COMMITTEES ON TRAUMA

B L U E B O O K

a guide to
ORGANIZATION
OBJECTIVES
ACTIVITIES
2007

TABLE OF CONTENTS

Committees on Trauma of the American College of Surgeons

Part One–ACS COMMITTEE ON TRAUMA
I. STATUS AS A COLLEGE COMMITTEE
II. HISTORY . . . 2
III. STRATEGIC CONCEPTS AND PLAN
A. Vision . . . 4
B. Mission . . . 4
C. Objectives . . . 4
IV. ORGANIZATION . . . 5
A. Officers . . . 5
1. Chair . . . 5
2. Vice-Chair . . . 7
B. Categories of Membership, Tenure, and Appointment Procedure . . . 7
1. Active Members . . . 7
2. Special Members . . . 8
3. Ex-Officio Members . . . 8
4. Consultant Members . . . 8
5. Liaison Members . . . 8
6. Election to Membership . . . 9
C. Executive Committee . . . 10
D. Membership on Subcommittees and Ad Hoc Committees . . . 10
E. Meetings . . . 11
V. SUBCOMMITTEES–PURPOSE AND OBJECTIVES . . . 12
Subcommittee on ATLS® . . . 13
Subcommittee on Education . . . 13
Subcommittee on Emergency Services–Prehospital . . . 14
Subcommittee on Injury Prevention and Control . . . 15
Subcommittee on the National Trauma Data Bank® . . . 15
Subcommittee on Performance Improvement and Patient Safety . . . 16
Subcommittee on Publications . . . 17
Subcommittee on Regional Committees . . . 17
VI. AD HOC COMMITTEES–PURPOSE AND OBJECTIVES . . . 17
Ad Hoc Committee on Disaster and Mass Casualty Management . . . 17
Ad Hoc Committee on Membership . . . 18
Ad Hoc Committee on Outcomes . . . 19
Ad Hoc Committee on Rural Trauma . . . 19
Ad Hoc Committee on Surgical Skills . . . 19
Ad Hoc Committee on TRAC (Trauma Registry Advisory Committee) . . . 20
Ad Hoc Committee on Trauma System Evaluation and Planning . . . 21
Ad Hoc Committee on Verification/Consultation . . . 21
VII. SUBSPECIALTY TRAUMA COMMITTEES . . . 21

Part Two–REGIONAL COMMITTEES ON TRAUMA
I. AUTHORITY . . . 23
II. HISTORY . . . 23
III. STRATEGIC PLAN . . . 25
IV. ORGANIZATION . . . 25
A. Officers of Regional Committees . . . 25
1. Chair of the Regional Committees . . . 25
2. Region Chiefs . . . 26
3. Chairs of State/Provincial Committees . . . 29
B. Categories of Membership, Tenure, and Appointment Procedure . . . 31
1. Categories of Membership in Regional Committees . . . 31
2. Tenure . . . 32
3. Appointment Procedure to State/Provincial Committees . . . 32

C. Affiliate Membership 32
V. MEETINGS 33
VI. ACTIVITIES 33
VII. REPORTS OF REGIONAL COMMITTEES ACTIVITIES 33
VIII. CAPITAL PROGRAM 35
IX. LIST OF REGIONAL COMMITTEES ON TRAUMA 36

Part Three–AWARDS
I. SCUDDER ORATION ON TRAUMA 37
II. MERITORIOUS ACHIEVEMENT AWARD FOR STATE/PROVINCIAL CHAIRS 43
III. ATLS® MERITORIOUS ACHIEVEMENT AWARD 44
IV. RESIDENT TRAUMA PAPERS COMPETITION 44
V. NATIONAL SAFETY COUNCIL AWARD 48

8/29/07

COMMITTEES ON TRAUMA of the AMERICAN COLLEGE OF SURGEONS

Since 1922, when its Committee on Fractures was established, the American College of Surgeons (ACS) has carried on a continuous campaign of professional and public education, designed to achieve improvements in all phases of the care of the injured and in prevention of injuries.

The College's campaign now is carried out effectively on a national level through the Committee on Trauma (COT), which is supported by a network of 65 State/Provincial Committees, 11 International Committees, and five Military Committees. These committees have an aggregate membership of approximately 2,200 members, the majority being Fellows of the College.

This booklet includes the purpose, objectives, and goals of ACS in the field of trauma. It is a statement of the strategic plan of the COT, which is updated on a regular basis.

DEFINITIONS

Committee on Trauma: A standing professional committee of ACS appointed by the Board of Regents. The words “Central” and “National” are commonly used but are not official designations of this committee.

State/Provincial Committee on Trauma: A committee within a state or territory of the United States or a province of Canada. Also included in this category are military regions and ten countries in Latin America. Three large urban committees (the District of Columbia, Chicago, and Greater New York) have the status of State Committees on Trauma.

Regional Committees: State/Provincial, Military, and International Committees as a group are known as Regional Committees. Outside the continental United States, committees in Argentina, Brazil, Chile, Colombia, Ecuador, Israel, Mexico, Panama, Peru, Venezuela, and South Africa are part of the Regional Organization, similar to State Committees.

Part One–ACS COMMITTEE ON TRAUMA

I. STATUS AS AN AMERICAN COLLEGE OF SURGEONS COMMITTEE

The Committee on Trauma (COT) was established by the Board of Regents of the American College of Surgeons (ACS) and functions under the authority of the Regents. The COT is one of ACS's standing committees and, with the Commission on Cancer, comprises a prominent part of headquarters-based professional activities. Administrative support is provided by ACS through the Medical Director of its Trauma Office and staff.

II. HISTORY

In 1922, the Regents established the Committee on Fractures, consisting of 18 Fellows; the Chair was Charles L. Scudder of Boston. Recognizing that, in general, fractures were treated poorly throughout the United States, the committee enunciated principles and guidelines for emergency splinting of fractures by ambulance personnel, and for definitive fracture treatment by physicians. In 1931, the committee published the first *Outline of the Treatment of Fractures*, which was subsequently revised and republished seven times. The eighth and last edition was published in 1965.

In 1939, an ACS Committee on Industrial Medicine and Traumatic Surgery was merged into the Committee on Fractures to form the Committee on Fractures and Other Trauma. Although fractures were still the committee's major interest, injuries other than fractures were increasingly considered.

In 1950, the Regents authorized the current title—the Committee on Trauma. Subsequently, COT activities have been directed toward the treatment of all types of injuries, with emphasis on the effects of trauma, skeletal and nonskeletal, and on the patient as a whole. The most recent set of objectives of the COT is listed in Part One, Section III.

In 1954, a manual entitled *Early Care of Soft Tissue Injuries* was prepared and published. This manual was revised and republished twice, the second time in 1965. The fracture and soft tissue manuals were replaced in 1972 with an entirely new book, *Early Care of the Injured Patient*. Revised second, third, and fourth editions appeared in 1976, 1982, and 1990. In 1980, the Advanced Trauma Life Support® (ATLS®) Course, emphasizing early management of the injured patient, became a major function of the COT. The course manual is revised and updated every four years. A Verification/Consultation Program for hospitals began in 1987. A committee to develop a hospital trauma registry, now called NATIONAL TRACS, and the National Trauma Data Bank® was appointed in 1989. Guidelines for a Trauma Systems Consultation Program were developed in 1996. In 2005, the technical aspects of NATIONAL TRACS were sold to support the next upgrade of the program.

In its history, the COT and its progenitors have had 17 chairs.

Charles L. Scudder, Boston	1923–1932

Fred Bancroft, New York	1933–1938
Robert H. Kennedy, New York	1939–1951
Arnold R. Griswold, Louisville	1952–1956
Preston A. Wade, New York	1957–1958
Harrison L. McLaughlin, New York	1959–1963
Oscar P. Hampton, Jr., St. Louis	1964–1967
Curtis P. Artz, Charleston, SC	1968–1973
Robert W. Gillespie, Lincoln, NE	1974–1978
C. Thomas Thompson, Tulsa, OK	1978–1982
Donald D. Trunkey, San Francisco	1982–1986
Erwin R. Thal, Dallas	1986–1990
A. Brent Eastman, LaJolla, CA	1990–1994
John A. Weigelt, St. Paul, MN	1994–1998
David B. Hoyt, San Diego, CA	1998–2002
J. Wayne Meredith, Winston–Salem, NC	2002– 2006
John J. Fildes, Las Vegas, NV	2006-

The first five chairs were general surgeons whose principal surgical concern was trauma, with a major interest in fractures. Orthopaedic surgeons whose dominant interest was skeletal injuries filled the next two chairships, but they were keenly concerned with improved care of all injuries. Conforming to the trend of COT activities of the past decade, the present Chair, like his nine predecessors, is a general surgeon whose principal interest is the entire spectrum of injuries. The COT recognizes that complete trauma care entails more than acute management of injury.

In 1922, the first appointees by the Regents to the Committee on Fractures were general surgeons, with the exception of one orthopaedic surgeon. As orthopaedic surgeons increasingly became regarded as responsible for managing fractures, particularly in the post-World War II era, more orthopaedic surgeons were appointed to the committee. Regental guidelines established in 1964 require that each surgical specialty for which ACS has an advisory council be represented on each ACS standing committee if the advisory council for that respective specialty so desires. Accordingly, broad surgical specialty representation now exists on the COT. In 1977, because they recognized the increasing significance of head and spinal cord injuries, the Regents authorized at least three neurologic surgeon members.

From the 1950s to 2002, the COT had about 40 active members and a variable number of senior members. In 2002, the Regents eliminated the senior category of membership. As senior members complete tenure, the number of active members was increased to approximately 70. Since Regental action in 1974, Region Chiefs who are not already active members are considered ex-officio members of the COT.

Emeritus Consultant status was granted by the Board of Regents to Dr. Fraser N. Gurd on June 5, 1976, at the request of the COT.

A more complete historical description can be found in the following books: *Fellowship of Surgeons*, by Loyal Davis, MD, FACS, and *American College of Surgeons at 75*, by George W. Stephenson, MD, FACS.

III. STRATEGIC CONCEPTS AND PLAN

The COT is dedicated to improving all phases of the care of the injured patient, including improvement in emergency care at the scene, transportation of the injured, care in the emergency department and hospital, teaching of the surgery of trauma (undergraduate, graduate, and continuing education), rehabilitation, injury prevention, and the practice of the surgery of trauma. Active cooperation with other national organizations having similar strategic goals augments the COT's effectiveness in improving trauma care. A strategic plan for the COT will be revised on a regular basis by the Executive Committee and approved by the COT membership. This plan is based on the Vision and Mission Statements of the COT, which allow definition of objectives and goals.

A. Vision

The COT strives to be a resource for our profession and other entities, professional, public, and governmental, in topics concerning trauma prevention and care. The COT's major areas of activity should include education, standards of care, quality of patient care, and financial assessment of care. The scope of its activities will be national and international.

B. Mission

The mission of the COT is to develop and implement meaningful programs for trauma care in local, regional, national, and international arenas. These meaningful programs must include education, professional development, standards of care, assessment of outcome, and financial accountability.

C. Objectives

1. Continue Leadership in Development of Standards for Trauma Care

a. Revise *Resources for Optimal Care of the Injured Patient*
   - Extend Verification Program
   - Consider International Pilot Program
   - Standardize reporting function

b. Develop guideline-derived outcome measures
c. Develop evidence-based outcome assessment (guidelines and clinical trials)
d. Use National Trauma Data Bank to develop standard outcome measures.
e. Develop standards for rural trauma care.

2. Continue Trauma Education

a. Revise ATLS with increased evidence-based focus.
b. Continue international promulgation of ATLS.
c. Continue evaluation of new course.
d. Continue involvement and development of CME courses sponsored by ACS.
e. Explore new CD-ROM technologies for educational formats.
f. Continue to promote resident involvement in the COT.
g. Continue to promote surgical involvement in prehospital care.
h. Promote education and involvement of surgeons in disaster and mass casualty planning and care.

