

OTA Presidential Address 2007
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It is my great honor and privilege to be the 23rd president of the Orthopaedic Trauma Association. To OTA members, thank you for the opportunity to be here addressing you this morning. To those who are not members, thanks for coming to our annual meeting, I hope it is interesting and useful to you all.

I'm going to take a few minutes this morning to talk with you a bit about what we've been doing over the past year in the OTA, to let you know the status of some of our programs and new initiatives, to share with you some recent successes, and to start a discussion, which I hope will continue beyond this meeting, about our vision of the future and the challenges that lay ahead. Before I start that, however, I'd like to take a moment to acknowledge the efforts of some key people.

This society is an active, vital and effective organization and it wouldn't be that without the tremendous efforts of large number of members who volunteer to serve as committee chairs and members. There are so many I couldn't possibly acknowledge them all individually, although all have done a great job this year; but there are a couple of significant names who have contributed to our success above and beyond the call of duty.

Andy Schmidt and Bill Ricci, chair and co-chair of the program committee, along with their members Bill Obremskey, Bruce French, David Ruch, Peter O'Brien, Shep Hurwitz, Victor DeRidder, Paul Tornetta and Ted Miclau have put together another in a long line of outstanding annual meeting programs, each of which seems somehow to top the preceding one. Dr. Ted Miclau organized the Basic Science Focus Forum that many of you attended on Wednesday, which added a unique and important scientific facet to our annual gathering. Chris Born organized and ran the Mass Casualty Management course. Thanks to all these members for their contributions.

One of our core missions is education, and, although I might be biased, I'm far from alone in my opinion that we do education better than any other orthopaedic subspecialty organization. Mike Baumgaertner is finishing up his second term as education chairman, a period of time which has seen tremendous success in this arena. Mike has overseen many excellent courses, both for residents and practicing surgeons, development of new courses, outstanding publications such as OKU Trauma III, co-branded ICLs with AAOS, the continued development of the resident lecture slide series and other electronic educational material. I know he would pass the accolades along to course directors and project leaders like Kevin Pugh, Steve Morgan, and Laura Prokuski with the Residents Basic Fracture Course; Mike Stover, Bill Ricci, Claude Sagi, and Jim Stannard with the Advanced Resident's Course; Dave Teague and Tom Higgins with the Resident Lectures slide series; Bill Burman with the web based RBFC lectures; Chris Born, Steve Olson, and Bob Probe with the combined OTA-AAOS course; and many others too numerous to mention who have given their time and expertise to OTA education as course directors,

section leaders, lecturers, workshop organizers, editors, moderators, reviewers and authors.

I want to say a special thanks to the OTA presidential line: Paul Tornetta, Michael Bosse, Tracy Watson and Dave Templman, who have been a source of support and guidance over the past year. Each one an outstanding leader in his own right, together they have been an exceptional team of effective and collaborative leaders advancing the OTA agenda on many fronts.

And of course, a huge part of our success is due to the long term sustained efforts and management skills of our executive director, Nancy Franzon, and her outstanding staff: Kathleen Caswell, Sharon Moore, Darlene Meyer, and Paul Hiller. Nancy has been the heart, soul and brains behind OTA the whole time that I have been involved, going back 16 years now.

The title of this talk is “Last Call”. That title came about due to the fact that I procrastinated a bit on writing the talk and, in fact, hadn’t actually written anything by the time the annual meeting program was scheduled to go to press. The staff kept after me for a title, until finally Sharon made one “last call” for my title. I had nothing, but I knew it would have to be largely about the call crisis – hence “Last Call”.

Over the past year, we have spent a great deal of time and energy trying to shape the Orthopaedic response to the emergency care crisis in America. Michael Bosse talked about this in his message last year, and you in this audience are well acquainted with the problem. To those of us involved in trauma every day, it is no surprise that the system of emergency care in this country is in big trouble. With the publication of the 3 volume Institute of Medicine report last year, this has now become widely known to the public as well, and to policy makers.

