The American Association for the Surgery of Trauma 75th Anniversary 1938–2013

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1938 – 2013

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Table of Contents

Preface
Robert C. Mackersie, MD.....i

Part I • The First 75 Years

1 History of the AAST
Steven R. Shackford, MD.....1

2 The AAST Gavels
Robert C. Mackersie, MD.....20

3 Conception, Maturation, and Transmogrification of *The Journal of Trauma*
Basil A. Pruitt, Jr, MD, and Ernest E. Moore, MD.....22

4 Acute Care Surgery
L.D. Britt, MD, MPH, Gregory J. Jurkovich, MD, and David B. Hoyt, MD.....71

5 AAST Research and Education Foundation
Erwin R. Thal, MD, and Michael J. Sise, MD.....82

Part II • Milestones in Trauma

6 1938–1949
Timothy C. Fabian, MD.....87

7 The 1950s
David V. Feliciano, MD, Basil A. Pruitt, Jr., MD, and Grace S. Rozycki, MD, MBA.....123

8 The 1960s
Charles E. Lucas, MD, and Anna M. Ledgerwood, MD.....137

9 The 1970s
Kenneth L. Mattox, MD.....150

10 The 1980s
David V. Feliciano, MD.....166

11 The 1990s
C. William Schwab, MD.....194

12 The 2000s
Ronald V. Maier, MD.....212

Part III • AAST Past President Interviews

13 Basil A. Pruitt, Jr., MD, *1982–1983*
Frederick A. Luchette, MD.....245

14 George F. Sheldon, MD, *1983–1984*
David H. Livingston, MD.....259

15 David S. Mulder, MD, *1984–1985*
Frederick A. Luchette, MD.....268

16 Francis C. Nance, MD, *1985–1986*
David H. Livingston, MD.....280

17 Donald D. Trunkey, MD, *1986–1987*
Frederick A. Luchette, MD.....291

18 Donald S. Gann, MD, *1987–1988*
David H. Livingston, MD.....298

19 H. David Root, MD, *1988–1989*
Frederick A. Luchette, MD.....306

20 P. William Curreri, MD, *1989–1990*
Frederick A. Luchette, MD.....316

21 F. William Blaisdell, MD, *1990–1991*
David H. Livingston, MD.....322

22 Lewis M. Flint, MD, *1991–1992*
Frederick A. Luchette, MD.....331

23 Ernest E. "Gene" Moore, MD, *1993–1994*
David H. Livingston, MD.....341

24 Cleon W. Goodwin, MD, *1994–1995*
Frederick A. Luchette, MD.....349

25 Kenneth L. Mattox, MD, *1995–1996*
David H. Livingston, MD.....357

26 Anthony A. Meyer, MD, PhD, *1996–1997*
David H. Livingston, MD.....365

27 Anna M. Ledgerwood, MD, *1997–1998*
Frederick A. Luchette, MD.....372

28 J. David Richardson, MD, *1998–1999*
David H. Livingston, MD.....382

29 Frank R. Lewis, MD, *1999–2000*
David H. Livingston, MD.....390

30 Ronald V. Maier, MD, *2000–2002*
David H. Livingston, MD.....398

31 David B. Hoyt, MD, *2002–2003*
Frederick A. Luchette, MD.....406

32 H. Gill Cryer, MD, PhD, *2003–2004*
David H. Livingston, MD.....414

33 Steven R. Shackford, MD, *2004–2005*
David H. Livingston, MD.....422

34 C. William Schwab, MD, *2005–2006*
Frederick A. Luchette, MD.....431

35 David V. Feliciano, MD, *2006–2007*
Frederick A. Luchette, MD.....440

36 Timothy C. Fabian, MD, *2007–2008*
Frederick A. Luchette, MD.....451

37 Gregory J. Jurkovich, MD, *2008–2009*
David H. Livingston, MD.....462

38 Andrew B. Peitzman, MD, *2009–2010*
Frederick A. Luchette, MD.....472

39 L.D. Britt, MD, MPH, *2010–2011*
Frederick A. Luchette, MD.....484

40 J. Wayne Meredith, MD, *2011–2012*
Frederick A. Luchette, MD.....494

41 Robert C. Mackersie, MD, *2012–2013*
Frederick A. Luchette, MD.....504

Preface

In 1938 a group of like-minded surgeons founded an organization whose primary focus would be on the management of the major trauma patient. Now, 75 years later, the American Association for the Surgery of Trauma has become the premier surgical association and the professional community for surgeons dedicated to scholarship and improving the care of the critically ill and injured patient. This commemorative book was created to help celebrate the accomplishments and expansion of the AAST over the past 75 years. Each of the sections is designed to focus on a key element of our organization and to convey a sense of shared accomplishment and of a legacy that will hopefully inspire the next generation of surgeons who choose to dedicate themselves to scholarly work related to trauma, surgical critical care, and emergency general surgery.

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Robert C. Mackersie, M.D.
President, American Association for the Surgery of Trauma
San Francisco, California
June 25, 2013

PART I
THE FIRST 75 YEARS

1

History of the American Association for the Surgery of Trauma

Steven R. Shackford, MD

Preface

The history of a medical society or professional organization can only have meaning when there is context—context with events happening in the world, in the United States, and in medicine. Using these frames of reference, I have tried to present the history of the AAST from its founding to the present day.

"Neither fish nor fowl"

It is the winter of 1937. The American College of Surgeons (ACS) is 24 years old and has already achieved an early goal of establishing the legitimacy of "surgery" as a discipline separate from "medicine."[1] The ACS is dueling with the American Medical Association (AMA) over issues related to which organization can best represent the interest of surgeons to the public and to the government. Representation of surgeons is not trivial; a national health consortium is gaining momentum and it is important that doctors speak with a single voice.

By 1937 surgeons were parsing this new discipline of surgery and already aligning themselves under a variety of rubrics by establishing "boards." Boards of Otolaryngology (1924), Orthopedic Surgery (1934) and Urology (1935) were well established. The American Board of Surgery was barely a year old.