3. **Develop Measurement Tools for Trauma Hospitals and Interhospital Comparison**
   a. Create partnerships to continuously evolve NATIONAL TRACS to serve individual hospital needs.
   b. Continuously develop the National Trauma Data Bank to provide a national resource for trauma center data, research platform, and interhospital benchmarking and comparison.

4. **Continue Development of Trauma Systems**
   a. Develop and mature the Trauma System Consultation process.
   b. Work with other agencies to promote cooperative attainment of trauma systems throughout the country.

5. **Foster and Develop Trauma Prevention**
   a. Develop resources and focus for the COT.
   b. Develop collaborative relationships with other organizations to promote and complement others' efforts.
   c. Develop policy statements for prevention.

6. **Continue to Develop Trauma Group Relationships**
   Work with professional and government organizations to meet all missions and goals.

IV. ORGANIZATION

A. Officers

1. Chair

The Chair is nominated by the COT and appointed by the Regents for a two-year term, with eligibility for reappointment to a second two-year term. As stipulated in the *Rules and Guidelines Governing College Committees* (Dec. 2002), the Chair's active membership on the COT will be continued during the period of the term as Chair.

The Chair is responsible for the actions of the COT.

The Chair of the COT is in a unique and special position. The rich heritage of the COT and the continued importance of trauma care to American surgery places the Chair in a number of roles where appropriate representation and action is required. The Chair is a representative of the COT and may occasionally be asked to speak for ACS or the COT. The scope of this position is continually changing, based on the direction the COT is taking. The chief responsibilities of the Chair are as follows:

a. Represent the COT in trauma issues.

   The Chair can serve as a spokesperson or contact person for the internal and external groups that want information on trauma issues addressed by the COT. The Chair must remember that statements that are made concerning policies of ACS must be cleared with the Board of Regents.

b. Act as the representative of the members of the COT to the Board of Regents.

c. Help formulate an action plan with objectives for the COT.

   Each Chair is responsible for an initial plan and regular updates, which are formulated with the help of the Executive Committee and by considering the current and future activities of the COT.

d. Preside over COT meetings.

   The Chair is responsible for obtaining appropriate speakers, appropriate entertainment, and other agenda and activity items associated with any COT meeting. The Chair is also responsible for presiding over all Executive Committee meetings.

e. Help select regional/COT members.

   The Chair should approve these appointments. The Chair is also responsible for nominating the Vice-Chair of the COT who usually serves as the Chair of the Regional Committees.

f. Define activities based on the strategic plan.

   Establish or remove subcommittees and/or ad hoc committees as dictated by the COT's planned activities. Identify needed relationships for the COT with external groups. Act as the contact person for these groups until an appropriate relationship has been established.

g. Organize selection committees for the new Chair.

   A questionnaire will be sent to COT and Regional Committee members asking for their first three choices of eligible candidates. A five-person committee will be appointed by the current Chair. The current Chair will serve as the Chair of this selection committee. The results of the membership poll will be reviewed by the selection committee. A short list of candidates will be identified, and a final meeting will be held with all members of the selection committee. It is recommended that each of the top candidates be interviewed by the entire committee. A final choice will be submitted to the Board of Regents as an action item to the October meeting before the spring meeting when the new Chair is announced.

h. Activate the process for revision of *Resources for Optimal Care of the Injured Patient.*

I. Be responsible for subcommittee activities and task completion.

   The Chair shall set time objectives for subcommittee activities, while recognizing the voluntary nature of COT membership. Ensuring that tasks assigned are recognized as worthwhile by the COT members may simplify this activity.

   Act to add or remove COT members in accordance with ACS and COT guidelines.

j. Ensure participation of the COT in ACS activities, as required.

k. Provide a yearly report to the COT and Board of Regents about the activities of the COT.

   This report should emphasize the accomplishments of the COT, the time commitments, and the current plans for the upcoming year.

l. Attend American Association for the Surgery of Trauma (AAST) Board of Managers meeting upon invitation of AAST.

2. Vice-Chair

The Vice-Chair of the COT is nominated by the Chair of the COT and is approved by the Executive Committee of the COT. This appointment is made by the Board of Regents. The Vice-Chair serves a one-year term which is renewable.

a. May serve as the Chair of the Regional COT organization.

b. Is a member of the Executive Committee and chairs COT meetings when the COT Chair cannot for any reason.

c. Organize and preside over the Resident Trauma Papers Competition at the Annual Meeting of the COT.

d. Assume responsibility for subcommittee and ad hoc committee assignments and activities as identified by the Chair of the COT.

e. Help organize the agenda for the COT meeting at the Clinical Congress and the Annual Meeting of the COT.

B. Categories of Membership, Tenure, and Appointment Procedure

Only Fellows of ACS are eligible for active and ex-officio membership.

1. Active Members

Fellows are nominated for active membership by the COT and are appointed by the Regents. Customarily, the Board of Regents will appoint members from these nominations. Each active member is appointed for a three-year term with eligibility for renomination by the COT and reappointment by the Regents to one additional term of three years.

Potential members are selected for their interest in trauma care within their community, state, or region. Continued membership on the COT is predicated on continued activity of the member in trauma-related activities and participation in COT activities. Attendance at yearly meetings is mandatory for membership. Unexcused absences for two consecutive years is cause for reevaluation of membership and possible dismissal.

An additional third term of senior membership (four years) was discontinued in 2002.

2. **Special Members**
   A class of special membership may be established at the discretion of the COT with Regental approval. These members may serve for a limited amount of time (but not to exceed two years) in order to lend expertise to an ongoing COT project or to remain involved in an activity that requires their attention. Special members may serve on subcommittees, but they may not vote or hold office.

3. **Ex-Officio Members**
   Ex-Officio members are Region Chiefs who are not active members.

4. **Consultant Members**
   The COT may, from time to time, want to appoint consultants. Consultants should be appointed for the purpose of adding specific expertise not provided by active members of the COT and do not represent other organizations or agencies. Consultant members are nominated by the Executive Committee and appointed by the Board of Regents for a three-year term and are eligible for one additional three-year term.

   Consultants to subcommittees and ad hoc committees will be invited to COT meetings at the discretion of the COT Chair and the appropriate subcommittee/ad hoc committee chair.

   Consultants will not have voting privileges nor hold office.

5. **Liaison Members**
   ACS, at the recommendation of the COT, currently has established liaison relationships with the following organizations:

Liaison Organizations	**Liaison Representative from Another Organization**	**COT Representative to Another Organization**
American Association for the Surgery of Trauma	David V. Feliciano	John J. Fildes
American College of Emergency Physicians	Jon Krohmer	Alasdair K. T. Conn
American College of Radiology	Stanford M. Goldman	
ACS Resident and Associate Society	Robert Shayn Martin	
American Society of Anesthesiology	Jill A. Antoine	
Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions		Seth D. Izenberg David E. Bentley

Committee on Pediatric Emergency Medicine, American Academy of Pediatrics		David W. Tuggle
Joint Section on Neurotrauma and Critical Care		Alex B. Valadka
National Association of EMTs	Norman E. McSwain	Norman E. McSwain
National Association of EMS Physicians	Jon Krohmer	
National Association of State EMS Officials	Dan Manz	
Orthopaedic Trauma Association	Jeffrey O. Anglen	
Prehospital Trauma Life Support Course	Norman E. McSwain,	Jeffrey P. Salomone
National Registry of Emergency Medical Technicians		Jeffrey P. Salomone
ACS Resident and Associate Society	R. Shayne Martin	

Federal Partners	
Agency	**Representative**
Centers for Disease Control and Prevention	Richard C. Hunt
Drew Dawson	National Highway Traffic Safety Administration
Emergency Medical Services for Children	Diana Fendya

Currently, the COT also invites the president of AAST to its Executive Committee meetings.

Each COT representative to liaison organizations is expected to file a report to his/her respective subcommittee/ad hoc committee chair, who is responsible for including this report in the subcommittee's annual report.

New liaison relationships can be established with a recommendation from a subcommittee to the Executive Committee that is forwarded to and approved by the Board of Regents. Liaison representatives serve a three-year term and are eligible for a second three-year term. Liaison members will not have voting privileges unless they are Fellows of the College. Liaison members may not hold office.

6. **Election to Membership**
   Election to membership is accomplished by soliciting the members of the COT yearly, as well as by active discussion by the Membership Committee on three separate occasions. Candidates in general surgery, as well as other surgical specialties, must also be identified to preserve specialty presence on the COT, and someone with

expertise in burns also needs to be present. Once candidates have been identified, recommendations are solicited to determine those who would be the strongest committee members. The final names are proposed once yearly to the Executive Committee for action.

C. Executive Committee

In 1973, the Board of Regents approved an Executive Committee for the COT to consist of the Chair, Vice-Chair, and six other active members of the COT. Members of the Executive Committee are nominated by the Chair, approved by the Executive Committee and the COT, and appointed by the Regents. Each Executive Committee member is appointed for one term of three years; the Chair is appointed for a term of two years with eligibility of a second two-year term; and the Vice-Chair is appointed for a one-year term with eligibility for reappointment.

The Chair of the Regional Committees usually will be a member of the Executive Committee. His/her tenure may be extended by the Regents beyond one term for as long as he/she remains an active member of the COT. (See Part Two, Section IV.A.1.)

The Executive Committee meets at least twice annually, at the time of the Annual Meeting of the COT and during the Clinical Congress. Special meetings may be called by the Chair. The Executive Committee reviews policy, plans activities, makes recommendations concerning membership, considers action on all matters coming before it, and recommends action to the members of the COT. The Executive Committee may meet independently of the whole committee. These meetings should be spaced between the Annual Meeting and the Clinical Congress and will be used to establish agenda items for COT meetings, review progress on current activities, and formulate and update the strategic plan of the COT. Since 1994, the Executive Committee has met in two separate Interim Meetings usually scheduled in the winter and summer.

D. Membership on Subcommittees and Ad Hoc Committees

1. Rationale

To establish a closer working relationship within the subcommittee and ad hoc committee structure between COT members and State/Provincial Committee members.

2. Organization

a. Regular subcommittee and ad hoc members, hereafter identified as members, will be appointed by the Chair according to COT guidelines. Committee membership will be limited in most cases to 17 members. An increase in the number of committee members for any committee must be recommended by the subcommittee or ad hoc committee chair and approved by the Executive Committee.

b. Members of subcommittees and ad hoc committees are chosen from the National and Regional Organization based on the needs of the subcommittee or ad hoc committee and the COT.

c. The term of membership on a subcommittee or ad hoc committee is governed by

the guidelines for membership on the COT.

d. Regional members can be appointed as Associate Members to any subcommittee or ad hoc committee from the regional membership. Regional members may have different responsibilities than regular members of the subcommittees and ad hoc committees. These duties will be identified by the chair of the respective committee.

e. Regional members will attend subcommittee or ad hoc committee meetings at the Clinical Congress and Annual Meeting of the COT. Attendance at other committee meetings will be left to the discretion of the respective committee chair and is not funded by ACS.

g. Subcommittees and ad hoc committee meetings at the Clinical Congress and Annual Meeting of the COT should be used to disseminate information about the individual committee's activities to the entire COT (National and Regional).

3. Standing Subcommittees and Ad Hoc Committees

Standing subcommittees of the COT are established consistent with current activities of the COT. The Chair appoints subcommittee chairs and members of each subcommittee. A subcommittee may be abolished at any time by the Chair of the COT. The formation of new subcommittees needs the approval of the Executive Director.

Being appointed chair of a standing subcommittee has implied membership on the Executive Committee. Historically, new committees are established and maintained as ad hoc committees because membership on the Executive Committee is limited. The presence of ad hoc committees is due to the perpetual need of the programs they support. Ad hoc committee chairs meet with the Executive Committee as an expanded committee four times a year at two Interim Executive Committee meetings, the Clinical Congress, and the Annual Meeting of the COT.

Current standing subcommittees are: Education, Publications, Emergency Services–Prehospital, Injury Prevention and Control, Trauma Registry Programs, Performance Improvement and Patient Safety, Advanced Trauma Life Support, and Regional Committees.