The causes of this situation are complex, multi-factorial, and often beyond our influence, but one undeniable aspect of the problem, which unfortunately makes a good “sound byte”, is the lack of surgical specialists who are available and willing to take Emergency department call. When orthopaedic surgeons are not available to take ED call in hospitals around the country, patients must be transferred or referred, sometimes for long distances, often for minor or routine musculoskeletal problems. Usually the burden falls upon a trauma center – truly the “last call” for patients with emergent conditions. The results of inappropriate transfer to trauma centers are unnecessary delay for the patient, inconvenience and hardship for the families, inefficient and wasteful use of vital scarce resources, overloading of trauma centers, which negatively impacts the care of the real trauma patient and burn-out of orthopaedic trauma surgeons.

As orthopaedic surgeons, we have knowledge and unique skills that no other group in our society possess, which make us the best qualified providers for patients with musculoskeletal problems, including injury. We have gained that skill and knowledge largely at public expense – there would be few or no medical schools and teaching hospitals without government funding. As a result of that public investment in our

training, we incur a responsibility to provide our expertise to our fellow citizens, in the community in which we practice - our neighbors, the people we see every day, our employees and their families, our own friends and families – to anyone in the community who needs that care.

In some cases, physicians have failed to live up to their responsibilities to provide the care that they are uniquely qualified to give. This is not to say that hospitals and governments are doing everything they can and should be doing toward providing the resources to enable physicians to provide that care. In many cases, they clearly are not. But to whatever extent our own professional behavior contributes to this problem, we need to fix that within our profession. We should not wait for others to correct their own deficiencies before beginning to correct ours.

Toward that end, the OTA has proposed to the AAOS a “Standard of Professionalism” which states that every orthopaedic surgeon should acknowledge a duty to his or her community, and should make a positive contribution toward solving this problem, including, when necessary and appropriate based on local circumstances, taking call. It doesn’t say that everyone should have to take general orthopaedic call under all circumstances, or that everyone has to “do trauma” – we certainly don’t want everyone to do trauma, that is what we in the OTA want to do. The SOP doesn’t let the hospitals or governments off the hook for meeting their own responsibilities. As a professional standard, it cannot be used by anyone outside the profession – not by hospitals, insurance companies, lawyers or bureaucrats. It can only be invoked by another member of the profession, another fellow of the AAOS.

We have not been successful, yet, in convincing the AAOS to adopt this proposal as part of their professional standards. Some officers in the Academy are reluctant to propose any standards that are not supported a priority by 90% of the membership. We think that this situation represents a key opportunity to exercise *true* leadership, for it takes no leadership at all to adopt positions that are already supported by a majority of the members. It is easy, non-controversial, and doesn’t lead to conflict. It also doesn’t lead to progress. We think that true leaders adopt positions dictated by their conscience and based on their values and vision of what is the right thing to do; and then use their skills to educate, motivate, and communicate that vision until the rest of the membership sees it too. Until the right way is obvious to all.

That is what we are trying to do. It is not easy, and we may fail. Those of you who know the members of the OTA presidential line, know that we are not people who like to fail, we are not accustomed to failure, but we think this issue is so important we are willing to fail in the attempt. What we are not willing to do is fail without making the attempt.

Everyone in the audience can contribute to this effort. Those of you who are AAOS fellows have a Board of Councilors representative. Usually they are appointed by your state orthopaedic association. Contact your AAOS Board of Councilors representative and urge them to support this initiative. Email the Academy leadership and let them know how important this is to your community, your patients, your practice and your

trauma center. Demand that they lead our profession in the right direction on this issue. While you are at it, contact the American Board of Orthopaedic Surgery, and tell them that living up to community responsibilities and maintaining and using core orthopaedic skills for the good of our society should be a central requirement for maintenance of certification.

We are a pretty small organization, but our membership is dedicated, hardworking, involved and influential. I believe that members of the OTA have respect disproportionate to our numbers – maybe even because of our small numbers. IF we raise our voices together, we can turn the tide of this debate and lead the profession in the response to this crisis.