By all accounts the groundwork for the American Association for Traumatic Surgery (as it was initially named) was laid at an annual meeting of the Western Surgical Association

in December of 1937. The occasion was a happenstance luncheon meeting of several surgeons who had an interest in trauma and who were concerned that there were very few papers about trauma or injuries on the program. Dr. Eslie Asbury, one of the surgeons at the lunch meeting, recalled, "At the meeting of the Western Surgical Association in Indianapolis … I had Ralph Carothers as a guest at the meeting. I got Ralph, Kellogg Speed, and one or two others to lunch, told them we were neither fish nor fowl, that general surgeons interested in trauma had no place to go (I had the only paper on fractures at this meeting) and that we should have a society of our own."[2] Dr. Asbury would later remember, "We were not welcome at orthopedic meetings, and societies such as the Western paid no attention to trauma. Fracture services were shunned by surgical residents." In the words of Dr. Carothers, "…we were very much concerned about the attitude of the surgical profession as a whole toward the treatment of trauma and that many of the better surgeons of the country were showing too little interest in this type of case. So we decided to band together and see what we could do about it."[3]

The coterie arranged to meet again the following week at the Southern Surgical Association meeting in Birmingham, Alabama. Several surgeons of a persuasion similar to Carothers and Asbury joined that meeting, including Edgar Gilcreest. As described by Dr. Carothers, "We talked for a time in that smoke filled room and all agreed that the whole subject of trauma had to be put on a better basis than it was."[3] In retrospect, the "better basis" referred to by Carothers, in all likelihood, had to do with advancement of the scientific underpinnings of the treatment of injuries other than fractures. Their concern appears to have been justified. While advances made in the surgical treatment of other diseases were presented at major surgical meetings, the subject of trauma had no forum and little representation on the program of these meetings. The ACS had established a committee on fractures in 1922, dealing primarily with, as the name implies, fractures. The ACS had also established a board on "Industrial Medicine and Trauma Surgery" in 1922, but this was devoted primarily to establishing needed standards of safety in the workplace. Neither of these ACS groups provided the forum necessary for the presentation of scholarly work on the breadth of injury.

A few good men

Emerging from that "smoke filled room"[3] in Birmingham was a "Committee for the Organization of the American Association of Traumatic Surgery," chaired by Dr. Gilcreest, with Dr. Carothers as secretary. Carothers' first task was to "reality test" the idea of a new organization with surgeons around the U.S. and Canada. Inclusion of Canadian surgeons is appropriate for an "American" association and may have been influenced by the ACS model.[3] Given the limits on air travel at the time (commercial air travel only became more widely available in 1930 and was quite expensive), Carothers accomplished a lot, visiting "many parts of this country to interview key men in various cities and, as a result, a goodly number became interested in the formation of a [trauma] society." Upon completion of his cross-country tour, Carothers was convinced that there was substantial interest and support. Chairman Gilcreest then composed a letter (dated May 4, 1938) inviting those interested to become a "Founder" of the association

and to meet in San Francisco during the meeting of the AMA. In the letter he explicitly stated the raison d'être of the proposed association, "This association is in no way to conflict with any other organization but is to be purely a scientific society limited in size and with membership by election only."[4]

Gilcreest's letter was favorably received, and 68 surgeons met in San Francisco in June of 1938. George Swift chaired the meeting and the first item of business was the Organizational Committee report read by Edgar Gilcreest.[5] He noted that he had reviewed the programs from the "American Surgical Association, the Southern, Pacific Coast and the Western" and found that "papers related to trauma" represented "less than 10%." With a bit of hyperbole (since it could not possibly be validated at that time) he stated, "It is interesting to note that half of the patients who are admitted to hospitals in America are cases of trauma and 90% of the doctors who treat these patients are not interested in trauma." He concluded his remarks with a prophetic comment, "It [the association] will, in time of war,[i] prove of considerable benefit to the Army and the Navy, and through the coming years will its name become large and luminous among the surgical associations of America."

Lively discussion and debate ensued, as some surgeons believed that formation of another society would lead to further fragmentation of "general surgery" (the term general surgery was in common use, but had not yet been explicitly defined).[1] Others raised concerns about the desirability of limiting the membership. In response, it was reiterated that "the aim of the society was to try to advance the scientific work associated with trauma and that this work could best be carried out by limiting the group to a small number of high grade men." There was also concern about the name, particularly the phrase "traumatic surgery" (because it implied that the surgery itself was traumatic, rather than being a means of treating an injured patient).

By any standard, this meeting was incredibly successful, producing a constitution, a set of bylaws, and the first slate of officers (Kellogg Speed was elected president). The constitution, modeled after those from the Western and American Surgical, articulated the objective of the association: "the cultivation and improvement of the science and art of the surgery of trauma and allied sciences, the elevation of the medical profession and consideration of such other matters as may properly come within its sphere." It provided for four categories of fellowship (founder, active, honorary, and senior), six positions of leadership (president, vice president, president-elect, secretary, treasurer, and recorder), a "council of five," and a board of managers. The bylaws defined the categories of fellowship and the qualifications for each category as well as the duties of the officers. Among the qualifications for active fellowship, the bylaws stipulated the candidate must "have contributed to the medical literature" and be certified by the (fledgling) American Board of Surgery. They also limited the number of active fellows to 200 (85% of which would be "general surgeons;" 15% would be made up of those who work in "other specialties" or allied sciences) and specified that the board of managers "may not nominate more than fifteen for Active Fellowship each year." Attendance at the meetings was emphasized and fellowship terminated if two consecutive unexcused absences occurred. In

i. Hitler annexed Austria in March 1938, two months before the organizational meeting.

addition to multiple housekeeping issues (i.e., terms of the officers, meeting planning, etc.) the bylaws (Article IX) specified the "seal and certificate" (containing images of rural and industrial America, an airplane, a train, an automobile, a warship, and a cannon). The seal symbolized the breadth of the American population at risk for injury; it remains unchanged 75 years later.

Based on available documentation, it appears that the founders intended that the association would be exclusive in its membership and scholarly in its proceedings. The requirement for 85% "general surgeons" might be viewed in the context of the time as a reflection of the concern that orthopedic surgeons might dominate the association.

"Calling back to the fold"

The first meeting of the American Association of Traumatic Surgery was held at The Homestead in Virginia from May 8–9, 1939, a little less than 18 months after the initial discussions. The minutes of the "Executive Session" included a note that "ladies could be invited to the banquet," a list of the officers for the following year, the obituaries, and a recording of the selection of Atlantic City for the second meeting. Ernest Avery Codman, the father of the morbidity and mortality conference and progenitor of practice-based learning with his "end results method," was elected as the first honorary fellow. Codman, a former regent of the ACS, had attended the organizational meeting. His attendance not only supported the need for the association, but also demonstrated that there was no opposition from the ACS to its creation.[6] At some point, either prior to or after this meeting, an agreement was reached with the *American Journal of Surgery* to publish the proceedings of the annual meetings (scientific papers and the presidential address).