Ad hoc committees and task forces may be established by the COT Chair as the need arises. Current ad hoc committees are: Membership, Outcomes, Rural Trauma, Verification/Consultation, Trauma System Consultation, and Disaster and Mass Casualty Management.

Subcommittees and ad hoc committees meet at least twice a year, at a meeting during the Clinical Congress and at the Annual Meeting of the COT. In addition, ACS-funded telephone conference calls and other forms of electronic meetings can be held by the ACS committee chairs.

E. Meetings

The COT holds an Annual Meeting, usually in March or April. An interim business meeting may be held during the annual Clinical Congress, and special meetings may be called by

the Chair.

V. SUBCOMMITTEES—PURPOSE AND OBJECTIVES

Subcommittee on Advanced Trauma Life Support® Course (2005 and 2007)
Purpose: To continually develop and enhance the ATLS® Course for doctors.

Objectives:
1. Revise the ATLS® Course on a regular basis using evidence-based methodology and outsourced resources.
2. Reevaluate educational concepts used in the course and explore opportunities to modify and change these as appropriate.
3. Search for and evaluate new technologies that may be useful in enhancing the content of the program and the educational structure of the course (eg, computer-based learning, including use of the Internet).
4. Evaluate alternatives and develop improved methods for teaching the essential surgical skills of the ATLS® Program.
5. Encourage and support research efforts to test the educational process of the program, determine the impact of the ATLS® Program, and validate the management guidelines proposed and the information disseminated in the course.
6. Continue international promulgation of the ATLS® Program.
7. Interface with other subcommittees directly and through the Executive Committee to ensure consistency with all COT activities and products, including the Ad Hoc Committee on Rural Trauma.
8. Monitor fees charged and profits generated by the course sites in the United States and provide reports to the Executive Committee.
9. Provide the TEAM Program for medical students and other health care providers. Periodically review the program and make improvements as necessary.
10. Working with the American College of Surgeons Foundation, continue to solicit funds for the Trauma Education Endowment Fund for resource-challenged countries and develop a plan to optimally use these funds.
11. Report to the Executive Committee any disciplinary actions taken with respect to course sites and/or individuals and the reasons for such actions.

Subcommittee on Education (2007)
Purposes:
1. To ensure excellent educational forums on the subjects of trauma and critical care for the membership of ACS.
2. To nominate candidates for the Scudder Oration on Trauma and National Safety Council Surgeons' Award for Service to Safety.
3. To enhance other COT programs and initiatives through education and the dissemination of information to the ACS membership.
4. To help improve trauma and critical care programs by developing educational forums and curricula covering important and emerging clinical and systems issues.
5. To stimulate and sustain interest in the practice of trauma-related surgery among general and specialty surgeons by developing educational programs that help maintain related skills and knowledge.

Objectives
1. To provide overall coordination for all national and regional ACS sponsored and endorsed

trauma and critical care activities, in particular, to ensure that the annual Clinical Congress have excellent and state-of-the art trauma and critical care programs. This coordination should help avoid duplication in the many regional and several national trauma educational activities.

- Postgraduate Courses
- Panel on Emerging Issues in Trauma Care
- Trauma Symposium
- Other Clinical Congress trauma programs

2. To regularly solicit the needs and interests of the ACS members in reference to trauma and critical care educational programs.
3. To develop and introduce to ACS new and innovative teaching forums, instruments, and tools (for example: computer-interactive video capability, practical skill instruments and technological symposiums, and so on.)
4. To work with ACS and other agencies in the development and implementation of any trauma-related educational programs, curricula, or instruments that are considered necessary by ACS, its committees, or its membership.
5. To maintain an appropriate educational focus on the multidisciplinary aspects of the care of the trauma patient.
6. To work closely with other COT subcommittees in the development of educational programs that help meet the goals and objectives of those subcommittees.
7. To establish and maintain an ongoing reference source for trauma-related lecturers and topics, including lecture and program evaluation data.
8. To regularly solicit nominations from current and past COT members for candidates for the Scudder and National Safety Council awards.
9. To help develop, implement, promote, and maintain an instructional course in essential operative skills for trauma.

Subcommittee on Emergency Services–Prehospital (2007)
Purpose:
To maintain a high level of visibility, involvement and commitment by surgeons committed to trauma care in the arena of emergency services and prehospital care. The subcommittee will take an active role in prehospital education, development of policies and guidelines for EMS and other prehospital providers, evaluation of prehospital medical treatment through the advancement of clinical and laboratory science, endorsement and enhancement of performance improvement to improve patient care outcomes, and participation as a local, regional and national advocate for prehospital care and emergency services. The subcommittee will maintain active and appropriate liaisons/representation to all organizations interested and involved in this area.

Objectives:
1. Develop evidence-based guidelines for BLS vs. ALS prehospital care and outcomes in trauma patients and identify areas where further research is needed.
2. Provide input to for the development of the *Resources* document and assistance to other subcommittees with common interests that pertain to prehospital care (e.g. verification, injury prevention, education).
3. Participate in the development and implementation of disaster and mass casualty management as it pertains to prehospital care through involvement with the Disaster and Mass Casualty Management ad hoc Committee.

4. Provide ACS COT input and representation to the American College of Emergency Physicians (ACEP), National Highway Traffic Safety Administration (NHTSA), National Association of EMS Physicians (NAEMSP), National Registry of Emergency Medical Technicians (NREMT), National Association of Emergency Medical Technicians and Prehospital Trauma Life Support (NAEMT/PHTLS), Centers for Disease Control and Prevention, Division of Injury Response (CDC), Committee on Accreditation of Educational Programs for the EMS Professions (CoAEMSP), Health Resources Services Administration and the Emergency Medical Services for Children program (HRSA/EMSC), Committee on Tactical Combat Casualty Care (CoTCCC), Department of Homeland Security (DHS), and the National Disaster Medical System (NDMS). In addition the subcommittee will continue to monitor the activities of other organizations in this arena and provide ACS COT input when appropriate.
5. Encourage State COT chairs to work collaboratively with PHTLS and become actively involved with their local, regional or state EMS programs and directors.
6. Monitor political issues/agendas on the national and federal government level that impact prehospital care.
7. Develop policies and joint position statements with other organizations and agencies regarding the prehospital care of the trauma patient in civilian and military settings.
8. Act as a resource/clearing house for requests or questions to the ACS regarding prehospital and EMS issues.

Subcommittee on Injury Prevention and Control (2007)
Purpose:
To become a centralized national resource for injury prevention for the membership of the ACS; to develop cooperative efforts with other organizations dedicated to injury prevention, to increase recognition of injury prevention within the COT; and to propose candidates to the Executive Committee for the National Safety Council Surgeons Award for Service to Safety (nominated in even years by the COT; odd years by the AAST).

Objectives:
1. Promote and update an injury prevention and control slide set.
2. Collaborate and develop cooperative ties with NHTSA, the CDC and other organizations involved in prevention activities for distribution of appropriate program materials.
3. Promote injury prevention and control topics for trauma CME courses.
4. Maintain and update an injury prevention and control web page linked with other prevention sites.
5. Promote a template for injury prevention and control programs.
6. Encourage regular updating of position papers.
7. Provide media training on injury prevention and control.
8. Encourage inclusion of injury prevention and control in medical school curriculum and residency training programs.
9. Facilitate the development of injury prevention outreach programs.

Subcommittee on the National Trauma Data Bank® (2007)
Purpose:
To improve the quality of patient care; to evaluate the processes of patient care; to improve methods of evaluating treatment; to be a rich source of data for injury research; and to encourage development of better outcome measures and injury scoring systems.

Objectives:

1. Work with the Ad Hoc Trauma Registry Advisory Committee to maintain technical compatibility of trauma registries and promote standardization with contributing hospitals and states, software vendors, and other agencies.
2. Along with the AHTRAC supervise the data accrual and aggregation process for the NTDB, including the performance of contractors.
3. Establish data analysis support within the ACS and through contractors.
4, Analyze and organize the NTDB data set to maximize its value as a performance improvement tool.
5. Create and distribute an annual report and a severity adjusted benchmark report that are useful to trauma centers.
6. Expand the presence of the NTDB at professional meetings, in publications, and through the internet.
7. Promote scientific research and publication using the NTDB.
8. Develop methods to evaluate and improve data quality in the NTDB.

Subcommittee on Performance Improvement and Patient Safety (PIPS) (2007)
Purpose:
To define quality in trauma patient care, to provide state of the art practical techniques for monitoring and improving performance and patient safety in trauma care at the local and national level and to establish standards for the measurement of care processes linked to good outcomes.

Objectives:

1. Revise the PIPS chapter in the Resources document when appropriate.
2. Revise the list and definitions of trauma-related complications for institutional tracking and national benchmarking.
3. Identify care processes that can be linked to complications, i.e., best practices that prevent of treat each complication so as to minimize it's impact.
4. Develop and maintain a web based reference manual for trauma performance improvement and patient safety.
5. Provide recommendations for integration of trauma performance improvement and patient safety into hospital-wide and system-wide PIPS programs.
6. Develop techniques for using evidence-based guidelines as tools for monitoring care processes and outcomes and for providing corrective action plans.
7. Incorporate national patient safety initiatives, such as those promoted by the American College of Surgeons, into trauma patient safety initiatives.
8. Incorporate into PIPS the promotion and measurement of competencies as supported by the Accreditation Council on Graduate Medical Education (ACGME) and the American Board of Medical Specialties (ABMS)
9. Work closely with the Subcommittee on Trauma Registry Programs and with the AD Hoc Committees on NTDB, Outcomes and Verification/Consultation to develop and test guideline-based performance improvement and patient safety.
10. Develop the methodology to use the NTDB for the systematic evaluation of risk adjusted performance and benchmarking of trauma centers nationwide.
11. Develop means to identify best practices in trauma centers with excellent performance and disseminate these best practices to all trauma centers.
12. Reduce variability in trauma care processes, outcomes and cost across trauma centers

nationwide.

Subcommittee on Publications (2007)
Purpose:
To assist in the development and dissemination of educational material relating to trauma.

Objectives:
1. Organized the Clinical Congress session on Trauma Video-Based Education.
2. Continue to update current trauma posters.
3. Develop new posters on issues related to injury and improve web-based publication.
4. Continue to explore new educational technologies including newer communication.
5. Explore the idea of developing a web-based repository of trauma pictures and videos.
6. Provide useful content for the trauma community on the ACS web portal.
7. Maintain liaison between COT and Portal Committee.

Subcommittee on Regional Committees (2005 and 2007)
Purpose:
To serve as a resource for State/Provincial Chairs initiating and sustaining COT activities and to advise the COT Executive Committee of state and regional concerns. The COT will be kept abreast of all activities of the Regional Committees.

Objectives:
1. Develop and nominate State/Provincial Chairs.
2. Ensure an appropriate succession plan for all State/Provincial Committees.
3. Develop and encourage International Committees.
4. File an annual report of state and regional trauma-related activities as directed by the Chair of the Regional Committees.
5. Coordinate and conduct the Resident Trauma Papers Competition.
6. Chronicle trauma-related legislative activities for states/provinces and serve as a resource for both health care providers and legislators.
7. Maintain state and regional involvement in EMS programs.
8. Submit candidates for the Meritorious Achievement Award.
9. Cultivate strong alliances with the ACS Chapters.
10. Ensure that the Capital Program has optimal communication.
11. Facilitate ACS-sponsored educational programs.
12. Encourage participation of both residents and medical students in COT activities.
13. Educate the public and policy makers on the significant burden of trauma care, the importance of injury prevention, and the need for improved trauma research funding.
14. Conduct orientation sessions for new members of the State and Regional Committees.

