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SCUDDER ORATION

THE COLLEGE AND THE ACCIDENT VICTIM

The Story of the Committee on Trauma

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This is a story rather than a history, because it is more than a record of events. While respect has been shown for fact and truth, as found in the College records and others, my interpretation will probably be somewhat different from what many of you would think following a similar review. My thoughts, necessarily, reflect the culture and the values of the period in which I live and work; however, I have tried to understand the values of the several environments in which the Committee on Trauma has worked during its history. I am grateful for the opportunity to have examined primary documents, as these have helped me not only evaluate the work of the committees, but to learn what these committee members wrote and thought about themselves, and the contemporary events that swirled around them.

Throughout the years, the College and its committees have reflected the changes in our unstable social fabric. The attack of the Committee on Trauma on the factors - tangible and intangible - that cripple and kill so many Americans each year has varied from era to era. The work of this Committee has been allowed to go on because, by tradition, in this country society recognizes voluntary associations and group competence. The

American College of Surgeons carries with it the voluntary consent of society, and from this springs the group authority. This is a fragile thing, and must be earned and re-earned. That is why, in each new era, the Committee is made up of new names and has new projects and new outlooks to cope with the many new problems by means of new methods. Society has insisted, and continues to do so, upon making the prevention of disease and injury a compelling purpose. We cannot disregard the relationship of accidental death and injury to social and economic factors and we cannot discount the political pressures inherent in society as one method of obtaining its way.

We usually think of the Committee on Trauma as dating from 1922, because this was the year that the first Committee on Fractures was appointed at a meeting of the Board of Regents in Washington, D. C. It is not quite that simple, because true beginnings are vague and shadowy things. Let us go back to a meeting of the American Surgical Association in Montreal, one year before the formal founding of the American College of Surgeons.

At that time, 1912, interest in the care of the injured was at a very low ebb, which was reflected in the quality of treatment fracture victims received. Aseptic surgical methods had been developed, and, since they were used mostly in abdominal operations, this field over-shadowed all others. Too few beds were available to those who had sustained injuries to the skeletal system, and work with such patients was considered principally

an outpatient endeavor. However, in 1909, a visit to the United States and Canada by Sir Arbuthnot Lane helped, and the presidential address of the American Surgical Association in 1911, given by Dr. Richard H. Harte, also helped. Of course, war, as it always does, provided a stimulus for better care of the injured and wounded.

In Montreal, on May 31, 1912, the following resolution was passed: - "Resolved that the President (of the American Surgical Association) appoint a committee ad hoc of five to prepare a statement of the relative value of the operative and non-operative treatment of fractures of the long bones - to which shall be added an opinion as to the value of radiography in the determination of the choice of the method of treatment." The chairman of this committee for the years 1912, 1913 and 1914 was Dr. John B. Roberts. The chairman in 1915, 1916, 1917 and 1918 was Dr. William L. Estes, Sr., of Bethlehem, Pennsylvania, who was in the chair in 1921, when it made its final recommendation. Dr. Scudder, who became a Fellow of the American Surgical Association in 1909, was not on the committee of five originally. Along with others, he was made an associate member in 1914, to broaden its geographic base. He established the first fracture service in the country at Massachusetts General Hospital in 1917.

There is certainly reason to believe that this committee may have considered itself an honorary one rather than a working committee, or we could be more generous and realize that, in another era, the medical profession was long a victim, as were other professions, of that aristocratic

attitude that shunned work as degrading. The beginning of this century found the practice of medicine still highly empirical and the scientific era just dawning. The traditional recourse to authority was still dominant. The practice of medicine was then a scholarly, somewhat theoretical activity, and downright practical and hard committee work as we know it now was not by any means the order of the day.

At any rate, the final report of the American Surgical Association Committee on the Treatment of Fractures in 1921 concluded by saying, "The first step in the betterment of practice is the study of results achieved by present-day methods. An adequate study is impossible without complete records." This report was accepted by the American Surgical Association, with the suggestion that the American College of Surgeons carry on this work.

Three years before, the American College of Surgeons had set out on its hospital-standardization program, and it was felt that fracture records could be obtained through this activity of the College, and approved hospitals were asked to prepare special forms for the study of fracture-treatment methods and the end results of each. On May 1, 1922, the first Committee on the Treatment of Fractures was appointed by the Regents, with Dr. Scudder as Chairman and Dr. John B. Walker of New York as Secretary. Sixteen others were appointed, as follows: - Nathaniel Allison, St. Louis; A.P.C. Ashhurst Philadelphia; Joseph A. Blake, New York; Frederick J. Cotton, Boston; William Darrach, New York; William L.

