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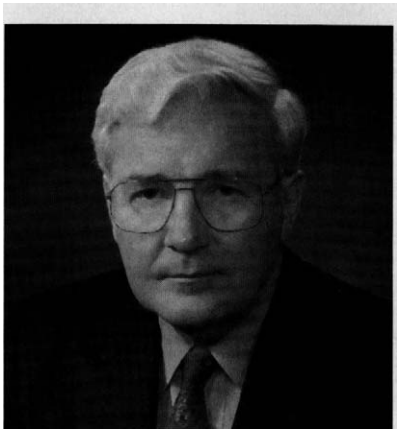

Presidential Address of the American Orthopaedic Society for Sports Medicine

Our Qualifications as Orthopaedic Surgeons to be Team Physicians*

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It was a great honor to have been asked to serve as President of this Society. The past year has been challenging, rewarding, and very enjoyable. I shall never forget my feelings when Jay Cox asked me to consider accepting the position of president. Initially, I was very anxious and apprehensive, concerned about the unknown responsibilities of the job. Later, I experienced a sense of pride and anticipation of the opportunity to work more closely with the officers, members, and the staff of this great organization. It has been a memorable experience, and I am grateful for the opportunity to have served.

In his presidential address last year in Toronto, Russ Warren talked of his early private practice years in Lynchburg, Virginia, and of being inspired and motivated, after attending one of our annual meetings, to become more involved in the Society. Like Russ, I spent most of the first decade of my orthopaedic career practicing in a small group—mine was in Winchester, Massachusetts, a suburb of Boston. During those years, I had the wonderful good fortune to be working part-time at the Harvard Athletic Department and the old Peter Bent Brigham Hospital with Dr. Thomas B. Quigley. "Quig," as he was known to us in the field house, or "Bart," as referred to by his contemporaries at the Brigham, was a legendary character, a general surgeon, who primarily did fracture work and was the head team physician at Harvard. He was truly an enthusiastic and inspirational teacher. His students, colleagues, and patients always knew exactly where he stood on the issues. He was the classic surgeon: incisive and decisive. Dr. Quigley was honored by this Society by being chosen Mr. Sports Medicine in 1978, an award of which I know he was extremely proud. He had expressed to me on more than one occasion, in his customary confident tone, that the AOSSM was the premier sports medicine organization in our country. He encouraged me to become an active member. It took me a while to heed his advice, but I shall always be grateful to him for his support and guidance.

I would like to speak to you now about two issues that have been debated by our Society during the past year. The first is, are we orthopaedic surgeons or team physicians?, and the second concerns the advisability of the Certificate of Added Qualification (CAQ). I will conclude with comments about two important initiatives taken by the Board of Directors during the past year—our strategic planning meeting in the fall and the executive changes that took place this winter.

When I chose the first topic, our identity as orthopaedic surgeons and team physicians, I was concerned that it might resurrect old conflicts. Nevertheless, I thought it was important not only to emphasize our unique qualifications to be team physicians, but also to encourage collaboration with our medical colleagues to afford the most complete care possible for our athletes.

The conflicts that some of our members have experi-

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enced in their team physician role reflect the overall confusion that seems to have befallen the medical delivery system nationwide and specialty-wide. Hospitals, medical groups, and individual practices are being absorbed or purchased by large hospital corporations and managed care organizations, with many of our associates becoming salaried providers within the impersonal and "bottom line-oriented" system. All of us have been overwhelmed by the ever-multiplying directives, regulations, and ultimata issued either by governmental agencies, insurers, and, not infrequently, our own hospital administrators, all of which usually limit not only our treatment options, but frequently restrict patients' access to our care. Is it any wonder that some of our colleagues have responded with anxiety, frustration, or anger, generated, in part, by their inability to influence the situation?

In the area of sports medicine, orthopaedic surgeons who have cared for college, university, and professional teams are being challenged for these positions by the aggressive marketing techniques of the hospital corporations, other managed care providers, and, at times, even our own members. Superimposed on this is the added competition from our primary care colleagues, many of whom have excellent backgrounds and are armed with the apparent advantage of a recognized CAQ. These factors have created uncertainty in the minds of some of our members about their security as team physicians.

Who is qualified to be a team physician?

At a Socratic debate held yesterday between Dr. Robert Leach of the AOSSM and Dr. Douglas McKeag of the AMSSM, the question asked was, "Who is better qualified to be the team physician, the orthopaedic surgeon or the primary care physician?" Should we have asked, "What is best for the patient and how can we give the injured athlete the best possible care?"