VI. AD HOC COMMITTEES—PURPOSE AND OBJECTIVES

Ad Hoc Committee on Disaster and Mass Casualty Management (2007)
Purpose:
1. To define, expand and reinforce the role of surgeons in the planning, rehearsal, and execution of mass casualty management following disasters, including both natural

(floods, earthquakes, hurricanes) and man-made (biologic, nuclear, incendiary, chemical, and explosive "BNICE") events.
2. To educate surgeons in the principles of disaster planning, and in logistical considerations, triage, and medical management of mass casualties
3. To serve as a resource for information and support of disaster management efforts and plans at the local, regional and national levels, and represent the ACS COT at these levels.

Objectives:
1. Promulgate principles and standards of disaster preparedness and mass casualty management for trauma centers in the COT *Resources* document.
2. Set standards for trauma systems through the creation of an optimal resource guide for disaster management and emergency preparedness.
3. Develop liaisons and cooperative efforts with outside organizations and agencies involved in disaster management, including but not limited to ACEP, NAESMP and the Centers for Disease Control and Prevention.
4. Develop educational lectures, conferences, symposia and courses on disaster and mass casualty management for surgeons.
5. Promote disaster management and emergency preparedness principles and practices through the Advanced Trauma Life Support course.
6. Develop posters which delineate basic principles of disaster planning and management.
7. Create a web page within the COT website to disseminate information and links relating to disaster management.
8. Develop a comprehensive resource manual for surgeons that delineates the principles and methods of disaster management.
9. Advance instruction in disaster management and emergency preparedness to surgeons in training and medical students.
10. Create a core bibliography of publications and other resources relating to disaster management.
11. Advocate effective utilization of national resources for the development of disaster response systems and infrastructure.
12. Collaborate with Operation Giving Back to develop and credential a cadre of volunteers to assist in local, regional and national emergencies.
13. Maintain a position statement for the American College of Surgeons on the role of surgeons in disaster planning and mass casualty management.

Ad Hoc Committee on Membership (2004 and 2007)
Purpose:
To maintain an appropriate list of candidates for membership on the COT and to recommend these candidates for membership to the Executive Committee according to membership guidelines.

Objectives:
1. Seek candidates for COT membership from members of the COT or any Fellow of ACS.
2. Verify that sponsored individuals for membership meet COT membership requirements.
3. Ensure that the nominations for membership are consistent with the mix of members by specialty.
4. Recommend nominees for membership to the Executive Committee.

Ad Hoc Committee on Outcomes (2007)
Purpose:
To evaluate the care given to trauma patients in relationship to the eventual health status and well being of the patient and his/her family after a course of treatment is completed. This evaluation would encompass all areas of care including prevention, pre-hospital, resuscitation, interventions, intensive care, floor care, disposition and rehabilitation. The evaluation would be specific to outcomes achieved in all of the above mentioned areas.

Objectives:
1. Evaluate and publish existing outcome information on trauma care.
2. Identify meaningful outcome end-points for trauma care delivery and establish trauma center benchmarks with respect to the following parameters.
   a. Mortality
   b. Morbidity
   c. Return to pre-injury activity and quality of life
   d. Patient and family satisfaction
3. Identify methods to evaluate care plans for outcome assessment.
4. Establish evidence-based guidelines for the treatment of specific injuries that can be prospectively measured and studied with respect to outcomes.
5. Collaborate with the Performance Improvement and Patient Safety, Trauma Registry, and National Trauma Databank Subcommittees to study existing outcome information and establish guidelines that can be utilized by trauma centers in their care of injured patients.
6. Collaborate with the Office of Evidence-Based Surgery of the American College of Surgeons in the development of outcomes based guidelines for trauma care.

Ad Hoc Committee on Rural Trauma (2007)
Purpose:
To provide leadership and advocacy for rural trauma/surgical issues and the rural trauma patient.

Objectives
1. Promote the development of regional health care systems by:
   a. Promoting the development of rural trauma systems as part of the public health system.
   b. Enhancing the preparedness of Critical Access Hospitals to meet the needs of rural trauma patients/disaster preparedness by research, education and evaluation programs.
   c. Improving rural public health by seeking solutions to the disparity of treatment outcomes in rural trauma patients compared to urban trauma patients.
2. Develop and promulgate rural trauma education:
   a. Continue refinement of the RTTDC through outcomes studies and planned revision cycle of four years.
   b. Explore web-based education to increase availability in rural and frontier communities, prehospital EMS, and critical access hospital networks.
   c. Promote telemedicine courses as a means of reaching the rural/frontier communities, prehospital EMS, and critical access hospital networks.
   d. Continue to develop and expand relationships with international organizations that

provide care and training in rural trauma.

3. Continue to work with the American College of Radiology's COT liaison on issues of mutual interest
4. Develop and maintain a rural trauma site on the ACS web page.
5. Establish an ongoing working relationship with the ACS Council on General Surgery Rural Surgery Subcommittee.
6. Collaborate with the ACS COT Injury Prevention and Control Subcommittee to promote rural injury prevention.
7. Collaborate with the ACS COT Trauma System Consultation committee.
8. Establish and maintain a working relationship with the Indian Health Service.
9. Evaluate and provide input into the rural prehospital EMS issues of triage and transport, communications, and treatment guidelines through collaboration with the ACS COT ES Pre-Hospital committee.
10. Develop a close working relationship with the EAST rural trauma committee to provide input on research needs, guideline development, and rural trauma legislative issues.
11. Develop relationships with the Health Resources and Services Administration of the Office of Rural Health Policy to provide insight into rural trauma and public health issues.

Ad hoc Committee for Surgical Skills (2007)
Purpose:
To continually evaluate and develop educational courses or tools for training in the principles of operative management for the injured patient.

Objectives:
1. Review training tools for use by physicians (medical students, residents, fellows and practicing surgeons).
2. Support established training courses that are compliant with accepted educational principles.
3. Develop training courses needed for all physicians.
4. Explore new educational technologies including all types of simulation.
5. Assure compliance with all criteria developed by the ACS Division of Education for maintenance of certification.

Ad Hoc Committee on TRAC (Trauma Registry Advisory Committee)
Purpose:
As an informatics liaison, the committee will:
1. Address the relationship between the NTDB and software vendors, contributing state registries, and the multidisciplinary efforts to achieve data standardization.
2. Assess the opportunity for data integration, sharing, and storage that may exist in other key initiatives of the COT.

Objectives:
1. Work in close collaboration with the Subcommittee on Trauma Registry Programs/NTDB® to:
    a. Maintain technical compatibility of trauma registries and promote standardization with contributing hospitals, states, software vendors, and other agencies.
    b. Supervise the data accrual and aggregation process for the NTDB, including the performance of contractors.

   c. Create and distribute an annual NTDB report.
   d. Expand the presence of the NTDB.
2. Interact with other COT Committees to address needs and provide informatics support for data accrual, integration, sharing, and storage.
3. Provide input and direction to Digital Innovation for NTRACS.
4. Oversee implementation and transition to the new National Trauma Data Standard.

Ad Hoc on Committee on Trauma System Evaluation and Planning (TSEPC) (2007)
Purpose:
To provide leadership, influence, and direction in the development of ideal trauma systems and the healthcare policy that governs them to ensure optimal, equitable, and accessible trauma care to all people across the United States of America.

Objectives:
1. Continue to improve the consistency of site reviewers.
2. Develop a method to measure the effectiveness of past consultation visits by analyzing the impact of ACS COT recommendations on a trauma system.
3. Establish lessons learned and best practices from previous consultation visits that will assist trauma systems in further refining and improving their systems.
4. Research and develop a new "Grey Book" by understanding the impact of the 2006 HRSA Model Trauma Systems Planning and Evaluation to states' development of Trauma Systems.
5. Train additional reviewers and TSEPC committee members to conduct a consultation visit by providing an interactive, educational experience to train new reviewers and TSEPC committee members.
6. Develop outside funding and support to become self-sustaining by developing governmental grants and projects to support future development of the TSEPC.

Ad Hoc Committee on Verification/Consultation (2007)
Purpose:
1. To assist in improving the care of the injured patient by on-site consultation & verification of trauma center performance according to *Resources for Optimal Care of the Injured Patient*.
2. To assist in the ongoing assessment of the criteria in *Resources for Optimal Care of the Injured Patient* for appropriateness, timeliness, and practicality.

Objectives:
1. Enlist more states and hospitals into the review process.
2. Add new reviewers to the existing pool.
3. Continue to improve the consistency of site reviews and written reports.
4. Educational programs for site reviewers.
5. Joint effort of the PIPS Committee and the Verification/Consultation Committee to clarify what is needed in the Performance Improvement process.
6. Revise reports - shorter and more discussion about recommendations.
7. Institute new PRQ and Report.
8. Update FAQ.
9. Develop a compendium of Rules and Regulations of V/C Program process.
10. Increase the number of verified trauma centers.

11. Serve as a resource for trauma centers; provide consultation and guidance; customer friendly.
12. Change "perception of Verification/Consultation Committee" as a resource and partner.
13. Further develop Verification/Consultation Program internal PI.
14. Educational programs - Trauma Programs.
15. Become more outcome based.
16. Revise "Conclusions of Verification reports" with more emphasis on issues to improve process of Verification.

VII. Specialty Trauma Committees for Pediatric Surgery, Orthopaedic Surgery, and Neurosurgery

These groups provide input to/from their specialty organizations to/from and the Executive Committee and the COT. The Chairs of the Specialty Committees are appointed by the Chair of the COT.

Part Two–REGIONAL COMMITTEES ON TRAUMA

I. AUTHORITY

Regional Committees (State/Provincial, Military, and International Committees) are established by the Committee on Trauma (COT) through the office of the Trauma Office Medical Director, under the authority granted by the Board of Regents of the American College of Surgeons (ACS), on recommendation of the Chair of the Regional Committees. Each action or activity of a Regional Committee is subject to review and approval of the Chair of the Regional Committees and the Chair of the COT. All actions and activities are subject to possible review and approval by the Board of Regents.

II. HISTORY

Regional Committees were initiated by the first Committee on Fractures during the 1920s and were located in or near the cities of residence of the committee members. Subsequently, the number of Regional Committees increased steadily until the United States was blanketed with State Committees. In many states, large numbers of local committees were established. In addition, committees were established in all of the populous Canadian provinces.

A Military Region, representing the Army, Navy, Air Force, and Veterans Administration, was established in 1980, and in 2003, the Canadian Military Committee was added. Each committee was given status equivalent to a State Committee.

State Committees now exist in every state. Actually, there are 65 committees in the United States with State Committee status because California is divided into three State Committees, Texas is divided into two, and certain committees in large metropolitan areas are given state status. Canada has eight Provincial Committees; the Military Region has five; and the International Committees have 10.

In order to crystallize an organizational plan for Region XIV, a meeting with representatives of the COT and of eligible Latin American countries was held in New Orleans at the time of the annual Clinical Congress in 1986. Representatives of five Latin American countries attended. The following principles were established whereby the surgeons of Latin American countries could participate in the proposed program:

- Any nation wanting to participate in the program must have an established ACS Chapter.
- Prior to membership in the Latin American Region, the Chapter should develop a Committee on Trauma.
- The Chair of a Committee on Trauma must be a Fellow of ACS.
- Committee membership and organization would be along the lines of existing Committees on Trauma of ACS.

During the six months after that meeting, Committees on Trauma were organized in Argentina, Brazil, Colombia, and Mexico. Including Chile's Committee on Trauma, a total of five Latin American committees then existed. Chairs of these committees were appointed according to COT policy and as recommended by their respective chapters.

Based on these organizational developments, Regental approval for the formation of Region XIV of the COT was sought and granted in June 1987. Ricardo Sonneborn, MD, FACS, of Santiago, Chile, was appointed Region Chief for Region XIV. In addition, approval was given for translating the ATLS® course materials into Spanish to facilitate the promulgation of the course in Latin America.

Since 1987, committees have been formed in Venezuela in 1988, Peru in 1989, Ecuador in 1994, and Panama in 1999.

At the Clinical Congress in 1995, Region XIV was renamed the International Committees on Trauma. Having no Region Chief, the Chairs of the International Committees report directly to the Chair of the Regional Committees.