Estes, Sr., Bethlehem, Pennsylvania; William E. Gallie, Toronto; Fraser B. Gurd, Montreal; George W. Hawley, Bridgeport, Connecticut; A. J. Jonas, Omaha; Paul B. Magnuson, Chicago; Lloyd Noland, Birmingham; Robert D. Osgood, Boston; William O. Sherman, Pittsburgh; E. A. Sommer, Portland; Kellogg Speed, Chicago. The first report of the Committee on the Treatment of Fractures was given in the year 1923, and published in the Year Book of the College. I quote: - "Surgeons are today, as never before, interested in fractures of bone. A well-grounded, latent enthusiasm exists, which may be advantageously utilized. There is no recognized authoritative standardization of principles governing the treatment of fractures... and the teaching of fractures in medical schools is at variance and most unsatisfactory...No argument is necessary to convince surgeons that the results of fracture treatment in the United States and Canada are deplorably bad...There are good results; there are remarkable results, but, in general, by and large, the results are poor - poor anatomically and poor functionally. We are surgeons desiring improvement in the results of fracture treatment. This Committee on Fractures has recently been formed, and, with the regional committees, over 200 men are serving on them. The general Committee has already asked three questions of the regional committees: - (1) What principles underlie first-aid treatment, including transportation? (2) What are the means by which these principles may be carried out? (3) What are your recommendations as to the equipment of ambulances, first-aid agencies, including hospital receiving wards, in

the effort to establish standardization of this phase of treatment? In due time, a study of the teaching methods in medical schools will be made by your Committee on Fractures. The Committee is alive to the grave situation in fracture treatment. There are many suits for mal-practice, and 60 per cent of mal-practice suits brought in New York State alone are because of fractures. Cases of blackmail exist, and are rapidly increasing in number. There is ignorance regarding simple and efficient methods of treatment of fractures. There is need for improvement in both graduate and undergraduate medical school instruction. Your Committee will spare no pains in its investigation and deliberations to help remedy these evils."

This sums up the first period of the Committee. During this period 1922 to 1926, the Committee formed an attitude toward itself, its work and its problems. The Committee worked very closely with those concerned with hospital standardization, because they were attempting to improve the organization, equipment and environment of the surgeon in his management of fracture problems in his own workshop. The regional committee idea was a great step forward, and each of the original 18 committee members was assigned a region in the United States and Canada, in which he was to promulgate the doctrines of the Committee as approved by the Board of Regents. This close liaison with the hospital standardization program continued until 1952, when the Joint Commission on Accreditation of Hospitals was formed. The College was thereafter able to share

the heavy burden of the hospital standardization program.

The second period of the Committee's work can be said to have begun in 1926 with the appointment of what became the Board on Industrial Medicine and Traumatic Surgery. Its formation was stimulated by the need for better organization and service in caring for the ill and injured in industry, for the elimination or control of industrial health hazards, and for the institution of other health preservation measures. The College was joined by medical departments of insurance carriers and industrial organizations in their study of an attempt to improve this situation.

Personal surveys were made of medical services and departments in industry at selected points in the United States, and these indicated that injured workers generally had not been cared for by those better qualified in surgery. It was also noted that many of the physicians involved were disinterested in the administrative and preventive phases of industrial medicine; that many physicians had not been delegated the appropriate authority by the employers; and that many of the smaller industrial establishments actually lacked adequate service. Based on the findings of these investigations, the Board on Industrial Medicine and Traumatic Surgery formulated a minimum standard for medical service in industry which was applicable to all industrial organizations, regardless of their size. Acceptance and maintenance of this minimum standard was a purely voluntary thing on the part of any industrial organization.

The first list of approved medical services was published in 1933, and by 1937 a total of 1,657 industrial establishments, representing approximately 5,500,000 employees, had been surveyed, and a certificate of approval was granted to about 50 per cent of them. To illustrate the importance of this effort, the first chairman of the Medical and Surgical Section of the American Railway Association suggested that "wherever possible only hospitals rated as Class A by the American College of Surgeons be recognized, and, where railroads have their own hospitals, that such institutions not already so classified will be brought to such a standard." A little later, the American Railway Association formed a permanent fracture committee out of its 300 chief surgeons and about 10,000 railway surgeons. This group looked to our fracture committee for guidance.