Speed's inaugural address left no room for doubt about the aim and purpose of this association, "In the rapidly developing field of general surgery several schisms have occurred within the last thirty years, ending in a breaking off of certain specialties and narrowed fields, such as ear, nose and throat surgery, genitourinary surgery, neurologic surgery, thoracic surgery and others—even one body devoted quite entirely to the surgery of goiter. It is not the primary desire or intention of the American Association for the Surgery of Trauma[ii] to cause the formation of an additional and possibly narrowed-vision group of surgeons under a different label, but to attempt an amalgamation and calling back to the fold of the well trained general surgeon of those interested in the maintenance of high surgical skill and scientific development in the phases of surgery which have to do with trauma, its immediate and distant effects and complications."[7] He reminded those in attendance that new discoveries in other fields had monopolized the programs of other societies such that, "old fashioned trauma and its connections, forever with us like the poor, have jogged along unheralded, poorly nourished and yet demanding a large share of hospital service, of operative time and skill in all parts of the world."

True to the intent of the founders, the first program had 20 papers devoted to subjects relevant to trauma—including management of a ruptured urethra, the treatment of chest injuries, methods of skeletal traction and experimental fat embolism.

ii. By the time of publication, the name had officially changed

"The colossal maelstrom"

The second meeting, in 1940, set the tone for the future of the AAST as collateral events brought into sharp relief the need for this society. In his prescient presidential address Edgar Gilcreest made this clear, "There never was a time when we stood more in need of a ready and sound knowledge of the cardinal principles of the surgery of trauma than at the present. With a great part of the world at war and with our not knowing when an incident may happen which may precipitate our entry into the colossal maelstrom, it is timely for a group of surgeons to gather and discuss the progress of the surgery of trauma."[8] The 'incident' would occur nine months later when the Japanese attacked Pearl Harbor. At this time the Selective Service and Training Act was passed establishing mandatory military service and active fellows who were in the military were relieved of the obligation to pay annual dues.

By 1942, the number of applications to the association exceeded the anticipated volume. As noted in the minutes, "The number of applications received, together with the many inquiries relative to Membership in the Association, presented a most gratifying acknowledgment of the value and need of our organization."[9] This, plus a large number on the deferred (waiting) list, prompted the board to suspend the bylaws limiting the number of candidates to 15 and to move that the number be increased to 25. The rapid growth continued, and by 1943, there were 202 active fellows and 10 honorary fellows. Because so many of the membership were on active military service, the annual meetings in 1943 and 1945 were cancelled.

Surgeons returning from the European and Pacific theaters of operation had their trauma skills honed by their military experience.[10] They were clearly the "well trained general surgeon" described by Speed and were easily "called back to the fold." As a result, AAST membership grew, and at the annual meeting in 1946, the bylaws were changed to allow expansion of the active fellowship from 200 to 250. The increased size of membership obviously impacted the size of the program, which in the original bylaws was restricted to 15 papers.

At the annual meeting in 1948, the association received a replica of Cotton's hammer, an instrument that had been used by orthopedic surgeons to impact the head of the femur into the shaft to stabilize fractures of the femoral neck.[11]

From 1947 to 1960, the association's annual program grew in size from 18 papers to 61. It is likely that an influx of surgeons from the military following the cessation of hostilities in Korea led to further membership expansion, and in 1961, the association voted to increase the number of active fellows to 300.

"Changes in attitude, changes in latitude"

In the post-WWII era, the AAST welcomed into membership its first woman member, Barbara Bartlett Simson, in 1946. As the '60s approached, the association's second woman member, Mary Margaret Martin, was elected in 1959. A little over a decade later, in 1973, William E. Matory became the first African-American member.

By the time of its twenty-fifth birthday in 1963, the AAST had undergone a number of significant changes that strengthened its commitment to education and research. With the

increase in the number of papers presented at the annual meeting, it became apparent that there should be consideration of "founding a journal to be devoted entirely to trauma, sponsored by the American Association for the Surgery of Trauma." This "consideration" had been discussed by the board as early as 1955 and approved by the association at the annual meeting in 1959.[iii] The "birth" of the *Journal of Trauma* and the gradual growth of the size of the program had a ripple effect on the board. Up to this time, the responsibility for the program had been assigned to the secretary. The recorder was responsible for editing the papers selected for submission to the *American Journal of Surgery*. In 1963, as he was completing his tenure as secretary, Dr. William Fitts suggested to the board that the association should have a "program chairman." This position was approved and, in 1965, formalized in the bylaws. The duties, formally performed by the secretary, were assigned to the recorder.

The program content also changed and evolved at this time. During the first two decades, the papers presented at the annual meeting were primarily clinical, with very few papers on basic scientific research. The first paper describing the use of animals in basic scientific research appeared on the program in 1947. By 1960, 26% of the papers dealt with basic research on subjects such as burns, shock, and stress metabolism. This emphasis on basic research, which has continued to the present, also catalyzed a broadened scope of association activities.

During this period of change in the content of the program, the board established a relationship with the National Society for Medical Research. As a result of that relationship, the secretary of the association became its official representative and a conduit to the board of the activities of the society. This allowed the association to develop the activity of public advocacy and, at the same time, maintain itself as a relatively parochial scientific organization. One of the first collaborative efforts of the AAST with the National Society for Medical Research concerned the use of animals in research. In the early 1960s, animal activism was getting a start in Great Britain and was gaining traction in the United States. Dr. James Stack, the AAST representative to the society, asked the board to adopt a resolution "directed to Congress to favor legislation to assure not only the continuation of laboratory animal research, but also the care of laboratory animals."[12] It was the opinion of the board that "our association was eligible to support such action" and approved the resolution. Over the ensuing years, the association provided much support not only for this resolution, but also for other initiatives of the National Society for Medical Research. This move into the public domain might be viewed by some as a corruption of the academic ideals and the aims of the association as set down by its founders in the constitution. On the other hand, public advocacy could very well be exactly what the founders intended in Article 2 (the Objective of the Association) with the phrase, "…the elevation of the medical profession and consideration of such other matters as may properly come within its sphere." As a scholarly association, it hardly seems necessary to justify that laboratory research should come within the sphere of the AAST. Of note, the continued support of this effort by the AAST (together with other professional organizations) culminated in the Animal Welfare Act of 1970 that satisfied all concerned, including the animal activists.

iii. The history of the *Journal of Trauma* is contained in chapter 3, pp. 23 - 71.