In January 1999, the following guidelines were proposed for the establishment of committees outside the United States and Canada:

International Committees on Trauma may be organized under International Chapters of ACS. No regional organization exists for Committees on Trauma outside the United States and Canada.

The Chair of an International Committee on Trauma must be a Fellow of ACS. Nomination of Fellows for the Chair of an International Committee on Trauma, from the respective International Chapter of ACS, are welcomed and will be respectfully considered, but are not binding upon the COT. The appointment of the Chair of an International Committee on Trauma is made through the office of the Trauma Office Medical Director on the combined recommendations of the Chair of the COT and the Chair of the Regional Committees.

The Chair of an International Committee is appointed for a period of three years and may be reappointed for a second three-year term. Under extraordinary circumstances, the Chair of an International Committee may serve for up to a maximum of 10 years. The Chair of an International Committee may be replaced at any time by appointment of a successor.

The Chair of an International Committee on Trauma will serve on the council of the International Chapter of ACS.

The Chair of an International Committee may appoint subcommittees conforming to those of the COT and for additional areas of local need.

The role of the Chair of an International Committee will be to:

- Consider issues relating to the surgery of trauma, that is, prehospital, emergency department, operating theater, intensive care, and rehabilitation, in order to improve the care of the injured. The scope of these components includes patient care, education, and

research. The Chair is also expected to encourage and support injury prevention efforts.

- Identify and recruit, for service on the committee, capable individuals who are committed to optimal care of the injured.

- Establish or maintain conduct of the ATLS® Course in accordance with ACS criteria for conduct of the course. The Chair is expected to be an ATLS® instructor.

- Submit an annual report on the activities of the International Committee to the COT.

A Committee on Trauma in Israel was established in 1999.

In 2007 three separate International Regional Committees were formed:

- Region 14 - Latin/South America
- Region 15 - Europe/Middle East/Africa
- Region 16 - Australia/New Zealand/Asia

III. STRATEGIC PLAN

State/Provincial Committees support the vision and mission of the COT. Emphasis on the various objectives conforms to priorities based on respective needs in the area pertinent to a given committee.

IV. ORGANIZATION

The United States is divided into 10 regions and Canada into two regions to facilitate operations of the Regional Committee on Trauma Organization. The boundaries of the U.S. regions conform to those of the U.S. Department of Health and Human Services and the U.S. Department of Transportation. Canada has an eastern and a western region. Each U.S. region is comprised of several states, and each Canadian region of several provinces. The military branches (Army, Navy, Air Force), together with the Department of Veterans Affairs and the Canadian military constitute one Regional Committee. The International Committees constitute another region for the purposes of the Resident Trauma Papers Competition.

A. Officers of Regional Committees

1. Chair of the Regional Committees

The Chair of the Regional Committees is appointed through the Trauma Office Medical Director by the Chair of the COT from among its active members. The Chair of the Regional Committees is responsible for the organization and activities of the Regional Committees and reports to the Chair of the COT at least annually. Appointment is for a two-year term with eligibility for reappointment to a second two-year term. The Chair of the Regional Committees serves at the discretion of the Chair of the COT and may be replaced at any time by the appointment of a successor. “Regional Committees” is a major subcommittee of the COT.

Other duties of the Chair of the Regional Committees are as follows:

a. Collate the annual reports from the State/Provincial Chairs and submit a report to the COT for publication in the Annual Report of the COT. Provide a brief summary/ report of the activities of the State/Provincial Committees to the Chairs of the State/Provincial Committees.

b. Submit names of trauma surgeons for appointment to regional and state positions within the State/Provincial Committees. Names need to be submitted for final approval according to established COT procedure.

c. Serve as Chair of the Subcommittee on Regional Committees.

d. Serve as contact person for the Capital Program.

e. Serve as a member of the Ad Hoc Committee on Membership.

2. Region Chiefs

Region Chiefs are nominated by the Chair of the Regional Committees, approved by the Chair of the COT, and appointed by the Trauma Programs Medical Director. A Region Chief is appointed for a period of six years. Based on extraordinary service, the Region Chief may be asked to serve for a period of up to four additional years. The duration of Region Chief appointment may not exceed that of combined active/senior COT service (10 years). The Region Chief serves at the discretion of the Chair of the Regional Committees in consultation with the Chair of the COT and may be replaced at any time by appointment of a successor. During tenure as a Region Chief, ex-officio membership on the COT is granted unless the Region Chief has been appointed to active membership by the Board of Regents.

A Region Chief is responsible for the organization and activities of the committees constituting the region and is the region's representative on the COT. The Region Chief reports annually on activities within the region to the Chair of the COT through the Chair of the Regional Committees.

Region Chiefs may appoint regional subcommittees conforming to those of the COT and in additional areas of regional needs.

Region Chiefs are ex-officio members of their respective State/Provincial Committees.

Because organization and oversight of regional activities should be the primary concern of a Region Chief, only in extraordinary circumstances should a Region Chief assume simultaneous duty as Chair of a COT committee. Likewise, State/Provincial Chairs who become Region Chiefs should recommend a successor for the state/provincial position as soon as possible.

a. Role of Region Chief

Region Chiefs should be experienced trauma surgeons familiar with the structure, purposes, and objectives of the COT, preferably through experience as a

State/Provincial Chair. They must be current ATLS® Instructors, with experience as a course director. They are to provide guidance and counsel to, and are accountable for the performance of, the regional State/Provincial Chairs.

b. Duties of Region Chief

I. State/Provincial Committee on Trauma

The Region Chief nominates State/Provincial Chairs, subject to approval of the Chairs of the Regional Committees and the COT. In making nominations, the Region Chief should consider the qualifications of the current State/Provincial Vice-Chair and solicit input from the ACS Chapter President, the Chair of the Regional Committees, and the COT Ad Hoc Committee on Membership. State/Provincial Chairs serve at the discretion of the Region Chief, who is accountable for their performance. Advancement to successive terms should not be automatic, but based on ability and accomplishments. Region Chiefs should encourage State/Provincial Chairs to appoint a suitable Vice-Chair early in their tenure. A checklist for selection of State/Provincial Chairs by Region Chiefs follows:

- Communicate with the outgoing Chair about his/her recommendation.
- Discuss the candidate with the leadership of the ACS Chapter.
- Assess consensus of the State Committee on Trauma.
- Review candidates' curriculum vitae.
- Confirm active participation in ACS and COT activities.
- Confirm ATLS® Instructor status.
- Confirm ACS Fellowship status.
- Confirm candidate's willingness to serve.
- Submit name and supporting documents to the Chair of the Regional Committees.
- Upon notification from Chicago, send formal notification to all State Chairs in the region.

ii. Advanced Trauma Life Support® Courses

By ATLS® policy, Region Chiefs are ATLS® national faculty. ATLS® is a major responsibility of every State/Provincial Chair, and Region Chiefs may be called on to troubleshoot problems with courses in their region. Appropriate oversight of this key activity is at the discretion of the Region Chief and may include site visits, regional meetings, and regional instructor courses. Region Chiefs should encourage promulgation of Pre-Hospital Trauma Life Support in conjunction with the existing ATLS® organizational structure in the region.

iii. Surgical Resident Trauma Papers Competition

The Region Chief should encourage State/Provincial Chairs to solicit papers and should organize the regional competition to provide winners to compete at the Annual Meeting of the COT. Guidelines are detailed in the call for abstracts distributed from the Trauma Office each year.

iv. Capital Program

Each January, the Region Chief will receive the current listings for the Capital

Program for every state/province in his or her region and should encourage State/Provincial Chairs to update their lists accurately and in a timely manner. Where controversy exists, that is, rival institutions in the same metropolitan area or in adjacent states or provinces, the Region Chief may provide guidance in conflict resolution.

v. Trauma Registry of the American College of Surgeons

Region Chiefs should encourage participation in NTDB. They should be sufficiently familiar with the program to serve as a resource in answering questions, troubleshooting problems, or in referring to the appropriate resource person.

vi. Verification Activities

Region Chiefs should be familiar with *Resources for Optimal Care of the Injured Patient* and with the activities and principles of the Ad Hoc Committee on Verification/Consultation. When possible, Region Chiefs should participate as site reviewers, under the guidelines of the Ad Hoc Committee on Verification/Consultation.

vii. Coordination of Regional Activities

Each state/province should have ongoing educational, prevention, and trauma legislation programs. Many aspects of these programs will affect adjoining states and provinces. The Region Chief can provide valuable service by the following:

- keeping informed about various programs in the region
- helping to coordinate activities of the various State/Provincial Committees
- arranging regional meetings, symposia, or joint legislative efforts when appropriate

At each meeting of the COT, Region Chiefs will have the opportunity to meet with the State/Provincial Chairs. It is expected that the Region Chiefs will attend these meetings on a regular basis. They should prepare and distribute in advance an agenda, and subsequently provide a *brief* summary of the meeting for the Chair of the Regional Committees.

viii. Meritorious Achievement Award

Each Region Chief has an annual opportunity to nominate candidates for this award that recognizes outstanding accomplishments of a current or former State/Provincial Chair. He or she may nominate individuals from other regions, but should give initial consideration to those from his or her own region. Each nomination should be accompanied by a brief explanation of the reasons for consideration. The Executive Committee selects the award recipient.

ix. Orientation of Next Region Chief

A list of suggested steps to ensure the continuity of the region are listed below:

- Orientation, education, and training of new Region Chief
- Orientation, education, and training of support staff

- Communication with Region Chief/staff/other related health care personnel
- Financial accounts assessment and transfer
- ATLS® Course information update (emphasis on problems)
- Resident Trauma Papers Competition
- Annual report (including an annual financial report)
- Legislative initiative (periodic reports and progress updates)
- Capital Program (strengths/weaknesses)

x. Annual Report (See Part Two, Section VII)

3. Chairs of State/Provincial Committees

Chairs are appointed through the Trauma Office Medical Director by the Chair of the COT following nomination by the appropriate Region Chief and approval of the Chair of the Regional Committees. Nomination of a State/Provincial Chair by a Region Chief requires consultation by the Region Chief with the President of the respective ACS Chapter. A State/Provincial Committee Chair is generally appointed for a period of three years. Reappointment for a second three-year term is assumed unless performance is inadequate. Under extraordinary circumstances, a State/Provincial Committee Chair may serve for up to four additional years. The Chair of State/Provincial Committees serves at the discretion of the Region Chief in consultation with the Chair of Regional Committees and may be replaced at any time by appointment of a successor.

By ACS policy, State/Provincial Chairs are to serve on their Chapter councils, which provides the Chair an opportunity to inform the members of trauma activities and to coordinate with other Chapter activities.

A State/Provincial Chair may, with the concurrence of the Region Chief, appoint a Vice-Chair. Notification will be made through the ACS Trauma Office. The purpose of the Vice-Chair is to assist the Chair in carrying out the objectives of the committee. The Vice-Chair should be sufficiently qualified and involved in committee activities that he/she could be a fitting successor as Chair.

State/Provincial Chairs are encouraged to invite Vice-Chairs to all meetings of the State/Provincial Chairs held by Region Chiefs and should function as alternates or substitutes at the Annual Meeting of the COT if the respective State/Provincial Chair cannot attend.

State/Provincial Chairs may appoint subcommittees conforming to those of the COT and in additional areas of local needs.