Dr. Frederick C. Besley of Waukegan, Illinois served as chairman of the Board of Industrial Medicine and Traumatic Surgery from its beginning in 1926 until 1939, when it was merged into "The Committee on Fractures and Other Trauma" with Dr. Robert H. Kennedy, of New York, as its chairman.

During this second phase, committee members also started the Fracture Exhibit at the A.M.A. convention in Minneapolis. It was such a success that a permanent committee for this purpose was established by the A.M.A., and for many years Dr. Kellogg Speed was its chairman.

In 1928, the second fracture service in this country was formed at New York's Presbyterian Hospital, under the full-time direction of Dr. Clay Ray Murray, a long-time member of this committee.

The annual Fracture Oration was instituted in 1929, and the first orator was Dr. Scudder, at the Clinical Congress in Chicago. Its name was changed to "Oration on Trauma" in 1952, and it has been called the "Scudder Oration" since 1963.

The "Principles and Outline of Fracture Treatment" was first published in 1931, and in that year Dr. Fred Bancroft of New York succeeded Dr. John B. Walker as Secretary. By 1932 - the 10th year of its being - the national Committee numbered 40 members, and there were 25 regional committees. The eight sub-committees were as follows: - Steel Bone Plates and Screws; The Use of the Fluoroscope; Motion Picture Film on the Treatment of Fractures; Fracture Organizations; Medical Education; The Ambulance; Physical Therapy; and Rehabilitation. During that year, it was noted that the National Board of Medical Examiners and the Federation of State Boards of Medical Licensure were including more questions on fracture diagnosis and treatment in their examinations. Also, the American Red Cross requested assistance in re-writing the fracture section of their first-aid manual.

In 1932, the "Outline of the Treatment of Fractures" was published, and has been revised by the Committee and reprinted many times, with distribution to students, house staff and physicians in practice numbering hundreds of thousands.

We then come to the end of the second period of formal concern about fractures, and the first decade of the Fracture Committee, and we can bring

out the strength, the stature and influence that it developed by comparison with the 10 years before the baton was passed to it by the American Surgical Association. We can also use this most productive period as the basis on which to judge future Committee activity. I speak of this as the end of the decade, because in the following year - 1933 - Dr. Scudder did not accept re-election to the chairmanship of the Committee. Dr. Frederick Bancroft, who had succeeded Dr. Walker as Secretary of the Committee in 1931, was then elected Chairman and Dr. Robert Kennedy of New York City, was made Secretary. He had been elected to the Committee two years before, and has been a member 36 years. Dr. Kennedy had the longest tenure as Chairman of the Committee - from 1939 until 1952. We can only hope that each of these years has been as rewarding to him as it has been to the College and its Committee on Trauma. *

In the third period of the Committee, from the time of Dr. Scudder's retirement until World War II, a gradual change took place in the personnel of the Committee, and this change has continued over a period of many years. This was a kind of delayed reaction from certain events and necessities that developed during World War I. Originally, the doctor who was in the specialty named after the straight child was an orthopedist rather than orthopedic surgeon. He was concerned, for the most part, with disease and deformity of bones and joints, and with casts, braces, straps, buckles,

*(College staff members who have served the Committee are as follows: Bowman C. Crowell, 1926-1946; Charles F. Branch, 1947-1949; Walter E. Batchelder, 1950-1953; James B. Mason, 1954-1963; James C. Spencer, 1964-1965; Robert J. Kamish, 1966-date.)

etc. rather than with bloodshed. The bleeding his patients did remained pretty much subcutaneous. During World War I, necessity led the U.S. Army to assign an increasing number of orthopedists to the care of fractures occurring in the Armed Forces. After the war, many American orthopedists maintained their interest in the care of fracture cases in their civilian practice. This circumstance led to a new definition of the scope of orthopedic surgery, which has been accepted by national organizations.

The specialty is now defined as that branch of surgery especially concerned with the preservation and restoration of the function of the skeletal system, its articulations and associated structures. Obviously, such a definition brings the care of fractures within the field of orthopedic surgery. For this reason, more and more orthopedic surgeons were being nominated and appointed for places, not only the central or national Committee, but for places of influence on the Regional Committees. The problem of the Committee on Fractures at that time, later called the "Committee on Fractures and Other Trauma," was that the fracture cases could not be taken out of the field of the general surgeon, because he supported his claim in the interest of fracture patients by drawing attention to the increasing amount of damage to viscera, muscles, vessels and nerves, which, in this machine age, so frequently accompanies damage to bones. He, of course, claimed a superior competence in dealing with these associated injuries.

