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Presidential Address of the American Orthopaedic Society for Sports Medicine

From adolescence to adulthood: Prepared for leadership in sports medicine in the 21st century*

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It has been my pleasure to have served you, the American Orthopaedic Society for Sports Medicine, as President this past year. Twenty-one years ago, a small group of orthopaedic surgeons dedicated to treating athletes of all levels envisioned our specialty society in sports medicine. Our Society has now grown to over 1000 orthopaedic surgeons representing the entire United States as well as associate members from several foreign countries. At age 21, our Society is quickly maturing, but it appears its adolescence has just ended. As an adolescent, our Society has overcome, at times, seemingly insurmountable odds, while at other times has sailed smoothly along its charted course.

Let me review with you some of our recent accomplishments. We are about to enter a milestone agreement between the American Orthopaedic Society for Sports Medicine (AOSSM), the Orthopaedic Research and Education Foundation (OREF), and the Foundation for Sports Medicine and Education Foundation (FSMER) that will maximize our recruiting of funds for peer review research as well as preserve funds to be solely administered by FSMER to provide seed money for first-time investigators and to fund special projects of interest to our Society, such projects as workshops for prepubescent strength training and extraarticular ligament reconstruction.

We have further refined our Committee structure to stagger the terms of office for the members, and to define the terms of office for chairpersons.

We have produced a Leadership Directory that not only provides an organizational chart and committee structure but also outlines the policies and procedures of our Society. This may be obtained by writing to the Society office.

Dr. Jeffrey Minkoff and his committee have produced a major revision and updating of our bylaws.

The Council of Delegates is maturing and has become a significant force in our Society.

On the educational front, we have provided our first postgraduate course. The course on anterior cruciate ligament was held in Tucson, Arizona, this winter under the direction of Dr. Champ Baker and was a success. This course was significant in that it established our Society as a significant educational resource for the orthopaedic surgeon. We plan to continue one such course each year, with the next course, on the shoulder, to be held in 1994. This will be our so-called "Marquee" course.

This summer we will produce a course in the basic science of sports medicine, to be held in Chicago.

We have completed a successful, cooperative effort with the American Medical Society for Sports Medicine (AMSSM) in producing a course entitled "Current Concepts and Controversies for the Team Physician." We plan to repeat this in the spring of 1994.

We plan to sponsor a postgraduate course in sports medicine in cooperation with the NFL Team Physician Society this spring.

The groundwork is set for a cooperative venture with the American Academy of Orthopaedic Surgeons (AAOS) to sponsor postgraduate courses in orthopaedic sports medicine

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Our Publications Committee, under Chairwoman Dr. Letha Griffin, in addition to our educational pamphlets, will produce an Orthopaedic Knowledge Update (OKU) on orthopaedic sports medicine. This is being done in association with the AAOS.

In the summer of 1996, we will host a World Congress in Orthopaedics Sports Traumatology. This will be in conjunction with our Society's annual meeting and we expect participants from all over the world.

We hope, by the end of this meeting, to have a joint statement with the AMSSM on HIV and the athlete.

At this meeting, we gave the first written examination for the fellows completing their fellowship this year. This was directed by Dr. David Drez and was a combined effort of the AOSSM Fellowship Committee and the Fellowship Director's Society.

All of this educational activity depends upon the efficient, hard-working central office staff. We have upgraded computer and graphic design equipment so that we can do many things in-house that we had to have done commercially in the past.

Our central office staff will be settled in the AAOS building soon and will have our Executive Director and office staff under one roof. This will not only increase efficiency, but will decrease our rent.

A Public Relations Task Force, under the chairmanship of Dr. Walt Curl, has been formed to help us let those outside our Society know who we are and what we are doing.

In view of the changing climate in medical credentialing, we have decided to keep open the option for our Society members who may want a Certificate of Added Qualification (CAQ). This necessitates us petitioning the American Board of Orthopaedic Surgeons (ABOS) and beginning an impact study as well as other procedures to develop a CAQ in orthopaedic sports medicine. This simply means we are beginning the process; we can stop at any time. A special extension to having a CAQ has been granted by the American Board of Medical Specialty Societies (ABMSS) while we accredit our fellowships. The standard procedure of the ABMSS is to first have a CAQ in place, then accredit the fellowships. This is the process our primary care colleagues in family practice, emergency medicine, internal medicine, and pediatrics are following. The first examination for a CAQ in sports medicine will be available to these primary care physicians this fall.