Active members of the COT are considered ex-officio members of their respective State/Provincial Committees.

a. Role of State/Provincial Chair

State/Provincial Committees on Trauma traditionally consider issues relating to all aspects of trauma surgery, that is, trauma systems, prehospital, emergency department, operating theater, intensive care, injury prevention, rehabilitation, and

disaster preparedness, within the state/province. The scope of these components includes patient care, education, and research.

b. Specific Duties of the State/Provincial Chair

I. State/Provincial Committee on Trauma

The Chair should identify, recruit, and maintain individuals who are capable and interested in serving as members, associates, advisors, or physicians-in-training on their committees. This effort should include surgeons from hospitals that are trauma centers, as well as hospitals that are not. The committee should be involved in all trauma-related activities and convene formally, at least annually, to discuss progress and establish priorities for its state/province. These activities should be performed in concert with the respective State/Provincial Committees; that is, it is the Chair's responsibility to communicate and collaborate with these ACS committees.

ii. Advanced Trauma Life Support® Courses

The Chair must be an ATLS® instructor and should establish ATLS® courses sufficient to meet the needs of the state/province. The Chair must approve all ATLS® courses and ensure their quality. State/Provincial Chairs should be familiar with ATLS® regulations published in the Instructor's Manual. The Chair should communicate directly with the ATLS® Program Office if there is any known or potential deviation from these regulations.

iii. Surgical Resident Trauma Papers Competition

The Chair should solicit abstracts and organize the formal Resident Trauma Papers Competition, providing a winning paper from the state/province to the respective Region Chief. Guidelines for this competition are detailed in the Call for Abstracts distributed from the Trauma Office each spring.

iv. Capital Program

The Chair is responsible for annually submitting a confidential list of capable trauma surgeons throughout the state/province to the COT Capital Program Director and providing necessary changes as soon as recognized. The White House may contact the Chair directly to verify the listing for anticipated visits.

v. Trauma Legislation

The Chair should formalize a list of existing legislation that addresses trauma systems (designation, triage, reimbursement, registry, and so on) and injury prevention (seatbelt, helmet, alcohol, gun control, and so on). The COT is developing a library of model legislation collated from all states/provinces. This information is listed in the COT Annual Report.

vi. Educational Programs

The Chair should encourage trauma-related education in the state/province, which may consist of providing a course/symposium or cosponsoring a program given by another organization. Cosponsorship may be provided by the State/Provincial Committee, but this is specifically *not* to be construed as

cosponsorship by ACS. Support may be in the form of financial assistance, providing speakers, or supplying a mailing list. Endorsing a program implies that the Chair has reviewed the material to be presented and that it does not conflict with principles advocated by ACS. The program brochure should acknowledge support of the State/Provincial Committee, but should not include the ACS seal unless specifically approved by the ACS Trauma Office.

vii. Injury Prevention

The Chair shall encourage and support injury prevention efforts in the state/province. This support may consist of providing educational materials, speakers for community program development, and utilizing the resources of the ACS Trauma Office. Development of strong cooperative efforts with other organizations that address injury control and prevention is encouraged. Cosponsorship can be provided by the State/Provincial Committee for both injury prevention programs and injury control legislation, but this is specifically *not* to be construed as cosponsorship by ACS. Endorsement implies that the Chair has reviewed the issue/program and that it does not conflict with the principles advocated by ACS.

viii. Orientation of Next Chair

A list of suggested steps to ensure the continuity of the State/Provincial Committee are listed below:

• Orientation, education, and training of new State/ Provincial Chairs
• Orientation, education, and training of support staff
• Communication with state/provincial member/staff/other related health care personnel
• Financial accounts assessment and transfer
• ATLS® Course information update on courses/providers/instructors/staff (emphasis on problems)
• Resident Trauma Papers Competition
• Annual report (including an annual financial report)
• Legislative initiative (periodic reports and progress updates)
• Capital Program (strengths/weaknesses)

ix. Annual Report (See Part Two, Section VII)

B. Categories of Membership, Tenure, and Appointment Procedure

1. Categories of Membership in Regional Committees

a. Active

Fellows of ACS

b. Associate

Non-Fellow doctors of medicine with interests, positions, and capabilities of value to a given committee.

c. Advisory

Nonphysicians who can contribute to state/provincial programs and activities.

d. Physicians in Training

Medical trainees who demonstrate an interest in trauma-related activities are eligible for membership.

e. Ex-Officio
Active COT members who reside in the state or province.

2. Tenure
Tenure continues until a member resigns, until the term of appointment ends, or until the appointment is terminated by the appropriate Chair.

3. Appointment Procedure to State/Provincial Committees
The authority for all appointments, granted by the Board of Regents, rests with the Chair of the COT. Names of nominees for membership on State/Provincial Committees should be submitted by the State/Provincial Chair to the ACS Trauma Office. A prospective member of any committee may be questioned regarding interest in serving but should not be advised of nomination until it has been processed. This procedure avoids embarrassment should the approving authority find the nominee unqualified. Letters of appointment, in the name of the Chair of the COT, will be transmitted by the Trauma Office, with copies to the proper Chairs and Region Chiefs. Informal local appointments are not authorized. Deletions of members from a committee for any reason should be reported by its Chair to the Trauma Office without delay.

C. Affiliate Membership

This category of membership was adopted in 2000 and allows a recognized member of the Regional Committees who resides in a country without an ACS Chapter to become an affiliate member of the COT.

1. Criteria
- A highly qualified practicing surgeon who is in good standing in his/her country with no recognized ACS Chapter
- Documented dedication to quality medical management of the injured patient
- Familiarity with adoption of the established principles and objectives of the COT
- Fellowship in ACS
- A member in good standing of the local surgical society

2. Application Process
- Letter of intent stating an interest in being an affiliate member of the COT and highlighting the applicant's current involvement in trauma management
- Curriculum vitae
- ATLS® status documentation
- References (three, including one from a current or former member of the COT or Regional Committees)
- The Executive Committee of the COT will review all applications and render a decision on each candidate. The authority for all appointments is granted by the Board of Regents.

3. Membership Requirements

Participation in COT activities includes attendance at the Annual Meeting and the COT sessions at the annual Clinical Congress. In a two-year span, a member must have attended at least one COT meeting, either at the Clinical Congress or the Annual Meeting.

4. **Terms**
   Each term is three years. An affiliate member can serve on the Regional Committees for a maximum of three consecutive terms. Membership can be terminated by the Executive Committee at any time if it is determined that the affiliate member is no longer in good standing.

V. MEETINGS

A State/Provincial Committee meets on call of its Chair. State/Provincial Committees should hold at least one meeting a year and preferably more, as determined by the needs of the organization.

VI. ACTIVITIES

Activities of the State/Provincial Committees may be generically similar to any or all of the activities of the COT and may also include others, according to the wishes and preferences of the committee concerned.

The Chair of the COT urges State/Provincial Chairs to interact with their respective Chapter Councils as defined by those Councils. Chapters may at their discretion assist the state ACS trauma organization by providing funds for trauma projects.

VII. REPORTS OF REGIONAL COMMITTEE ACTIVITIES

The State/Provincial Chair develops his/her annual report, which is submitted to the Region Chief by mid-January, covering the period from January through December of the previous calendar year. The Region Chief then makes his/her annual report on the activities of his/her region to the Chair of the Regional Committees by the end of January. Dates vary depending on the date of the Annual Meeting.

The Chair of the Regional Committees consolidates the reports from Region Chiefs and submits his/her report to the COT at its Annual Meeting. In addition, he/she forwards information on activities of interest to the respective chairs of the several subcommittees for incorporation into their annual reports.

A format for reports is furnished to the Chair of the State/Provincial Committees by the Chair of the Regional Committees four weeks prior to the due date.

The proceedings of the Annual Meeting of the COT are included in the Annual Report, which is sent to COT members, the Region Chiefs, and the Chairs of State/Provincial Committees. This

document outlines policies, projects, and programs that the COT deems important and should serve as an important source for the development of programs at the state/provincial level.

VIII. CAPITAL PROGRAM

A. Purpose

To provide the White House medical unit with accurate information about appropriate local and regional trauma care facilities when the President, Vice-President, and any others for whom the medical unit assumes responsibility, travel to various parts of the United States.

B. Objectives

1. To maintain, through state and regional trauma Chair input, an accurate and current database of the following:

    a. Verified and/or designated trauma centers (including level of care)

    b. Local and regional contact person, ideally a general surgeon

2. To educate committee members about the rationale for the program

3. To educate the White House medical unit about the program and how to access it

4. To develop a similar database for international presidential travel

IX. LIST OF REGIONAL COMMITTEES ON TRAUMA

Organization of Regions by States, Provinces, Territories, and Countries

Region 1
Connecticut
Maine
Massachusetts
New Hampshire
Rhode Island
Vermont

Region 2
New Jersey
Greater New York
New York State
Puerto Rico/
Virgin Islands

Region 3
Delaware
District of Columbia
Maryland
Pennsylvania
Virginia
West Virginia

Region 4
Alabama
Florida
Georgia
Kentucky
Mississippi
North Carolina
South Carolina
Tennessee

Region 5
Chicago
Illinois
Indiana
Michigan
Minnesota
Ohio
Wisconsin

Region 6
Arkansas
Louisiana
New Mexico
Oklahoma
Northern Texas
Southern Texas

Region 7
Iowa
Kansas
Missouri
Nebraska

Region 8
Colorado
Montana
North Dakota
South Dakota
Utah
Wyoming

Region 9
Arizona
Hawaii
Nevada
Northern California
San Diego-Imperial County
Southern California

Region 10
Alaska
Idaho
Oregon
Washington

Region 11
Alberta
British Columbia
Manitoba
Saskatchewan

Region 12
Maritime Provinces
Newfoundland
Ontario
Quebec

Military Region (13)
Army
Navy
Air Force
Department of Veterans Affairs
Canadian Military

Region 14
Argentina
Brazil
Chile
Colombia
Ecuador
Israel
Mexico
Panama
Peru
Venezuela

Region 15
Europe
Middle East
Africa

Region 16
Australia
New Zealand
Asia

Part Three–AWARDS

I. SCUDDER ORATION ON TRAUMA

The following excerpt is reprinted from an article in the October 1979 Bulletin of the American College of Surgeons*, entitled "The Committee on Trauma: Its Men and Its Mission," by George W. Stephenson, MD, FACS.*

Twenty-six surgeons from across the country met at the Massachusetts General Hospital in April 1922 "to come to some agreement" as to "the essentials of the treatment of fractures." Dr. Charles L. Scudder was probably the prime mover in this effort, which resulted in a 23-page syllabus in the *Archives of Surgery* in January 1923, entitled "Outlines of Treatment of Fractures." It was a creditable base for an ultimate manual.

In May 1922, Dr. Scudder appeared before the College's Board of Regents, on his own petition, to present the problem of traumatic surgery, and fractures in particular. He urged the Regents to authorize a large-scale study, primarily to enunciate fundamental principles. They asked him to be the chair of a committee on the "Treatment of Fractures." Almost all members of the committee were also participants in the production of the syllabus.

Dr. Scudder promptly organized his committee and appointed twelve of its members as area chairs, with 66 local chairs. Thus, from its beginning the committee has had a structure involving Fellows of the College at the grass roots.

The committee developed standards for the hospital care of fractures, approved by the Regents in 1924 and published in Hospital Standardization Manuals thereafter. They prescribed splints, x-ray apparatus, special record forms, and supervision by a physician. The following year, 1,947 surgeons caring for fractures in hospitals were listed and 151,000 fractures reported from 1,050 hospitals.

Articles by committee members appeared in the *Bulletin,* and Dr. Scudder wrote "Essentials for Efficient Fracture Service in Hospital" for January 1926 issue.

Clinical conferences, including one-day programs at sectional meetings, were started, and the first "Fracture Oration" was given at the Clinical Congress by Dr. Scudder in 1929.

In 1922, the Regents established the Committee on Fractures and named Charles L. Scudder the Chair. Dr. Scudder guided this committee until 1932. This committee eventually became the American College of Surgeons Committee on Trauma. Dr. Scudder was instrumental in emphasizing the need for professional standards in trauma care and ensuring that the ACS took an active role in this process.

The first criteria for a Scudder Orator is to have shown a sustained commitment to trauma through his/her career and to have endeavored to improve trauma care. Second, these contributions must have made a difference in how trauma care is provided.