You are all familiar with fracture services in this country where the burden is shared by both the general surgeon and the orthopedic surgeon. The attitude of the Committee has been that the prevailing requirement should be interest, enthusiasm and competence rather than a label as this, that or the other kind of a surgeon. Those who have been concerned with the various subcommittees on membership of the Committee on Trauma have been aware of the necessity of maintaining the interest of the general practitioner and general surgeon in the care of the injured person, particularly at the state and regional levels. This is an example of why history must be re-written at least every generation to review new information and to get the changing viewpoint. The environment that faced the Committee on Fractures and Other Trauma in the middle and late 1930's was not the same as that which faced the original committee of the American Surgical Association. Standards and values also change, and the gradual change in the committee personnel is an example of this.

As the end of one period (1933) is identified by Dr. Scudder's retirement from active participation in the Committee's work, so another period ended with his death in 1949. In that year, the February meeting of the Board of Regents happened to be in Boston, and they authorized a change in the name to the "Committee on Trauma." During this meeting, we learned of Dr. Scudder's illness, but celebrated his 89th birthday on August 7 in spite of chronic lymphatic leukemia, pneumonia and cataract surgery. Death came to him in The Phillips House of the Massachusetts

General Hospital, on August 19, 1949.

At the Clinical Congress of the College in 1949, the following was recorded: - "As the Chairman of the first 11 years of the Fracture Committee, Dr. Scudder was the spark plug of all of our efforts. His interest was maintained in spite of advancing age, and for many years he had been the Honorary Chairman of the Committee. The regional committee idea represents a fitting memorial to his zeal for widespread education in fracture problems."

The fourth period of the Committee began after World War II and during the nation's recovery from the effects of it. Dr. Frederick A. Coller, in his Presidential Address, in 1950, said that "this Committee represents one of our most important activities. It has done as much to help the injured as has any other influence in surgery. Our Fellows who have labored so unselfishly to bring about this precept and example deserve the gratitude of countless patients."

It may be said that the Committee then began to show a social consciousness which was not quite so noticeable in earlier years. In the formative years, the concern was more with things, such as plates, screws, and handbooks, and people, because it was of the utmost importance to have a Committee composed of competent, influential and enthusiastic people. In the period beginning about 1950, it would seem that ideas were becoming more important in the Committee's activities than events, people or things. For instance, in this year a Subcommittee on Industrial Relations was appointed with the approval of the Board of Regents. Their activity was

in support of the concept that the rehabilitation of the injured worker was the responsibility of the medical profession. Organized labor and industrial management were invited to appoint representatives to discuss problems common to all three groups. The basic idea was that the rehabilitation of the injured worker, and his return to gainful employment at his highest attainable skill should be the purpose of an improved Workmen's Compensation system rather than the perpetuation of claims settlement based upon cash award for total or permanent partial disability.

The chairman of this committee was Dr. Alexander Aitken, of Boston. The result of their long and hard labors is attested to by the number of influential people in the labor movement and in industrial management who did insist upon more and better rehabilitation institutes and services.

It was also in this period that the idea of prevention of injury was considered within the province of the Committee on Trauma as well as the care of the injured after the event. The idea that stimulated the participation of the Committee on Trauma in prevention of injury is found in the Articles of Incorporation of the American College of Surgeons as amended November 3, 1955: - "...by formulating standards and methods for the improvement of all adverse conditions surrounding the sick and injured wherever found... To accomplish these aims, this corporation will enlist the cooperation of other agencies or institutions already established, or which may hereafter be established."

In the spring of 1957, at the instigation of Dr. Charles G. Johnston,

of Detroit, a meeting of top-level representatives of the American College of Surgeons, the American Association for the Surgery of Trauma and the National Safety Council was held at the Drake Hotel in Chicago. Dr. Johnston was then President of the A.A.S.T. The purpose of this meeting was to explore the idea of a joint effort to minimize accidents and the serious effects of accidents. As the Secretary of the A.A.S.T. that year, it was my privilege to attend this first meeting, and to follow the subsequent developments. A joint policy committee was formed the following year, and out of that came the Joint Action Program, and you are familiar with the manual which ensued. President Howard Pyle, of the National Safety Council, said that it was most impressive to see surgeons concern themselves with the problems of prevention, and commended the groups for the important roles they are playing in the interlocking problems of prevention and restoration.