Because our group is rather small, we have to learn the importance of developing alliances and coalitions to achieve our goals. Our true allies are anyone who is dedicated to providing the optimal quality of care to those with musculoskeletal injuries, no matter what their training or background. Toward that end, we are encouraging OTA members to become involved in other trauma care organizations. Join the hospital committee on trauma, and attend the meetings in your center. I know that they meet in the middle of the afternoon when you are usually in the OR, and that much of their agenda is not very important to your practice, but important decisions are made at that table and we need your voice there. Join the American College of Surgeons and participate in your regional committee on trauma. Investigate and consider joining the AAST, WEST, and EAST. Find out if your trauma center has a chapter of the Society of Trauma Nurses, and build a connection to them. Although we have grown up within the “House of Orthopaedics”, and the Academy remains our strongest and best ally, we also live in the “House of Trauma”. Our efforts can be amplified by working together with other trauma organizations.

While I am talking about other trauma organizations, I should mention the development of the new specialty known as the acute care surgeon. As you know, we have been cautious and a bit skeptical about the concept of any non-orthopaedic surgeon providing treatment for musculoskeletal injuries. Paul Tornetta and Michael Bosse were very engaged with the AAST as this initiative developed, and were able to help shape the curriculum for training these new specialists to include very few musculoskeletal procedures, ones we felt could safely be performed by those practitioners. We will continue to monitor how this develops, but rather than spend our energy on turf battles and arguing about who is best trained to provide certain types of care, our emphasis and priority will be focused on getting the best possible care to the injured patient. An absolute prerequisite to providing that care, the minimum acceptable standard if you will, is the willingness to show up and do it. We can work with any provider who will meet that standard, but cannot accept any who will not.

I'd like to turn our attention now to some of the other exciting areas of activity within OTA. As you will see on the program this year, we have begun an initiative to extend our mission of education, research and improvement in care to the developing areas of the world. There is an alliance with Dr. Lewis Zirkle's SIGN organization, which will

allow us to provide our educational content to those surgeons in over 40 countries around the world and to facilitate OTA membership for those who qualify. Our first SIGN surgeon scholarship recipients is with us at the annual meeting this year – Dr. Lelei from Kenya. The second surgeon selected, Dr. Lwin from Myanmar, unfortunately had visa problems and couldn't make the meeting, but we hope he will be here next year. Lew Zirkle and Dave Templeman have made connections with Doctors without Borders, and several of our members are participants in Orthopaedics Overseas. This involvement brings with it a tremendous opportunity for the organization and for individual members not only to teach and care for patients in the third world, but to learn, and to experience the personal fulfillment of providing care to patients who otherwise wouldn't get treatment at all.

We have continued to expand our effort to work together with the AAOS and the US military to study and improve the care of victims of combat related injury. Through the efforts of Andy Pollak, Dick Kyle, Roman Hayda, Michael Bosse and others, the OTA has instituted the Distinguished Visiting Surgeons program sending senior orthopaedic traumatologists to Landstuhl Regional Medical Center to teach and learn from our military colleagues caring for injured soldiers, sailors and airmen. We have participated in developing and reviewing grants for the Orthopaedic Trauma Research Program of the DOD, and in advocating for increased funding to this vital program. We have participated in sponsoring the Extremity War Injury symposium for the past two years, and will be involved in the third next January. Through these programs we hope to harvest something positive from this worldwide epidemic of tragedy, by improving our understanding and treatment of those injured in armed conflict.

I mentioned previously our education program and how we are way ahead of most other specialty societies in this respect – our research program similarly sets the standard for development and promotion of orthopaedic trauma research. Research has always been one of our core values. Under the leadership of Joe Borrelli, the research committee will this year award over a half million dollars for high quality research grants. Joe has built upon the excellent work of previous research committee chairs such as Ted Miclau, Michael Bosse and Marc Swiontkowski, who have brought us much success and respect in this area. Not only are the numbers of grant proposals increasing every year, but the quality keeps getting better and better through our efforts to develop and improve the grant-writing abilities of our investigators. As most of you have heard, we are now in our second year of the campaign to increase the OTA participation as OREF donors to 100% of our membership. This is an ambitious goal, but we made substantial progress on it last year, and our members have always been in the forefront of the specialty societies both in terms of percentage of members who donate and the dollars per member. In recognition of this and of our excellent research grant awarding program, OREF has started a trial program just for OTA, in which they will share a percentage of all OTA members' donations to OREF with OTA, no matter what the size of the donation. WE encourage every member to make an OREF donation this year. In addition, at our Board of Directors meeting Tuesday night, we voted to open an OTA endowment fund within the Shands Circle program of the OREF. This is open to any OTA member who wants to become a Shands Circle level donor, by contributing \$20,000.00 or more to OREF.

