportunity to exchange knowledge between the practitioner, who applies new scientific principles in the real world, and the full-time academic physician, whose daily charge is to expand the scientific basis. Indeed, some of the most enlightening overviews have been presented by private specialists, e.g., "Magnetic Resonance Studies of the C.N.S.," by Charles Seibert (radiology) and "Immunologic Consequences of Splenectomy" by Robert Edmondson (internal medicine). Panel discussions of controversial multisystem trauma cases have been another highly effective vehicle to eliminate the potential town-gown barrier. The W.T.A. membership quota of 100 will be strained continually in the future. I believe the expansion must be curtailed at 125 to promote the free, open exchange of scientific material as well as offer a reasonable selection of winter meeting sites. Therefore, it will be extremely critical that membership retention is based on documented performance rather than the potential for contributions.

The W.T.A. can also provide services as a regional trauma society in areas such as pre-site visits for trauma center verification, establishing trauma registries, and job placement. Collaboration in multicenter studies is extremely valuable, and this concept should expand into prospective, randomized clinical trials ultimately funded by private corporations, pharmaceuticals, or other agencies coordinated via the W.T.A. The ongoing academic mission of the W.T.A. is best assured by maintaining an active liaison with the A.A.S.T. as well as the *Journal of Trauma.* Moreover, the continued growth and vision of the W.T.A. as a functional regional society will be enhanced by an open interchange with other such organizations; e.g., the recently developed Eastern Association for the Surgery of Trauma (E.A.S.T.).

The future viability of the W.T.A. will require anticipating changes in the medical, legal, social, economic, and ethical climate related to trauma from a national as well as regional perspective. The diverse backgrounds and specialty interests of our Association compound this decision making. I suggest an Advisory Committee, composed of the past presidents who remain active members, meet to identify critical issues and offer constructive suggestions. The immediate past president should chair this committee and present a formal report at the Annual Board and Business Meetings. Finally, I submit it is an obligation of the President to critically review one of these issues, and present his or her ideas in the form of a Presidential Address to the membership at the Annual Meeting.

Addendum:

On the afternoon of February 27, 1989, past-president Earl G. Young died skiing in the Gad II chutes of Snowbird. A memorial service was held at the next sunrise on the top of the mountain and was attended by all those present at the meeting. An annual Resident Paper Award was established in Earl's name at the ensuing business session. We will miss our dear friend; the W.T.A. has lost an extraordinary leader.

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