Another move into the public domain had commenced in 1956 when then AAST President Charles Johnson sent a letter to the National Safety Council (NSC) proposing that the NSC, the ACS, and the AAST "band together to form a Joint Action Plan. The objective of this program was a joint approach on a solid front to prevent accidents[iv] and to minimize the serious effects of trauma." This collaborative effort produced a document appropriately titled the "Joint Action Program" published in 1958 that called for the development of ordinances at the local and state level mandating the appropriate training of ambulance personnel and the appropriate equipping of ambulances. On the heels of the Joint Action Program came enactment of the Highway Safety Act of 1966. A provision of this law established the requirements for education, certification and registration of emergency medical technicians as well specifications regarding the design and equipping of ambulances. Concurrent with the passage of this legislation, fellows of the AAST worked with members of the ACS Committee on Trauma (ACSCOT) and members of the National Academy of Sciences to produce a sentinel white paper entitled "Accidental[v] Death and Disability: The Neglected Disease of Modern Society."[13] This was truly a clarion call that identified major problems with emergency medical services and trauma care in general. The white paper galvanized surgeons, legislators, and public policy makers to improve the care of the critically injured. It also helped to change how surgeons viewed trauma care. Previously, the process of care was viewed as beginning in the emergency room and ending with discharge from the acute care hospital. Now it was seen as a process beginning in the field and ending at discharge from rehabilitation services.

Concurrent with these public efforts by the AAST and the ACS Committee on Trauma, the National Safety Council commissioned an annual award recognizing the work of both organizations in improving the care of trauma victims. Nominations for the award were made jointly by the AAST and the ACS-COT. The first award was given in 1960 to Dr. George J. Curry, primarily for his 1951 work as chairman of the Committee on the Investigation of Practices in Hospitals that documented the inadequate number of properly trained physicians caring for trauma victims.

The success of these legislative efforts and the widespread acceptance of the resulting authoritative publications demonstrated the synergistic effect of the collaboration between the AAST and the ACS-COT. In the 50-plus years since that initial effort, the AAST and the ACS-COT have continued to collaborate with similar productive results.

Not every effort during the period from 1950–1963 had a successful outcome. One failure is particularly salient and worth mentioning because it would resurface almost 60 years later. During the "gestational period" of the AAST, as mentioned previously, the founders felt that they were 'neither fish nor fowl'—they did not have a medical "board" that recognized their particular talents in caring for the injured. They were shunned by the American Board of Orthopedic Surgery and none of the other boards in existence at the time seemed appropriate, with the possible exception of the newly established American Board of Surgery (ABS). In the early '50s, the AAST Board of Managers officially ratified ABS certification as the "minimum

iv. In those days crashes were called "accidents" and viewed as such. It was not until the 1970s when trauma was viewed as a disease with a distinct etiology, and not as an "accident," that the terminology changed.

v. There is that word again.

requirement for membership." At the meeting in 1951, "the Board of Managers passed a resolution to sponsor the establishment of a Board of the Surgery of Trauma as predicated upon the applicants having previously met the requirements of the American Board of Surgery." The records are not completely clear on the motivation for establishing this specialty board, although Arthur Metz in his 1952 presidential address suggested that it was the creation of other specialty boards: "The trend of modern times is to designate minimum qualifications and standards for a surgeon to have in order to treat different types of surgical conditions as provided by the ten Boards already organized. The logical answer is to organize a Board for the Surgery of Trauma—with this association as the Founder Group…".[14] It was discussed repeatedly at the annual board meetings, but there was no action to bring it forward to the membership. It is not clear why it was not pursued, although it was apparent that the Advisory Board of Medical Specialties was opposed.[6] Gaston writes, "The reader may make his own judgment whether or not this irresolution of the matter was in the best interests of the surgery of trauma, taking into consideration the present day standards of excellent quality of specialized care rendered the injured patient in all categories of injury…"[15, vi]

At the board of managers meeting in 1967, Jonathon Rhoads suggested that the AAST Board "approve in principle" the creation of a "non-profit corporation to promote research in the field of trauma and to engage in other appropriate activities related to that field." The ACS was asked to do the same. At the Executive Session that year, the membership voted that "the American Trauma Society be approved in principle, and it was voted to recommend Doctors William T. Fitts and Rudolf J. Noer to represent the AAST." By 1968, the American Trauma Society was incorporated. This marked the beginning of a long collaboration between the AAST and the American Trauma Society and was the initial commitment of the AAST to public education.

By 1970, the *Journal of Trauma* had become an integral part of the association, not only because of its intellectual currency with the readership, but also because the association had invested significant assets in its success. For these reasons, the board of managers proposed amending the bylaws to make the editor of the *Journal* a member of the board. The amendment successfully passed at the subsequent Executive Session in 1971. It is not mentioned in the available documents, but there was an additional reason for having the editor on the board. Most professional organizations attempt to provide "institutional memory" by having the president-elect, as well as a specified number of past presidents as members of the leadership. In the case of the AAST, an individual elected to the office of president can have input on board actions for a total of five years (one as president-elect, and then president, and three as a past president). Because the editor's term exceeds five years, he or she can provide additional a longer span of "institutional memory."

Continued growth in applications for membership[vii] by very qualified candidates resulted in another change to the bylaws that increased the number of active fellows to 350. At this time, there was also increased international participation in the annual meeting, so much so

vi. Gaston was describing events in the early '50s, but his "present day" was the '70s. Trauma care in hospitals was improving, but there was still much to be done.

vii. Again stimulated by the return of military surgeons from the conflict in Southeast Asia.

that the board created an ad hoc committee, chaired by Dr. Curtis Artz, to evaluate the need to form a new membership category for surgeons who did not "reside in either Canada or the United States." The board proposed amending the bylaws to recognize this group and to create a new category of membership, the Corresponding Member. The bylaws change was unanimously passed at the meeting in 1975.

The "Fitts"

Named lectureships are the mark of a mature professional organization. They are named to recognize the multiple contributions of an individual member and to perpetuate his/her memory and legacy. The lecturer selected is often one who personifies the ideals of the organization. The AAST created the William T. Fitts Lectureship in 1975 to memorialize the many contributions made by Dr. Fitts as president and secretary of the association and as editor of the *Journal of Trauma*. Each year the AAST president is responsible for selecting the William T. Fitts Lecturer. Since its inception, "the Fitts" has become one of the major highlights of the annual meeting.

The continued growth in membership led to repeated discussions at board meetings about the concept of changing the association from an "exclusive" to an "inclusive" society. One argument was articulated by Dr. Alexander Walt in 1975 during the board's consideration of the possibility of offering an international symposium on trauma: "Now we are saying that we are thinking of getting out into the big world, exerting a role of leadership, trying to get into Washington and have them recognize what we do…trying to get into international relationships…" It seems that, in retrospect, the board was a little self-effacing—the association, through its work on national safety legislation, had already attained gravitas in Washington. Through its *Journal*, AAST was already internationally recognized. However, the board did eventually approve a motion to hold the international symposium, which took place in May of 1978. The meeting may have increased the profile of the association with the NIH and with the international community, but it did not achieve the expected attendance.