I believe we should attempt to organize our medical coverage so the athlete will have the most comprehensive care possible. Although there may be occasional disagreements, "turf battles," and communication breakdowns, I think the primary care sport medicine specialist and the orthopaedic surgeon can and should respect each other's expertise and contributions, work together, and share appropriately in the management of our athlete's medical needs.

We must also keep in mind two facts that Dr. Kenneth DeHaven pointed out in his first vice presidential address in Atlanta, and reiterated here on Sunday, that orthopaedic surgeons compose only 3% of the physicians in this country and, at this time, care for only 25% of the musculoskeletal problems. Add to that the proposed reduction in orthopaedic residency positions, and one should begin to realize that we will need additional qualified physicians to supply adequate medical care to our injured athletes in the future. It appears evident to me, therefore, that we should take a leadership role in educating our primary care sport medicine colleagues so that they can assist in the coverage of teams and be sufficiently knowledgeable in the diagnosis of musculoskeletal injuries so they can refer patients for consultation or definitive orthopaedic care in a timely and appropriate manner.

Having said that, however, let me also support our qualifications to be team physicians, emphasizing strongly that we should not be excluded from involvement in this area. Historically, there is little doubt that the orthopaedic surgeons who founded the AOSSM were also team physicians: Jack Hughston at Auburn, Don O'Donoghue from Okalahoma, Jim Nicholas of the New York Jets, and Joe Godfrey from Buffalo, to name only a few. In addition, our admissions process continues to give considerable weight to the documentation of the applicant's service in this area. In our recent membership survey, over 82% of our members indicated they were still actively serving as team physicians, and 76% as the leaders of the medical team.

Being a team physician is indeed the unique characteristic of the members of our Society. Although many of us are members of the Arthroscopy Association of North America, the American Shoulder and Elbow Surgeons, or the American Orthopaedic Foot and Ankle Society, it is the broader issues related to the overall care of the athlete, not just the operative techniques, that concern us and separate us as a group from the individuals in the other orthopaedic societies. Our annual meetings have included both lectures and instructional courses on the nonorthopaedic problems confronting the team physician. John Bergfeld has been particularly active and productive in this area, compiling a syllabus, addressing the diagnosis and management of the nonorthopaedic athletic medical conditions.

Since musculoskeletal injuries compose the majority of the problems with which athletes come to our sports clinics, it appears clear to me that the orthopaedic surgeon is an appropriate individual to serve as a team physician. Those of us who have been in leadership positions caring for high school, college, and professional teams have medical colleagues on their staffs to evaluate and treat the inevitable nonorthopaedic problems. I certainly respect their expertise, appreciate their dedication, and am grateful for the very important contributions they make to the care of athletes. I also know that some of them have had excellent training in the diagnosis and nonoperative management of musculoskeletal injuries, often acquired in fellowships directed by some of our most capable AOSSM members. Nevertheless, I believe there is no specialist more qualified than the orthopaedic surgeon to evaluate and treat the injuries that predominate in our athletic population. Only we have had the opportunity to observe and treat these problems from the beginning to the end of the healing process. It is our unique opportunity to assess intraoperatively, both the severity of tissue damage and the quality of its repair, that sets us apart from the other providers. This knowledge gained in the operating room places us in the best position to determine whether an injury should be treated operatively, to prescribe the most appropriate postoperative rehabilitation, and to confidently advise the athlete as to when he or she may safely return to competition.

As an aside, when I began working in 1969 at Harvard Stadium with Dr. Quigley, I recall that when a player was injured, only he ran out onto the field. He would evaluate the situation and then, if necessary, call the trainers out to

assist in helping the player off the field. When I asked him why he didn't have the trainers go out with him initially, he said that it was his firm belief that the most qualified individual present should be the one to do the important initial evaluation. He added firmly that he surmised that the concerned parents in their seats above him in the stadium probably shared his opinion.

Those who work closely with primary care physicians have confidence in their ability to evaluate the majority of acute injuries on the field. Nevertheless, I share Dr. Quigley's sentiment and believe that the surgeon is the most qualified individual and should be in a position of responsibility and authority to assess the musculoskeletal problems. I also believe that our athletes, their parents, and their coaches are aware of our knowledge and expertise in the area of sports trauma, and that they would appreciate and support our continued presence on the sidelines. We are eminently qualified to be in leadership roles in sport medicine services, and the AOSSM will continue to advocate that position.

Dr. DeHaven, in his address in Atlanta, outlined the advocacy programs initiated by the American Academy of Orthopaedic Surgeons, pointing out the dramatic effect that the addition of lay groups to their coalition of specialty care providers has had in getting people in Washington to listen to our concerns about our patients' access to specialty care. I believe it will be our injured players, their parents, and coaches who will be our most important and persuasive allies in months ahead. We in the AOSSM have neither the financial nor administrative capacity to duplicate the Academy's effort. We must, therefore, wholeheartedly support their programs and encourage them to include our needs in their agenda. With Ken DeHaven at the helm, and Doug Jackson on deck, we can be assured that our voices will be heard and our recommendations seriously considered.