Proceeds from that endowment will be controlled by OTA and used to fund trauma related research. And while I'm mentioning research, I can't fail to acknowledge the wonderful generosity of all our donors, who are listed in your annual meeting program. Our corporate partners have been consistently generous and supportive, as have our foundation partners, such as the Foundation for Orthopaedic Trauma and AO North America. AO North America has loyally supported our research fund annually for many years. This year, they tripled their donation amount. This represents not only their generosity, but their confidence in our research granting process. Thank you to AONA.

In closing, I would like to make a few comments about the future. As many of you are aware, this year for the first time, we had more ortho trauma fellowship applicants than there are positions offered in North America. There were approximately 90 fellowship applicants through our website. This has created some challenges for us, and Dr. Lisa Cannada and the OTA fellowship committee have been working to improve our processes in this vital area. In part, the increasing numbers are due to our success in convincing hospitals and groups about the importance of things like protected OR time for orthopaedic trauma, providing adequate assistance and equipment, call pay and salary support and other measures for which we have long advocated. In part, it may be due to a concerted effort at recruitment – discussions at our resident courses, career nights at AO courses, institution of a resident (candidate) member category, the outstanding DVD about ortho trauma as a career that Jeff Smith and others produced. The primary factor is probably the role modeling provided by you, the members of the OTA. As I talk with residents and fellows around the country, I hear over and over again that within the faculty of the residency programs, the trauma guy or gal is the one with the most dedication, enthusiasm, and commitment to teaching. This newfound popularity of trauma as a career within orthopaedics raises questions and poses challenges for us as a group, forcing us to think of who we are, and how we may change and evolve in the future. I hope that as our numbers grow, we will continue to be the unique group of dedicated individuals that we have been and continue to exhibit the qualities that attracted me and you to this profession. Some of those qualities are -

Creativity – any surgeon who does a lot of trauma has to be willing to try new techniques, and sometimes to make them up as new situations are encountered. You have to be flexible enough to get rid of old things that don't work, to question the accepted wisdom and established practices, yet couple this with honesty and rigor in evaluating outcomes.

Boldness – When I was a resident rotating through Shock Trauma in Baltimore, I remember my first exposure to orthopaedic traumatology, working with Andy Burgess, Attila Poka, Bobby Brumback and Howard Bathon - one of the things that impressed me most about those guys was that they seemed fearless – not in a reckless way, but just from enthusiasm and joy in the work.. They seemed like lions surrounded by herbivorous herd animals. They were absolutely undaunted by hard work, or the most challenging clinical problems. They would take on anything in the OR or elsewhere.

Professionalism – not in the sense that it is often used in the medical school by the bureaucratic fun suckers who seem to run everything nowadays, to whom “professionalism” is conforming, being politically correct, sartorially elegant, culturally aware, gender sensitive, smoke free, and low fat, but professionalism in the sense of

taking unwavering, unflinching responsibility for putting the patient's best interest above your own, even when that means standing up to administrators, insurance companies, accountants and lawyers. Professionalism is doing the right thing, and staying until it is done.

And finally, the ability to make it fun and keep it fun. It is the pure joy of the work itself that you experience after the hard cases, when it is finally acceptably reduced and stably fixed, and that wave of exhaustion long kept at bay finally washes over you, but you see those X-rays and your first response is – “That was great, I can't wait to do it again, tomorrow night!”

As I meet the younger members coming into our group, I am struck that they seem to be just like us, only smarter – and for that reason, I am optimistic about the future of orthopaedic traumatology and the OTA. Thank you for your trust in electing me President, and for the opportunity to serve this great association. I would also like to say my personal thanks to my two mentors in this profession who got me started many years ago and who preceded me in this job, Dr. Marc Swiontkowski and Dr. Roy Sanders; and to the one who makes it all meaningful, my wife Diane Anglen.