Growth in membership resulted in increased attendance at annual meetings and an increase in the assets of the association. At about the same time, the tax laws relating to large professional organizations made it necessary for the association to incorporate. Without such incorporation, members of the association could be liable for any legal judgment against the association that exceeded its assets. The resulting incorporation was approved by the membership at the annual meeting in 1977, and subsequently the association applied for 501(c)(3) status from the Internal Revenue Service. Approval for both objectives occurred in 1978. Other issues considered at this time by the board included: allowing commercial exhibitors at the annual meeting (voted down), creating a registry of available "trauma fellowship" positions (a questionnaire sent to the membership to determine if such existed),[viii] meeting management (several firms invited),[ix] and the possibility of members obtaining continuing education credit

viii. The questionnaire was mailed in July, 1976—there were only five replies, dampening, somewhat, the board's enthusiasm for the registry.

ix. Two firms presented their proposals at the Board meeting in 1977. After what appears to be lengthy discussion, the item of meeting management was tabled until the next meeting at which it was unanimously rejected.

from the American Medical Association for attendance at the AAST annual meeting.[x]

Dollars and sense

By 1984, the AAST achieved two important benchmarks for successful academic associations. Abstract submissions exceeded 200, and the improved quality of the submitted abstracts was sufficient to justify more acceptances for podium presentations, necessitating concurrent sessions at the annual meeting.

There were now sufficient assets to fund a one-year scholarship,[xi] and a Scholarship Committee was convened to define qualifications of applicants and expectations of the recipient. The guidelines were subsequently developed, but there were insufficient funds to provide the scholarship in perpetuity. As a result, the board began to explore ways to increase funding for the scholarship, which generated lengthy (and lively) discussion and debate. Eventually, the board proposed an increase in annual dues and future consideration (when the time was right) of the possibility of allowing commercial exhibitors at the annual meeting. Both proposals represented a significant reversal of previous board positions. Yet, both passed unanimously. Debate, discourse and discussion are the attributes of a healthy and vibrant organization. That the board and the membership approved these recommendations unanimously demonstrated their willingness to change in order maintain their commitment to their principles and to the support of scholarship. Though not apparent at the time, the decision to allow proprietary interests to exhibit their wares at the annual meeting would eventually result in significant industry support of research and education. Over the ensuing 25 years, suture manufacturers, pharmaceutical corporations, surgical instrumentation companies and an automobile manufacturer (General Motors) would contribute a total of $1.1 million to support the AAST's scholarly endeavors. Based on discussion at the board meetings in 1985, the first industry support came at a time when the funds available to the AAST for the support of scholarship were dwindling.[xii]

At this time several major revisions of the bylaws occurred. One of these recognized the contributions of non-surgical scientists to the care of trauma patients by creating a membership category of "Associate Member;" Susan Baker became the first associate member. Increasing the categories of membership produced some significant introspection by the board regarding the "future direction of the AAST." Based on a review of the minutes of past board meetings, that introspection has continued, almost annually, from 1983 to the present day. Topics of this introspective reflection have included: "specialty certification," "renaming the AAST," "qualifications for membership," "defining trauma and critical fellowship guidelines," "relationships with other trauma organizations," "critical care certification," "inclusive or exclusive membership," and "branding", among others. The discussions were always substantive, and though not often productive of some policy change, they served to move the leadership

x. At this time the *AMA Category I* credit was not obtained. Eventually CME credit would be supplied by the ACS.

xi. In the minutes of the board meeting this is referred to as a "trauma fellowship". In order to avoid confusion in this document, what the minutes describe is now called a scholarship.

xii. It appears from the minutes that, without industry support, the funds giving in support of the scholarship were to be reduced.

and organization ever so gradually toward important decisions that would result in major changes as the new millennium[xiii] approached. The first "product" of these discussions was the creation of an Ad Hoc Critical Care Committee, which led to a session on "critical care" at the annual meeting. In 1991, the Ad Hoc Critical Care Committee was made a standing committee.

In 1985 the National Research Council (NRC) published "Injury in America: A Continuing Public Health Problem."[16, xiv] This report recommended the establishment of an office of trauma research at the Centers for Disease Control (CDC). The publication of this document and the subsequent establishment of the National Center for Injury Control represented a significant achievement in which the AAST played a major role. For many years, members of the AAST had written letters, traveled to Washington, and worked with legislators and policy makers to establish a center, similar to an Institute at the NIH, with a focus on injury treatment and prevention. Their work, along with the work of members of other organizations, ultimately resulted in the publication of the NRC's report on injury in America, a report which had profound effects on improving trauma care and furthering research on injury.

In 1986, the AAST became a sponsoring organization of the American Board of Surgery, and with that came representation on the board. This strengthened the bond between the two organizations and allowed for a robust and frequent interchange of information. At the time it was a singular achievement, and with the increasing stature of the AAST, this would become a formidable relationship that enhanced the establishment of training programs and certification in critical care.

Growth continued through the 1980s, and by 1987, abstract submissions exceeded 300.[xv] This growth resurrected the possibility of having professional program management because planning and implementing a larger meeting could be unwieldy without professional help. Furthermore, the meeting venue for 1987 was in Montreal, Quebec, further adding to the complexity of making arrangements. This topic of employing professional management was repeatedly discussed and a small committee (consisting of *only* Dr. David Mulder) was established to investigate the possibilities. The board reviewed the "committee" work, which suggested that the association, despite its relatively phenomenal growth, was still "too small" and that a membership of at least 750 would be required for the venture to be affordable. It was decided that the association would not pursue the matter of professional meeting management further until the membership exceeded 700.

