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# Western Trauma Association: Past, Present and Future

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As the Western Trauma Association (W.T.A.) enters its 20th year 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.

Recognition of the enormous socioeconomic impact of trauma in this Country over the past decade has culminated in a nationwide effort to develop organized trauma systems in which patient care, research, and education 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[12] and the American Trauma Society [11] have provided leadership from a national perspective, but there is now a growing need to accomplish these goals at a regional level. The W.T.A. has evolved into a society which has been effective at this level. 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 is somewhat arbitrarily 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. are Robert G. Volz (Orthopedic Surgery, Denver), Peter V. Teal (Orthopedic Surgery, Billings), William 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 accomplished most of the spadework which resulted in the incorporation of the W.T.A. in Colorado on December 16, 1970. The Articles stated the purpose was to: "--- exchange educational and scientific ideals and principles at the highest level, in the diagnosis and management of traumatic injuries and 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 origin 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 family. The later was in part fulfilled by providing a spouse's breakfast each day, dedicating an afternoon session to nonmedical topics of interest to the spouses and family and, conducting the scientific program in the early mornings and late afternoons leaving the balance of the day for skiing and other outdoor activities.

The first meeting was held in Vail February 4-6, 1971 (room rates were $25.00 double occupancy). Early membership was predominately 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 three days. The meeting was lengthened to five 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 been formalized, but did not change substantively during the first decade.

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 Present (1980-1989)

The most significant change over the next decade was the insinuation of active members from major academic trauma centers, and their strong 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 King's 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 in Rochester and George Washington University. Collectively, these groups changed the program to a more traditional academic format with 10 minute papers and critical 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 [6,7,8]. 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.

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 1335 hepatic injuries in six different centers [1]. The current multicenter effort has addressed the controversial issue of nonoperative management for splenic rupture. Subject material for the afternoon session dedicated to nonmedical topics has changed from outside 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 W.T.A., 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 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% of the 1988 meeting. The educational dialogue between orthopedic and trauma surgery is particularly critical at regional societies because of its decline at a national level. The later 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 underrepresented specialties must take an active role in recruiting their younger academic colleagues and demanding their active participation. The best resource for membership is the current senior residents and fellows. An annual resident award for scientific work, funded by pharmaceutical support, should be developed to attract these future leaders of the W.T.A.

An equally important objective for the future is to maintain the active participation of private physicians in the W.T.A. program. A regional society should capitalize on the unique opportunity to exchange knowledge from the practitioner who applies new scientific principles in the real world alongside the full-time academic physician whose daily charge is to expand this scientific basis. Indeed some of the most enlightening overviews have been given by private specialists; eg, "Magnetic Resonance Studies of the C.N.S." by Chuck Seibert (radiology) and "Immunologic Consequences of Splenectomy" by past-president Bob Edmundson (internal medicine). The W.T.A. membership quota of 100 will be strained continually in the future, but 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. Membership retention should be 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. Multicenter studies are extremely valuable and this concept should evolve into prospective, randomized clinical trials 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 continuing an active liaisonship with the A.A.S.T. as well as the

Journal.

The future viability of the W.T.A. will require anticipating changes in the medical, legal, social, economic, and ethical issues related to trauma from a national as well as regional perspective. The diverse backgrounds and specialty interests of our Association compound the 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 in a formal report annually to the Board. Finally I submit it is an obligation of the President to critically review one of these issues, and present their ideas to the membership at the annual meeting.

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