The issue of a CAQ has indeed been controversial. Our Society has surveyed our members and debated the subject, both in the Counsel of Delegates and at the Board level. We also understand and appreciate the Academy's position against additional CAQs in orthopaedic subspecialties. Nevertheless, since the application has already been initiated, and will undoubtedly require several more months to complete its course through the approval process in Chicago, it has been the unanimous recommendation of your AOSSM Board to actively continue the process. We have an ad hoc committee pursuing our application's progress. If we are granted permission to have a CAQ, we shall then have sufficient time to reassess the need, to consider the advice and opinion of the Academy, and, I assure you, to put it to the vote of the entire membership before finalizing this important issue. Although many of our members have taken the Academy's position that a sports medicine CAQ may be devisive and potentially harmful, opinions may change if managed care directors make a CAQ a requirement for us to continue our work as team physicians. Let's be patient, explore other alternatives, such as our required recertification examinations, but also let us be prepared with a completed CAQ application in the event it becomes necessary.

I would like to conclude my remarks by commenting on two initiatives taken by your Society since our last annual meeting, a strategic planning meeting in Chicago in October and the executive changes introduced in January.

At our final Board meeting at our 1995 annual meeting in Toronto, we decided to reevaluate the Society's goals and restructure the executive and office personnel to more effectively function and serve our members. To help us, we sought the professional advice of Tom Nelson, who served as our executive director in the late 1970s through the middle 1980s, and was the Academy's executive director for the next 11 years.

We convened a strategic planning session in the fall with Tom as the facilitator. At that time, we listed the Society's strengths and weaknesses, prioritized our activities and issues, and outlined the urgent initiatives. Our strengths are as follows:

1. Our dedicated members who support our programs, volunteer to serve on committees, and conscientiously return our surveys. They are the reason the society exists and is viable.
2. Our educational programs, including our annual meeting and specialty day, which always has the largest attendance of all the subspecialty programs offered.
3. The Journal, which has flourished under Bob Leach's editorial direction and, with over 10,000 subscribers, is without question the premier sports medicine publication in print.

The Board of Directors also realized it was paramount to redefine our leadership role and to address more meaningfully the needs of our members, particularly the new members. With the changes taking place in our profession, many young orthopaedic surgeons entering practice will be salaried employees of managed care groups. As such, they will undoubtedly have limited budgets with which to join organizations such as ours and with which to attend meetings. With this in mind, we thought it essential to assess, define, and prioritize their needs, to consider changes in our educational offerings to assure that they are cost-effective, and to streamline our decision-making process and administrative organization to allow timely delivery of our programs. Indeed, all of our members, young and old alike, will be more critically assessing the value that they receive for their dollars spent on registration and dues.

To seek consensus and establish our agenda, we realized that a thorough membership survey was essential. Walt Curl of the Public Relations Committee chaired the work group which included Paul Shirley from the Council of Delegates, Tom Wickiewicz of the Education Committee, and Bob Leach from the Journal. That survey has been completed and we are delighted with your cooperation and response. Fifty-six percent of our members returned the questionnaires. We are also encouraged by the results, which have just been tabulated, indicating that your concerns, interests, and priorities coincide with the conclusions that the Board reached at its strategic planning meeting last fall. I can assure you that this valuable information will be incorporated into our Society's future

agenda and will help us address the changing needs and goals of our members.

Finally, I would like to sincerely thank our Chicago staff. Irv Bomberger, a colleague of Tom Nelson at Smith Bucklin Associates, was hired as our executive director in January. He came to us with eight years of experience in health care association management, most notably as director of the AMA's Department of Specialty Societies. He is knowledgeable, conscientious, and a very thoughtful person. I have unqualified confidence in his ability to assist the Board in leading our Society in the years ahead.

Camille Petrick, who has worn many hats for us this past year, has been the glue in our office, particularly during the transition period between medical directors. She very capably manages the daily activities of the Society and organizes our programs. Lisa Doty, Pat Kovack, Theresa Kruger, and Michelle Schaffer all have specific committee assignments, but help each other out effectively when deadlines arrive in other areas. My job this year has been made much easier and most enjoyable because of them. I sincerely thank all of them for their support to me and their dedication to our Society.

I am extremely confident that the AOSSM will continue to be, in Dr. Quigley's words, the premier sports medicine society in the land. Thank you all again for your attention and support.