By 1986, because of some seminal work done by members of the AAST, regionalization of trauma care had occurred in several states. Regionalization was controversial because it diverted patients from the closest, i.e. local, hospital to a center that was better equipped to

xiii. The choice of these words 'new millennium' was purposeful because it not only represents the chronological benchmark of entering a new century, but it also branded a new generation of medical students and physicians who viewed medicine, in general, and surgery, in particular, in a far different light than did their predecessors. As will be seen, the change in the culture was a consideration as the AAST morphed into its present form.

xiv. The AAST was represented by Drs. John Davis, Donald Gann, and Susan Baker on the editorial board of this monograph. It is probable that their interaction with David Viano, head of the research laboratories at General Motors who was also on the editorial board, was helpful in securing continuing support for the AAST General Motors Scholarship.

xv. It is interesting to note, given the impetus for forming the AAST, that its growth was noted by the American Surgical Association in a letter from Dr. Hiram Polk "concerning the duplicity of subject matters at the various associations' programs." The AAST secretary was advised "to commiserate with Dr. Polk and send the American Surgical Association copies of the abstract program once available."

care for the patient. While regionalization may have inflated the reputations of the centers, it is important to note that the quality of care was indeed better at these centers than at the hospitals being bypassed. In short, trauma centers had to demonstrate that they had better outcomes. Appropriate analysis of outcomes requires risk adjustment, particularly for the severity of injury. Dr. Susan Baker and her co-authors provided anatomic risk adjustment for injury severity (the Injury Severity Score)[17] and Dr. Howard Champion[xvi] and his co-authors provided physiologic risk adjustment (the Trauma Score).[18] While the Injury Severity Score provided an aggregate index of the severity of anatomic injury, there was no scale to assist in comparing treatment of specific injuries. In 1987, President Donald Trunkey[xvii] appointed the Ad Hoc Organ Injury Scaling Committee. First chaired by Dr. Ernest E. Moore, the committee's work resulted in multiple, frequently cited publications that advanced the management of specific types of organ injury. The clinical value of the AAST Organ Injury Scales became particularly apparent as imaging technology improved and nonoperative management of lower grade injuries became commonplace. The Ad Hoc Organ Injury Scaling Committee eventually became a standing committee with expanded duties (Injury Assessment and Outcome Committee).

Recognizing the potential for collaborative research within the organization, Dr. Trunkey also appointed an Ad Hoc Multi-Institutional Trials Committee in 1987. This committee, initially chaired by Dr. J. David Richardson, has been prolific since its inception, providing an evidence base for the management of trauma and its complications. A bylaws change in 2000 made the Multi-Institutional Trials Committee a standing committee.

A steeper growth curve

Interest in trauma grew throughout the 1980s. Stimulated by public awareness that injury was the leading cause of death in the first three decades of life, regionalization of trauma care spurred competition, and hospitals[xviii] became eager to develop trauma centers and surgeon-led trauma teams. As the membership of the AAST continued to grow, expanding research opportunities for surgical residents and new members was a subject frequently discussed by the board. The leadership had to carefully balance the funds allocated to future development with those needed to operate its growing set of commitments. In 1989, President Donald Gann commissioned board member Dr. Lewis Flint to develop "the concept of a foundation or endowment" to support research and education. Work[xix] on this continued until 1993 when the AAST had one year's operating expenses in reserve allowing an "irrevocable transfer" of seed money for the endowment. The board approved a motion from Dr. Flint to form a foundation to support research and education.[xx]

xvi. Drs. Baker and Champion are AAST members.

xvii. Dr. Trunkey and his former resident, John West, wrote one of the seminal papers advocating for the regionalization of trauma care.

xviii. It is possible that 'community service' fueled the interest of hospitals to become trauma centers, but it is likely that financial interests were the driving force. The hospitals perceived that the "halo effect" of being designated a trauma center would bring in more patients. The "halo effect," however, did not materialize and many centers eventually withdrew from regional systems.

xix. Dr. Anthony Meyer had worked with the association's legal representatives in establishing a 501(c) (3) foundation and had assembled incorporation documents (modeled after those of the American Surgical Association).

xx. Not surprisingly called the "AAST Research and Education Foundation" that, at the time of this writing, has amassed a corpus of over $3.5 million and has provided over $110,000 for research fellowships to qualified applicants.

In 1989, at the behest of the (then) Ad Hoc Critical Care Committee, the board approved adding a Saturday session devoted to critical care presentations and provided $15,000 in support of this undertaking. The board also proposed a bylaws change that would remove the attendance requirement to maintain fellowship.[xxi] The bylaws were also amended to "broaden the definition of an Active Member so that surgeons practicing primarily critical care" could be included in that category. A second part of the amendment would create a standing committee on critical care.

In 1991, the board established the Peter C. Canizaro Award in recognition of his multiple contributions to the care of injured and burned patients. The award, first presented in 1993, is given to a new member who, in the judgment of the scholarship committee, has given the best paper among all new members presenting.[xxii]

After years of discussion, the board agreed in 1991 to finalize the Trauma Fellowship requirements and to submit them to the *Journal of Trauma* for publication. The fellowship requirements represented the work of both the AAST and the ACS Committee on Trauma.[xxiii]

The topic of professional meeting management continued to surface at board meetings. As was mentioned previously, the association was thought to be "too small," and there was concern that employing such a professional manager might put a strain on the financial reserves by increasing the cost of the annual meeting. The board ultimately decided to bring this before the membership, explaining that the cost of professional management could be offset by increasing the meeting registration fee, an idea favored by those present at the business meeting. Subsequently, after evaluating proposals from several professional management groups, the board approved an initial three-year contract with a meeting management firm to manage the 1994, 1995 and 1996 meetings. Meeting management has continued from the initial three-year period to today.

Professional meeting management allowed program expansion and in 1992 the board decided to phase in this expansion by approving a combined meeting with the orthopedic surgeons in 1993,[xxiv] a poster session in 1994, and breakfast sessions in 1995.[xxv] The poster session and the breakfast sessions were immediately popular. By 1996, the number of posters grew from 35 to 60,[xxvi] and the number of surgical residents attending the meeting to present posters increased from 13 to 51. The breakfast sessions were immediately oversubscribed and the number of sessions was increased in the ensuing years.

One intention of the founders that had remained unfulfilled was adding trauma education to the medical school curriculum. An attempt to do so had been made in 1944, but it was not enthusiastically endorsed by medical school deans, and the attempt was laid to fallow. It

xxi. The attendance requirement, set forth in the original bylaws, may have reflected the founders' desire to make sure that the meeting space was full. By 1990, attendance at the annual meeting was definitely not a problem.

xxii. In 1994, the bylaws were changed to establish a Canizaro Award Committee; eventually this function was undertaken by the Scholarship and Awards Committee.

xxiii. Trauma fellowship guidelines had been a board agenda item for several years and their finalization and publication was a significant step. Significant because there were objections from other specialties, primarily orthopedics, who "felt that this may infringe on their domain."

xxiv. The meeting with the orthopedic surgeons had already been planned and announced, but it did impact the other planned expansions, which were new.

xxv. The meeting in 1992 had 449 attendees, the largest to date. The new attendance record likely added support and enthusiasm for expanding the program.

xxvi. Eventually the number of posters would be capped at 100.

was resurrected, in a manner, almost 50 years later at the meeting in 1993. Qualified medical students were awarded a stipend to attend the annual meeting. Students were selected by the scholarship committee following an application process that included a letter of support from a fellow. This Student Scholarship Program continues to be fully subscribed and has resulted in an enhanced interest in trauma and critical care among medical students.