Past Recipients are:

1929 Oration on Fractures
Charles L. Scudder (*SG&O*, 1930, 50:193-95)

1930 Splint Grafts in Treatment of Delayed and Non-Union of Fractures
Dallas B. Phemister (*SG&O*, 1931, 52:376-81)

1931 Some Old Truths about Fractures
William Darrach (*SG&O*, 1932, 54:290-93)

1932 Fractures and Dislocations in the Region of the Elbow
Philip D. Wilson (*SG&O*, 1933, 56:335-59)

1933 Treatment of Fractures Involving the Joints
W. Edward Gallie (Unpublished)

1934 Unsolved Fracture
Kellogg Speed (*SG&O*, 1935, 60:341-52)

1935 Fundamentals Versus Gadgets in the Treatment of Fractures
Paul B. Magnuson (*SG&O*, 1936, 62:276-86)

1936 Essential Features in Fractures of the Shoulder
George E. Wilson (*SG&O*, 1937, 64:347-57)

1937 Present Status of the Operative Treatment of Fractures
William O'Neill Sherman (*SG&O*, 1938, 66:353-59)

1938 Evolution of Fracture Treatment
Isidore Cohn (*SG&O*, 1939, 68:362-71)

1939 Ambulatory Treatment of Fractures of the Lower Extremity
Fraser B. Gurd (*SG&O*, 1940, 70:385-91)

1940 Treatment of Traumas of Skin and Subcutaneous Tissues
Frederic W. Bancroft (*SG&O*, 1941, 72:318-27)

1941 General Surgeons' Approach to the Problems Presented by Fractures and Other Traumas
Walter E. Lee (*SG&O*, 1942, 74:514-28)

1942 to 1945 WAR YEARS–Lecture not presented

1946 Modern Methods in the Treatment of Fractures
Edwin W. Ryerson (*SG&O*, 1947, 84:562-66)

1947 Fractures of the Upper End of the Radius and Ulna
Frank D. Dickson (*SG&O*, 1949, 88:69-78)

1948 Colles' Fracture
Henry C. Marble (Unpublished)

1949 Fracture Hazards
Otto J. Hermann (Unpublished)

1950 Thoughts on Fractures and Other Trauma
J. Huber Wagner (Press release)

1951 Fallacies of Internal Fixation and Contract Compression of Fractures
Sir Reginald Watson-Jones (*Clinical Congress Bulletin*, San Francisco, Nov. 8, 1951, p.1)

ORATION ON TRAUMA (1952–1962)

1952 Working Man's Hand
Sumner L. Koch (ACS *Bulletin*, 1953, 38:5-14)

1953 Present Day Problems in Nonpenetrating Abdominal Trauma
William L. Estes, Jr. (ACS *Bulletin*, 1954, 39:11-18)

1954 Our Fashionable Killer
Robert H. Kennedy (ACS *Bulletin*, 1955, 40:73-81)

1955 Medical Management of Mass Casualties
Frank B. Berry (ACS *Bulletin*, 1956, 41:60-66)

1956 Treatment of Open Wounds
Michael L. Mason (ACS *Bulletin*, 1957, 42:33-38; 80-81)

1957 Education in Trauma
Harrison L. McLaughlin (ACS *Bulletin*, 1958, 43:41-44; 70-71)

1958 Immediate Care and Transportation of the Injured
George J. Curry (ACS *Bulletin*, 1959, 44:32-34; 64-67)

1959 Wounds of the Abdomen and Pelvis
R. Arnold Griswold (ACS *Bulletin*, 1960, 45:31-36)

1960 Trauma and the Living Cell
J. Trueta (ACS *Bulletin*, 1961, 46:73-77; 102)

1961 The Injured Patient and the Specialist
Preston A. Wade (ACS *Bulletin*, 1962, 47:73-82; 94)

1962 Organization and Management of Trauma Surgery in Austria
Jorg Bohler (ACS *Bulletin*, 1963, 48:107-11)

SCUDDER ORATION (1963–present)

1963 Trauma, Specialism and the College
Edwin F. Cave (ACS *Bulletin*, 1964, 49:61-65)

1964 The Acute Burn as a Catastrophic Illness
Truman G. Blocker, Jr. (ACS *Bulletin*, 1965, 50:141-3; 181-2)

1965 Cervical Spondylosis–A Source of Pain, Paresthesias, Paralysis and Plaintiffs–Is It Traumatic?
Frank H. Mayfield (ACS *Bulletin*, 1966, 51:5-10)

1966 Tissue Repair in Burns
Tord Skoog (Press release)

1967 The College and the Accident Victim–Story of the Committee on Trauma
James K. Stack (Manuscript)

1968 Acute Injuries of the Liver
Rudolf J. Noer (ACS *Bulletin*, J/F 1969, 54:11-19)

1969 Achievements and Problems in the Treatment of Trauma
Sir Frank Holdsworth (ACS *Bulletin*, Mar, 1970, 55:13-16)

1970 Men for the Care of the Injured: Crisis Facing the 70's
William T. Fitts, Jr. (ACS *Bulletin*, Dec 1970, 56:9-17)

1971 The significance of Infection in Trauma
William A. Altemeier (ACS *Bulletin*, Feb 1972, 57:7-16)

1972 Care of the Injured–The Surgeon's Responsibility
G. Tom Shires (ACS *Bulletin*, Feb 1973, 58:7-21)

1973 The Seven Years' War
J. D. Farrington (ACS *Bulletin*, Nov 1973, 58:15-22)

1974 Education in Trauma: The Surgeon's Responsibility
Jack Wickstrom (ACS *Bulletin*, Apr 1975, 60:7-14)

1975 The Role of Leadership in the Quality of Fracture Care
Sawnie R. Gaston (ACS *Bulletin*, Nov 1975, 60:16-23)

1976 Optimal Care for the Injured Patient: The Role of the Specialty Training Programs
Fraser N. Gurd (ACS *Bulletin*, Feb 1977, 62:7-16)

1977 Unlocking the Mysteries of the Burn Wound
John A. Moncrief (ACS *Bulletin*, Nov 1977, 62:14-19)

1978 In Praise of Surgical Hedgehogs: Trauma and the Compleat Surgeon
Alexander J. Walt (ACS *Bulletin*, Oct 1979, 64:4-16)

1979 You've Come a Long Way, Baby, in Improving Trauma Care
John H. Davis (ACS *Bulletin*, Oct 1980, 65:10-18)

1980 War and Peace
Francis D. Moore (ACS *Bulletin*, Oct 1981, 66:14-19)

1981 Microsurgery in Trauma: Its Evolution and Future
Harold E. Kleinert (ACS *Bulletin*, June 1982, 67:10-19)

1982 Traumatic Shock: The Search for a Toxic Factor
F. William Blaisdell (ACS *Bulletin*, Oct 1983, 68:2-10)

1983 The Management of Trauma Imperatives for Hospital Cost Containment
William R. Drucker (ACS *Bulletin*, Oct 1984, 69:12-19)

1984 The Universal Trauma Model
Basil A. Pruitt (ACS *Bulletin*, Oct 1985, 70:2-13)

1985 The Accident Hospital
Robert J. Freeark (ACS *Bulletin*, Oct 1986, 71:24-30)

1986 Injury in America
Donald S. Gann (ACS *Bulletin*, Jul 1987, 72:12-15)

1987 Specialization in Surgery - Abdominal Trauma Management in America
David S. Mulder (ACS *Bulletin*, Oct 1988, 73:15-25)

1988 Yesterday, Today, and Tomorrow: Abdominal Trauma Management in America
Gerald W. Shaftan (ACS *Bulletin*, Mar 1989, 74:21-35)

1989 What's Wrong with Trauma Care?
Donald D. Trunkey (ACS *Bulletin*, Mar 1990, 75:10-15)

1990 Trauma: Responsibility, Resources and Responsiveness
Norman M. Rich (ACS *Bulletin*, May 1991, 76:6-13)

1991 Trauma Manpower in the Decade of Aftershock
George F. Sheldon (ACS *Bulletin*, May 1992, 77:6-12)

1992 Out of Apathy
Erwin R. Thal (ACS *Bulletin*, May 1993, 78:6-14)

1993 Our Second Responsibility in Trauma Care: A New Clause in the Social Contract
Ben Eiseman (ACS *Bulletin*, Mar 1994, 79:23-35)

1994 The Surgical Management of Life-Threatening Injuries in Children: What Have We Learned and What Are the Challenges?
J. Alex Haller (ACS *Bulletin*, May 1995, 80:8-18)

1995 Verification–The Pursuit of Optimal Trauma Care
Frank L. Mitchell, Jr. (ACS *Bulletin*, May 1996, 81:20-27)

1996 With Liberty and Justice for All
Anna M. Ledgerwood (ACS *Bulletin*, Jan 1997, 82:16-26)

1997 Trauma: The Next Frontier
H. David Root (Unpublished)

1998 In Search of a Voice
C. James Carrico (ACS *Bulletin*, May 1999, 84:14-22)

1999 TraumaLine 2000
Kenneth L. Mattox (ACS *Bulletin*, Nov 2000, 85:24-34)

2000 The Water of Life (*JACS,* 2001, Vol. 192, No. 1)
Charles E. Lucas

2001 Management of Colon Wounds (Unpublished)
H. Harlan Stone

2002 Blood Substitutes: The Future is Now (*JACS*, 2003, Vol. 196, No. 1)
Ernest E. Moore

2003 Prehospital Care from Napoleon to Mars: The Surgeon's Role
Norman E. McSwain (*JACS*, 2005, Vol. 200, No. 4, 487-504)

2004 Changes and Management Strategies for Injuries to the Liver and Spleen
J. David Richardson (*JACS*, 2005, Vol. 200, No. 5, 648-669)

2005 Trauma in Transition (*JACS*, 2006, Vol. 202, No. 3, 389-394)
C. Thomas Thompson

2006 Physiology for the 21st Century: An Iconoclastic Analysis of Cardiopulmonary Function in Sepsis and Critical Illness
Frank R. Lewis, Jr.

2007 Dario Birolini

II. MERITORIOUS ACHIEVEMENT AWARD FOR STATE/PROVINCIAL CHAIRS

A. Purpose

To recognize a member of the state/provincial organization for contributions to the care of the injured patient.

B. Selection Criteria

1. Must be or have been an active State/Provincial Chair. Preferably, the recipient should be in his/her second term as State/Provincial Chair.
2. Must be nominated by the Region Chiefs.
3. The recipient is recognized for local/regional activity in trauma, which is consistent with the mission of the Committee on Trauma (COT).
4. Specific areas considered in the selection process include contributions that advance local/regional trauma activity in the areas of injury prevention, education, acute care, or rehabilitation.

C. Process

1. Nominations are solicited from the Region Chiefs in the summer.
2. The Region Chiefs select a list of nominees to submit to the Executive Committee at the Clinical Congress. These nominees should be accompanied by substantiating information for review by the Executive Committee.
3. The Executive Committee will select a recipient.
4. The award will be presented to the recipient at the Annual Meeting of the COT.

D. Past Recipients

1972	C. Thomas Thompson
	Richard J. Field
1973	Clifford B. Blasi
	Lawrence W. Greene
1974	Henry Limbacher
1975	Harry G. Becker
1976	Samuel E. Landrum
1977	Joseph C. Darin
1978	J. Cuthbert Owens
1979	Frank L. Mitchell, Jr.
1980	Gerald O. Strauch
1981	Erwin R. Thal
1982	Paul E. Collicott
1983	Kimball I. Maull
1984	C. Doyle Haynes
1985	Joseph P. Dineen
1986	Stuart A. Reynolds
1987	Richard B. Fratianne
1988	Henry C. Cleveland
	Charles C. Wolferth, Jr.
1989	A. Brent Eastman
	Steven R. Shackford
1990	Michael Rhodes
1991	Rea A. Brown
1992	Raymond H. Alexander
1993	Charles F. Rinker
1994	Robert L. Coscia
1995	J. Octavio Ruiz
1996	Brent E. Krantz
1997	Charles Aprahamian
1998	Sylvia D. Campbell
1999	Lenworth M. Jacobs,Jr.
2000	Gregory J. Jurkovich
2001	Norman E. McSwain
2002	Palmer Q. Bessey
2003	Albert E. Yellin
2004	Jameel Ali
2005	David A. Kappel
2006	Thomas M. Foley

III. ATLS® MERITORIOUS ACHIEVEMENT AWARD

A. Purpose

This award is presented at the Annual Meeting of the COT to a member of the national, regional, or state/provincial ATLS® faculty commending the physician for his/her unselfish commitment to the ATLS® training efforts in his/her area.