Assistance in the overall work of the Joint Action Program came from the American Academy of Pediatrics, the American Medical Association's Committee on the Medical Aspect of Sports, the International Association of Chiefs of Police, the National Committee on Uniform Traffic Laws and Ordinances, the Automotive Safety Foundation, the Public Health Service programs related to mass trauma, and the American Red Cross' elements concerned with accident prevention and first-aid.

Among the items discussed at the third meeting of the joint policy committee in 1959 was the National Safety Council's Award for Surgeons.

The Board of Directors of the National Safety Council accepted this idea, and the first recipient was Dr. George J. Curry, a long-time member of the Committee. It was in recognition of his work in safety through the medium of the transportation of the injured.

To further the expansion of Committee on Trauma activities, the Board of Regents of the College, in December, 1959, passed a resolution accepting a grant of about $150,000 from the John A. Hartford Foundation. The purpose of the grant was to improve the treatment given an injured person. The Regents accepted the conditions of the grant, and instructed the Committee on Trauma to formulate a clearly and minutely-defined program, to be presented at the February, 1960 meeting of the Regents. A subcommittee of the Regents was appointed to work with the Committee on Trauma, and a master plan was worked out with Dr. Harrison L. McLaughlin, the Chairman of the Committee at that time, and Dr. James B. Mason, the College staff secretary, carrying on for the Committee on Trauma. In addition to this, an intensive search for a field director was carried out.

The plan called for a three-year effort, the first to be spent in organization, surveys and detailed planning. Field representatives would assist in surveys designed to uncover deficiencies in existing programs for the care of the injured. They would, thus, stimulate local committees, and provide technical assistance to local committees in their community projects already underway. Pilot experiments were to be set up in

selected areas. The second and third years of the grant were to be devoted to the furtherance of these efforts. Needless to say, the program is now in full swing, and we are now in the eighth year that this grant has been available to us.

Another highlight of the early 1960's was the report of the Committee on Transportation of the Injured, which was prepared chiefly by the present Chairman of the Trauma Committee, Dr. Oscar P. Hampton of St. Louis. This report, which was a project of the Joint Action Program, received excellent press and editorial reviews, and was sent to the 1,050 cities which had participated in the National Safety Council Annual Inventory of Traffic Safety, the year before. It did much to dispel the myth of the speeding ambulance. It also served to build the concept of transportation of the injured into the local, grass-roots, community plans.

The numerous refresher courses for physicians, given annually by local committees in various parts of the country are familiar to all of you. The report on the transportation of the injured stimulated many courses in transportation and first-aid designed for the lay public whose work brings them in contact with accident victims of one kind or another, namely emergency-vehicle personnel, firemen, workers in construction in hazardous areas, and the like. The first such course in which the Committee on Trauma participated was given by the local committee in Chicago, and it is now in its 7th year, always over-subscribed.

As the years have gone on, and the number of accidental deaths and

injuries increase each year, more and varied citizens' groups are developing an interest in this problem. This increasing accident rate (28.1 per 100 population in 1965) also plays a significant role in the demand for health services. The magnitude of the current medical manpower shortage would be relieved in at least some degree if less time and effort were needed for the care of the accident victim.

In 1966, the National Academy of Sciences of the National Research Council prepared a booklet on this subject, and entitled it "Accident Death and Disability: The Neglected Disease of Modern Society." They pointed out that research on trauma has not been supported or identified at the National Institutes of Health on a level consistent with its importance as the fourth leading cause of death and the primary cause of disability. The Academy pointed out that in recent years the Committee on Trauma of the American College of Surgeons has provided recommendations on architectural design and equipment of emergency departments and manuals of treatment of the injured. The Academy then went on to state that these commendable efforts by this section of the medical profession are but a beginning, and called for the development of a joint lay and medical approach to this serious epidemiological threat.

It appears that the future of the Committee on Trauma lies along the lines of such joint efforts. Such a move would really be a kind of expansion of the present Joint Action Program.

Now, in closing, let me say how much I appreciate this opportunity

to review the work of this splendid group of men, and let me admonish all those who are members of working committees that your work, however insignificant you may think it, will be far more rewarding if done with a sense of history.