One of the first of many accomplishments of the newly incorporated AAST Research and Education Foundation was the establishment of the John H. Davis Research Fellowship in 1994. Dr. Davis was a past president of the association and served as the editor of the *Journal of Trauma* from 1975–1993. The association and the *Journal* flourished under Dr. Davis's capable leadership. The *Journal*, which had been a financial burden on the association, came into its own while Dr. Davis was at the helm. The *Journal* generated excess revenue over expenses, such that the investment in the *Journal* by the association was paid back with interest many times over.

Between 1993 and 1995, a number of new initiatives surfaced and were approved, resulting in some changes to the bylaws. Additional standing committees were established: Prevention, Publications, and Program. Trauma nurse coordinators were now frequent attendees at the annual meeting and the board approved reducing their registration fees.[xxvii] A Contributing Scientist category was also established. The expansion of the program and the inclusion of a broader group of medical professionals further strengthened the organization.

The 1995 meeting in Halifax, which was a combined meeting with the Trauma Association of Canada, attracted a record-breaking 602 participants.

In January of 1996, a "trauma summit" was held in Houston. Approximately 30 individuals from 20 organizations[xxviii] with an interest in trauma care met to discuss ways to improve communication and to discuss issues of common interest. President Dr. Kenneth Mattox capably represented the AAST. The meeting was a sentinel event as it indicated that interest in the care of the injured patient had become widespread, no longer perceived as "old fashioned trauma and its connections, forever with us like the poor…unheralded… poorly nourished."[xxix] On the contrary, as evidenced by the summit, trauma care had entered the mainstream of medicine due in large part to the efforts of the association and its membership.

In 1997, a joint meeting with the Japanese Association of Emergency Medicine was held in Hawaii. The total number of abstracts submitted exceeded 400 for the first time, and the increased number of abstracts provided real fodder for the initial discussion of electronic abstract submission.[xxx] The meeting was well attended and represented the initial joint venture outside of North America.

Bits and bytes, odds and ends

The new millennium brought with it a number of changes. The *Journal* adopted electronic

xxvii. This was a long overdue recognition of a group that had been indispensible as hospital trauma programs developed and matured.

xxviii. The organizations included governmental agencies and professional societies. That termed themselves the Federation of Trauma Organizations (FOTO).

xxix. This quote is from Kellogg Speed's inaugural presidential address.[7]

xxx. The board began an investigation of electronic submission in 1998.

publication, abstracts for consideration at the annual meeting were electronically submitted, and all presentations at the annual meeting were digitized ("slides" were a thing of the past). The board approved a bylaws change that added the chairperson of the Critical Care Committee to the board of managers. The format of the poster session at the annual meeting was modified to serve as a platform for Professors' Rounds. The professors, 10–12 in number, were selected by the recorder to discuss individual posters with the poster presenter. Professors' Rounds became an immediate success, not only because the professors added to the education of the presenter and those on the rounds, but also because it provided an opportunity for the attendees to have personal interactions with the senior members of the association. A second breakfast session was also added to the program format.

After much deliberation, the appointment of several small committees, and a poll of the membership, it was finally decided to allow commercial exhibitors at the meeting in San Antonio in 2000.[xxxi] Exhibitors were an immediate "bottom line success;" exhibitor space was sold out six weeks before the meeting and pre-meeting revenue from exhibitors exceed $220,000. In addition, the meeting drew over 650 attendees for the first time.

The perfect storm

Despite the expansion that the AAST had enjoyed through the 1990s, there were early warning signs that sustained growth in trauma surgery was in jeopardy, resulting from a number of factors. First, there was declining medical student interest in surgery in general and in trauma in particular, and a career in trauma was not always well regarded by surgical residents. Second, the trauma operative caseload was decreasing as a result of the advent of less invasive therapies[xxxii] and the proven success of non-operative management for selective blunt visceral injuries. Third, more emphasis was being placed on "education" versus "service", and the Accreditation Council for Graduate Medical Education was considering limiting resident work hours, thereby decreasing exposure to trauma and emergency surgery. Finally, there were reports appearing in the medical literature and the lay press that a majority of America's emergency rooms were not being adequately covered by surgical subspecialties. These issues were coalescing simultaneously and needed to be addressed. To address some of these issues, a retreat was convened at the spring meeting of the board in April of 2001 to better define the role of the AAST in this changing environment. The retreat assisted greatly in crystallizing ideas for dealing with these multiple issues. It was decided that the AAST would develop a sub-committee to examine the requirements for a sub-board on surgical critical care,[xxxiii] and would pursue the notion of being the "lead" organization assuring and assessing competency of those surgeons managing trauma and critical care.

The meeting in September of 2001 was cancelled because of the terrorist attacks on New

xxxi. The board first formally considered exhibitors at its meeting in 1985. It was discussed intermittently at meetings over the ensuing 15 years, often stimulating heated debate. It is interesting to note that one board member vacillated—first strongly opposing the idea and becoming a strong advocate two years later.

xxxii. Interventional radiology had become adept at draining abscesses and embolizing thrombogenic sub stances into bleeding vessels to arrest hemorrhage.

xxxiii. The consideration of a certifying board for trauma surgeons had been discussed formally in 1951 and a resolution passed to consider it in 1952. The minutes subsequently were silent on this consideration for almost 50 years.

York City and Washington, DC, so it was 2002 before the board and membership were able to address the issues raised at the spring 2001 retreat. It was decided that competency and issues related to the quality of care would be assessed by a program similar to the National Surgical Quality Improvement Program (NSQIP), which had been developed by the ACS in collaboration with the VA hospital system. This would be a responsibility shared with the American Board of Surgery and the ACS-COT.[xxxiv] A "Future of Trauma Surgery" meeting was convened in August of 2003 with representatives from the ACS-COT, the ABS, the Residency Review Committee, and the Society of Critical Care Medicine. An ad hoc committee on the "Consideration of Trauma Specialization"[xxxv] was formed. As a result of that meeting and additional correspondence, the executive director of the ABS requested that the AAST develop a template "for combining trauma surgery, surgical critical care and emergency surgery." With approval of the board, President H. Gill Cryer directed that this mandate be achieved by the Ad Hoc Committee on the Future of Trauma Surgery. This was truly a sentinel event because the ABS had previously discouraged such further specialization. It is also worth noting how quickly this moved from discussion at the retreat to an actionable item.