B. Selection Criteria

1. Establishing the ATLS® Course(s) in a manner unique to the needs of his/her state/province or region.
2. Organization and promotion of quality ATLS® Courses.
3. Unselfish dedication to trauma education as related to the ATLS® Course(s).
4. Maintaining the high ideals of the COT.

C. Process

The ATLS® Subcommittee is charged with nominating and voting for this individual, with subsequent approval by the Executive Committee of the COT. Each member of the subcommittee is asked to nominate two individuals for this award, listing them as priority one and two. The names are returned to the ATLS® Program Office. Names of the nominees are placed on a ballot, along with the reasons for nomination. Ballots are returned to the subcommittee for voting. The individual with the greatest number of votes is selected to receive the award. In the event of a tie, a ballot is resubmitted to the subcommittee with the names of those individuals who were initially tied.

D. Past Recipients

1984	George H. Longenbaugh
1986	Jameel Ali
1987	James M. Salander
1988	Paul E. Collicott
1989	Norman E. McSwain
1990	Herbert J. Proctor
1991	Stuart A. Reynolds
1992	Charles Aprahamian
1993	Max L. Ramenofsky
1994	Kimball I. Maull
1995	Richard M. Bell
1996	Norman E. Hamilton
1997	Brent E. Krantz
1998	Dario Birolini
1999	J. Octavio Ruiz
2000	Charles F. Rinker
2001	Gregory J. Jurkovich
2002	John A. Weigelt
2003	Steven N. Parks
2004	Gregory A. Timberlake
2005	Arthur Cooper
2006	Gerald B. Demarest
2007	Christoph R. Kaufmann

IV. RESIDENT TRAUMA PAPERS COMPETITION

A. Purpose

To promote trauma research among surgical trainees and encourage their participation in COT-related activities.

B. Eligibility

The competition is open to general surgery residents, surgical specialty residents, and trauma fellows in the United States, Canada, and Latin America. To be eligible for competition at the national level, papers submitted cannot have been published (except

for the Surgical Forum) before the paper is presented at the COT Annual Meeting.

C. Scope

The papers should describe original research in the area of trauma in one of two categories: (1) basic laboratory research or (2) clinical research.

D. Time Schedule for Submission of Papers

Residents or trauma fellows should submit papers to the appropriate State/Provincial Chair. Each Chair will select a winning paper from his/her state/province. Deadlines are established by individual states/provinces.

E. Process

Each State/Provincial Chair may submit two papers, one in each category. These local winning papers are submitted to the appropriate Region Chief. Each Region Chief will establish a regional competition to select the winning papers in both basic science and clinical research. Two copies (one blind copy for judging) of an extended three-page abstract are sent to the ACS Trauma Office by the established deadline, usually in December. A preselected panel of judges from the Regional Committees will rank the abstracts and select a balance of basic and clinical papers to represent each of the 14 regions by the established January deadline. The 14 regional winners will submit completed manuscripts to the Trauma Office by February.

F. Past Winners

1978 1st Place John A. Weigelt Runner Up Mary H. McGrath	**1979** 1st Place Joseph V. Boykin Runners Up Christopher C. Baker Frank D. Manart
1980 1st Place Robert Tranbaugh Runners Up Gary M. Gartsman John B. Moore	**1981** 1st Place Kenneth Kollmeyer Runners Up Kenneth A. Kudsk James Hammesfahr
1982 1st Place Raj K. Narayan Runners Up George S. Fortner Hani Shennib	**1983** 1st Place Mark DeGroot Runners Up Gregory Luna Mercedes Dullum
1984 1st Place Ronald B. O'Gorman Runners Up Louis Ostrow Frederick A. Moore	**1985** 1st Place Lawrence Reed Runners Up Frank Shannon M. Rebot
1986 1st Place Richard S. Downey Runners Up Richard Kiplovic Wiley W. Souba	**1987** Basic Laboratory Science 1st Place Nicholas B. Vedder 2nd Place B. Timothy Baxter Clinical Research 1st Place Eric DeMaria 2nd Place John D.S. Reid

1988 Basic Laboratory Science 1st Place Gary Fantini 2nd Place David H. Livingston Clinical Research 1st Place Christoph Kaufmann 2nd Place Tomasso Bochicchio	**1989** Basic Laboratory Science 1st Place David K. Magnuson 2nd Place Matthew L. Cooper Clinical Research 1st Place Bradley Reeves 2nd Place Danielle Desloges
1990 Basic Laboratory Science 1st Place William J. Mileski 2nd Place Gary A. Gelfand 2nd Place Jon C. Walsh (Second Place Tie) Clinical Research 1st Place Miguel Lopez Viego	**1991** Basic Laboratory Science 1st Place Roy W. Hong 2nd Place Benjamin O. Anderson Clinical Research 1st Place Karl Illig 2nd Place Carson Agee
1992 Basic Laboratory Science 1st Place Michael O'Reilly 2nd Place David Bensard Clinical Research 1st Place William S. Hoff 2nd Place Juan Manuel Sarmiento-Martinez	**1993** Basic Laboratory Science 1st Place Thomas T. Sato 2nd Place Paul A. Taheri 2nd Place Alastair C.J. Windsor (Second Place Tie) Clinical Research 1st Place Patricia Yugueros I.
1994 Basic Laboratory Science 1st Place James T. Wilson 2nd Place Robert F. Noel, Jr. Clinical Research 1st Place Stefan J. Konasiewicz 2nd Place Paul J. Gagne	**1995** Basic Laboratory Science 1st Place Donald W. Pate 2nd Place Carol J. Cornejo Clinical Research 1st Place Russell R. Lonser 2nd Place John J. Keleman
1996 Basic Laboratory Science 1st Place Kenneth E. Drazan 2nd Place Carlton C. Barnett, Jr. Clinical Research 1st Place Peter D. Wearden 2nd Place Nicholas Namias	**1997** Basic Laboratory Science 1st Place Randy J. Irwin 2nd Place Molly M. Buzdon Clinical Research 1st Place Preston R. Miller 2nd Place Katharina Pellegrin J.
1998 Basic Laboratory Science 1st Place Geoffrey Manley 2nd Place Gregory J. McKenna Clinical Research 1st Place E. Lynne Henderson 2nd Place Juan P. Carbonell	**1999** Basic Laboratory Science 1st Place Andrew Kramer 2nd Place D. Kirk Lawlor Clinical Research 1st Place Garret Zallen 2nd Place Avery B. Nathens

2000 Basic Laboratory Science 1st Place Philip P. Narini 2nd Place George D. Oreopoulos Clinical Research 1st Place Joseph T. Rabban 2nd *Place* Avery B. Nathens	**2001** Basic Laboratory Science 1st Place Deepa Soni 2nd Place Daron C. Hitt Clinical Research 1st Place John-Paul Veri 2nd Place Moishe Lieberman
2002 Basic Laboratory Science 1st Place Jonas Gopez 2nd Place Steven Casha Clinical Research 1st Place Ram Nirula 2nd Place Seong K. Lee	**2003** Basic Laboratory Science 1st Place Eve C. Tsai 2nd Place Katherine Barsness Clinical Research 1st Place Steven Fox 2nd Place David J. Schultz
2004 Basic Laboratory Science 1st Place Rachel G. Khadaroo 2nd Place Manuel B. Torres Clinical Research 1st Place Matthew Rosengart 2nd Place Carlos V. R. Brown	**2005** Basic Laboratory Science 1st Place John M. Hwang 2nd Place Aaron M. Cheng Clinical Research 1st Place Felicia Ivascu 2nd Place Stephanie P. Acierno
2006 Basic Laboratory Science 1st Place Preya Ananthakrishnan 2nd Place Jessica Deree Clinical Research 1st Place Alexander L. Eastman 2nd Place David O. Francis	**2007** Basic Laboratory Science 1st Place Alexander Q. Ereso 2nd Place Sagar S. Damle Clinical Research 1st Place Alexandra Mihailovic 2nd Place Heather F. Pidcoke

V. NATIONAL SAFETY COUNCIL AWARD

A. Purpose

Recognition of outstanding service to safety by surgeons or surgical organizations. The Surgeons' Award for Service to Safety is sponsored by the National Safety Council and nominated by the American Association for the Surgery of Trauma in odd-numbered years and the COT in even-numbered years. The nomination is approved by both organizations before it is forwarded to the National Safety Council.

B. Objectives

1. Strengthen the work of surgeons or surgical organizations by identifying and enhancing their emphasis on the interlocking problems of the prevention and restoration of accidental injuries.
2. Strengthen the work of safety councils through the increased participation of surgeons in organized accident prevention activities.
3. Continue progress in the development of criteria to ascertain the effectiveness of activities conducted for the prevention of accidents.

C. Sponsor

National Safety Council

D. Process

1. Nominee must be a surgeon or a surgical organization (or unit thereof).
2. By March 1, the National Safety Council will invite the American College of Surgeons and the American Association for the Surgery of Trauma to submit, by July 1 of the same year, one jointly agreed-upon nomination.
3. Nomination should be made without publicity.
4. Nomination must by submitted by July 1 for an award to be made in that calendar year.
5. Nomination should be sent to the Program Manager, National Safety Council.
6. The complete record of the awards made and the reasons for such awards will be kept on file in the National Safety Council offices.

E. Criteria

Individual or organization's service and activity which make outstanding contributions to the prevention of accidents, establish or demonstrate methods and results adaptable to other individuals or groups, or result in stimulating others to undertake or take part in safety projects or programs. Program organization, activity, and accomplishments may be evaluated. For example, a surgeon might be the first one to recognize a new accident hazard; involve his/her associates in a study of this problem; report his/her findings by writing scientific papers for professional periodicals and speaking at professional and other meetings; take an active part in safety council work; and participate in committee work so that other organizations can be alerted to the problem and know how they can help to prevent such accidents.

F. Presentation

Presented at occasions closely allied with the recipient's activities and interests, but no later in the year than the time of the National Safety Congress of the National Safety Council, or the Clinical Congress of the American College of Surgeons, or the Annual Session of the American Association for the Surgery of Trauma. The award is a suitably engraved plaque.

G. Past recipients

1960 George J. Curry
1961 Charles G. Johnson
1962 Robert H. Kennedy
1963 R. Arnold Griswold
1964 Harrison L. McLaughlin
1965 Preston A. Wade
1966 Isidore Cohn
1967 Paul Magnuson
1968 Oscar P. Hampton, Jr.
1969 John P. North
1970 Rudolph J. Noer
1971 William T. Fitts, Jr.
1972 Sam Banks
1973 Joseph D. Farrington
1974 Curtis P. Artz
1975 Jack Wickstrom
1976 Sawnie R. Gaston
1977 John A. Moncrief
1978 Robert W. Gillespie
1979 John H. Davis
1980 Henry C. Cleveland
1981 Walter A. Hoyt, Jr.
1982 C. Thomas Thompson
1983 John E. Raaf

1984 G. Tom Shires
1985 Fraser N. Gurd
1986 Carlton Mathewson, Jr.
1987 Robert J. Freeark
1988 Alexander C. Hering
1989 Donald D. Trunkey
1990 J. Cuthbert Owens
1991 Basil A. Pruitt, Jr.
1992 Paul E. Collicott
1993 George F. Sheldon
1994 John D. States
1995 Gerald W. Shaftan
1996 Barbara A. Barlow
1997 H. David Root
1998 Norman E. McSwain
1999 F. William Blaisdell
2000 Charles C. Wolferth
2001 C. James Carrico
2002 Charles Aprahamian
2003 Norman M. Rich
2004 Charles E. Lucas
2005 Lenworth M. Jacobs, Jr.
2006 David R. Boyd