The value and necessity of a CAQ for orthopaedic sports medicine can be effectively argued. It would be a real disaster if our Society did not keep open this option for our members. At the same time, to provide an alternative to a CAQ, we will petition the ABOS to reactivate the voluntary process of recertification based on practice profile in the specialty of sports medicine. This has been in place but put on hold because it was not used. This will provide an alternative pathway to demonstrate expertise in the field of orthopaedic sports medicine for those who may not want to pursue a CAQ.

What I have discussed thus far is the past and the present; what about the future of the AOSSM?

Put simply, the potential is awesome. To plunge forward into the exciting future of sports medicine, each and every one of us must start with a *positive attitude* about ourselves as physicians and our practice environment. This *positive attitude* is imperative as we face the uncertainty of health reform in the United States. One thing we know for sure, there will be active, exercising human beings at all levels, from the couch potato to the elite amateur and professional athlete, for us to care for. We can sit back and let someone else tell us how to provide this care and then *react* to what we do not like, or we can be *proactive* and help guide this reform to best care for our patient-athletes. We need to be *proactive*, not *reactive*. To be effective, we need to be willing to compromise and produce winning combinations. I look at our agreement between the AOSSM, OREF, and FSMER as one such example of this.

We need to recognize that we are not the only players in the field of sports medicine. Sports medicine is more than repairing torn ligaments or skillful arthroscopy, it is the application of the knowledge and skills of the medical practitioner to the physically active person. In addition to orthopaedic surgeons, the other practitioners are physiologists, basic scientists, primary care physicians, athletic trainers, physical therapists, and other allied health personnel. These people have their own specialty societies, most prominent of which are the American Medical Society for Sports Medicine, the American College of Sports Medicine (ACSM), the National Athletic Trainers Association, and the Sports Physical Therapy Association.

We, the orthopaedic surgeons, are *leaders in sports medicine*, but, like our Society, we are coming out of our adolescence. We must mature as leaders; we must look at the big picture of sports medicine. We must make ourselves aware of the changes occurring in sports medicine, in the clinic, operating room, laboratory, and the political arena. *We must* develop the ability to act quickly and decisively. *We must* not allow divisiveness and self-interest to inhibit our decision-making, much less dictate policy. *We must* form successful coalitions based on mutual respect and long-term relationships. These relationships do not develop overnight. They require give and take, and solid educational and workplace interaction.

This sounds like so many words but it is not so, for we can find many examples of failure to apply these principles. We need to look no further than at some of our foreign colleagues who have developed a system that keeps an anterior cruciate ligament reconstruction patient in a hospital for 16 days. There certainly has to be some divisive self-interest and inability to act, to allow a situation like this to occur. I am happy to say that the surgeons in the countries where I have observed this tell me that their system is being changed. We cannot let something like this happen to us. If we take action as mature, knowledgeable, decisive, *proactive* leaders, we can certainly minimize these disasters.

As our Society matures and steps from adolescence to

adulthood in this 21st year, we will be looked at as a role model by our fellow orthopaedic surgeons. We must not lose sight of the fact that we, as individuals, should be role models for our young members, as well as the fellows and residents in training. I want to encourage our residency and fellowship directors to send their young men and women to our annual meetings where they can observe sports medicine in action. As a Society we need to do more for those entering the sports medicine practice than have an examination and fellows papers presented in an empty room. Please give us any ideas you may have as to how to improve our Society for these young people.

In 1984 I had the opportunity to serve as President of the ACSM. At that time I likened sports medicine to an orchestra, the instruments being the many different practitioners in sports medicine and the sections their respective societies. Playing together, we in sports medicine can make beautiful music. Left to our own individual self-interests, we will have a cacophony of horrible sound. At present, sports medicine is like the orchestra ten minutes before the concert, each player tuning his or her instrument. The conductor is in the wings. Is the conductor a politician, bureaucrat, and insurance executive, hospital administrator, or physician? I certainly hope it is the latter.

The first step to a successful venture is to set goals. One of my goals has been to see the AOSSM, AMSSM, and ACSM working together. A portion of this goal has been realized. Witness the AMSSM meeting back-to-back with us in San Diego in 1992 and here in Sun Valley in 1993. Our plans are to continue this conjunctive meeting in the foreseeable future.

I am thinking positively about the future!

I would like to give my heartfelt thanks to the members of our Society who have served on our committees, and especially to those who have served as chairpersons. Most especially, I would like to thank the Board members who have worked hard and endured our many meetings. Though long, I thought they were very productive. In addition, I want to thank our national office staff, Don Rome and Carol Rosegay and their staff, for a job well done.

Finally, I would like to thank my wife, Wilma, for inspiration and guidance. (She told me I needed a haircut this morning.) I especially thank Wilma for keeping together a wonderful family, my daughters, Onee and Sigrid, and their spouses, Ken and Paul.

Thank you for a wonderful year.