"Changing to light speed"

By 2004–2006, the association was involved in a number of important initiatives including specialization, competency, careers in trauma care, and research collaborations. The slope of change for the association was no longer linear; it was now exponential. It became increasingly clear to the board that all of these issues could not be managed well under the current administrative structure with leadership changes occurring annually and very little in the way of association "institutional memory" about details. Consensus was reached about the need for an executive director.[xxxvi] Over the ensuing 18 months, a job description and budget were developed. In order to accommodate the expenses of hiring an executive director, an increase in membership would be necessary. The proposal to hire an executive director, co-locate the office in the ACS building in Chicago,[xxxvii] and raise the membership dues by $100 was presented to the membership by President Steven R. Shackford and passed unanimously. A search committee was formed, interviews held, and the association's first executive director, Ms Sharon Gautschy, was recruited and began work in March 2006. Sharon entered the "fray" of a vigorous surgical organization seamlessly and with great efficiency. She functioned in the role extremely well and easily exceeded the board's expectations. As the work load of the AAST central office expanded over the following years, two additional staff members were recruited, Tamara Jenkins and Jermica Smith.

Meanwhile, work initiated in 2004 on a research collaboration with the National Institute of General Medical Science (NIGMS) reached fruition in the form of KO8/K23 grant to be awarded to successful applicants. Successful candidates would be selected by the AAST after

xxxiv. This later became known as 'TQIP' or the Trauma Quality Improvement Program.
xxxv. This subsequently morphed into Ad Hoc Committee on the Future of Trauma Surgery.
xxxvi. Most professional societies the size of the AAST already had executive directors
xxxvii. Having the executive director's office in the ACS Building allowed co-location with the ACS-COT office that eventually facilitated collaboration between the two organizations.

review by the NIGMS. This was the association's first such collaboration with the National Institutes of Health.

Work was initiated on obtaining Advisory Council status with the ABS as this would be the first step toward a specialty board. Under the capable leadership of Dr. Gregory J. (Jerry) Jurkovich, the Ad Hoc Committee on the Future of Trauma Surgery[xxxviii] completed a strategic plan, developed a 40-page curriculum for trauma and acute care fellowship training, and produced a white paper on acute care surgery. Nominations for the initial membership to the Advisory Council were made and approved by the board.[xxxix]

Following the terrorist attacks of September 11, 2001, President George W. Bush declared a "war on terror." As part of the war on terror, the United States invaded Afghanistan in 2001 and Iraq in 2003. To assist military physicians and surgeons in their deployments to the theaters of operation, the AAST developed a Military Liaison Committee in 2005. Working with this committee, President-elect William C. Schwab, developed the "Senior Visiting Surgeon Program." Senior surgeons in the association rotated through the Landstuhl Regional Medical Center in Germany to provide consultations and assistance to military staff caring for injured soldiers, sailors, and Marines evacuated to the center from "down range." In the years since its establishment, the program has won high praise from the military and from the surgeons who have participated.[xl]

Multiple changes in the AAST bylaws occurred during this very busy period from 2000 through 2010. Sixty-seven years after its establishment, the Honors Committee was "sun-downed." In light of the adoption of electronic publishing and the establishment of the association's website, the Publications Committee was renamed the Publications and Communications Committee, and an International Relations Committee was formed, in recognition of the fact that the association had established an international reputation and had informal ties with a number of countries.

Beginning in 2005, the association hosted several "trauma summits" focusing on the collaboration of professional organizations involved directly with the care of the critically ill and injured patient. Officers of the American Burn Association, the Eastern Association for the Surgery of Trauma (EAST), the ACS-COT, and the Western Trauma Association (WTA) participated. . The primary purpose was to establish a platform for dialogue and to discuss projects of mutual interest such as research, disaster response, and trauma system management. This collaboration was particularly important in the effort to garner support for the Acute Care Surgery Fellowship program. Eventually, the leadership of these sister organizations were invited to give regular reports to the AAST's board of managers.

By 2006 the Acute Care Surgery Committee had completed a final draft of the curriculum and circulated it to the membership with a specific set of requirements necessary to establish Trauma and Acute Care Fellowships. The curriculum included exposure to vascular and general surgery, orthopedics, surgical critical care, and neurosurgery. Initially, the plan

xxxviii. This would eventually become a standing committee—the Acute Care Surgery Committee.

xxxix. Unanimously approved for the positions were Dr. David B. Hoyt and Dr. Gregory J. Jurkovich.

xl. The Senior Visiting Surgeon program benefited both military and civilian surgeons with educational transfer occurring in both directions.

was to implement the fellowship program in 2007, but it was slowed to allow some refinement and time for beta testing.

The Secondary Survey

In 2006, the board discussed the possibility of another retreat. Much had happened in the six years since the previous retreat in 2001 and it was time to reassess where the association stood and, more importantly, where it was going. In an effort to provide the board with greater input and, perhaps a different perspective, younger members of the association were invited to participate in the retreat. When the retreat convened in January of 2007, several working groups were established to address research, branding and identity, communication, and strategic planning. It was clear to the attendees that the association was on the right track and that it needed to hold the current course.

The annual meeting in 2007 drew a record number of attendees, 869, attributed by some to the growing awareness of acute care surgery as a defined discipline. The success of this meeting stimulated interest in creating a separate category for abstract submission to the annual meeting on the subject of acute care surgery/emergency surgery.

In 2007, members of the Acute Care Surgery Committee initiated visits to evaluate possible sites for fellowship programs. These were eventually approved in 2008, and programs were started first at Las Vegas, and later at Denver. By 2009, several fellowship programs were well established, and graduating fellows were being recruited to high-profile trauma centers.

In 2011, under the capable leadership of President L. D. Britt and immediate Past-President Andrew B. Peitzman, the annual meeting was expanded and re-named the Annual Meeting of the American Association of the Surgery of Trauma and the Clinical Congress of Acute Care Surgery. The name of the *Journal* was changed to the *Journal of Trauma and Acute Care Surgery*, thus capping a significant expansion of the role and, some might say, the mission of the American Association for the Surgery of Trauma.

"Large and luminous"

Dr. Speed and our AAST founders would be gratified to see what has happened in the 75 years since the birth of the association, proud of their own foresight and proud of all of us for achieving their "attempt [at] an amalgamation and calling back to the fold of the well trained general surgeon of those interested in the maintenance of high surgical skill and scientific development in the phases of surgery which have to do with trauma, its immediate and distant effects and complications."[7] We honor them with the achievements of the past 75 years, including the expansion of the association's role in the profession of surgery, all of which validates Edgar Gilcreest's 1939 prediction about the future of the organization that would come to be known as the American Association for the Surgery of Trauma: "through the coming years will its name become large and luminous among the surgical associations of America."

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