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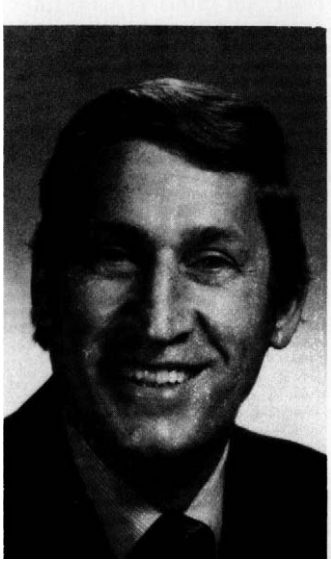

Presidential Address of The American Orthopaedic Society for Sports Medicine*

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President, AOSSM

This setting, with the multitude of recreational activities available—golf, tennis, sailing, swimming, hiking, etc.—provides an appropriate backdrop for our Society of Sports Medicine to assess our proposed goals and our achievements. A golfer who never bothers to keep score may get some exercise, but it's a poor way to improve his game. It's necessary, in our AOSSM, to know if we're playing a good game, not just talking it. Talking about a problem is not the same thing as doing something about it. Sports medicine physicians, probably more than any others, have the opportunity to bask in the limelight of their patient athlete's or team's successes. We, though we have the opportunity, should not capitalize, promote, or use this opportunity for self-aggrandizement. I humbly approach you with the full knowledge of the achievements of my illustrious predecessors into this office of President of The American Orthopaedic Society for Sports Medicine. I should first like to pay tribute to Dr Don O'Donoghue, from whose innovative mind developed the seed that has germinated into this organization and whom we honor at this meeting with the presentation of the First Annual O'Donoghue Award. This year, because of doctor's orders that he not travel, Don cannot be with us. This is the first of our meetings that he has missed. I'm sure his disappointment is as great as our own, that he cannot be in attendance.

It's been eight years since this Society had its first scientific meeting in Las Vegas, in February of 1973. Dr O'Donoghue, at that time, expressed the hope that our membership "will expand by the addition of new members chosen not so that they could say that they belonged, but rather with the aim of fostering the ideals and helping to implement the projects of the Society." I am happy to say that this hope has become a reality. As President of the Society for the past year, it has been a revelation and a pleasure to experience the willingness of any member when asked to perform and to find so many who have volunteered to serve on committees or in any capacity to help the Society.

Our Membership Committee has recently screened over 100 applicants for membership. The task of finding those who will continue to stimulate and develop the Society for the benefit of the athlete is not an easy one. Those who commit themselves to membership must recognize the heritage they join. Associate membership is the initial and primary category and is specifically designed to allow those who profess an interest in sports medicine to become an active participant. The elevation to active membership, though limited to 25 to 50 per year, is purposely left small so that it becomes an incentive and allows the demonstration of an active contribution to the field of sports medicine to those who wish to attain this status.

Eight years ago, when Dr O'Donoghue delivered the first presidential address, he announced our Society's initial affiliation with the Academy of Orthopedic Surgery. In the past three years some problems developed with the affiliation which had to be clarified. This required a mutually cooperative effort by both the Academy and by the Society to rewrite an affiliation agreement which was acceptable to each. Our new agreement allows for both organizations to share in the educational efforts in the field of sports medicine. This has allowed us a broadening of our goals in both research and education. Our Board of Directors and members of the Education and Research Committee had within the past month a long-range planning workshop directly charged with developing our future direction in education. Many of the plans formulated at this workshop are beginning to be implemented.

When one recognizes that fully one-third of all patients seen by orthopaedists represent conditions related to sports- or recreation-related activities, when it is realized that there are some 2.6 million hospital visits for sports-related injuries

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per year, when it is appreciated that some 17 million Americans will sustain a significant injury yearly from participation in sports and recreational activities, when one feels the impact of some one million high school football players injured each year and some 70,000 college players sustaining injuries every year, as well as the 50,000 knee injuries which require surgery each year, we can understand the potential that this Society has in influencing the care and well-being of the athlete whether he be competitive or recreational. Tom Peterson's O'Donoghue Award-winning paper demonstrated how one orthopaedist interested in sports medicine has been able to bring about rule changes making football a safer sport.

The changing trends of orthopaedics in sports medicine causes one to ponder as to where we have been and where we are going. If you look at the surgery schedule of your hospital on any given day, I would venture to say that some 50 to 75% of the surgery was not being done 15 or even 10 years ago. In orthopaedics, total joint procedures, arthroscopy, arthroscopic surgery, some knee ligamentous reconstructions, compression plating of fractures for nonunions, and so on, are relatively new in our armamentarium of orthopaedic care. Our concepts on meniscectomy have undergone a radical change from total meniscectomy by arthrotomy to partial meniscectomy by arthroscopy and even reattachment. Anterior cruciate repair and substitution continues to provide confusion, conflict, and consternation. Our scientific attempts to provide answers to this difficult challenge remain at best grossly inadequate. The multitude of studies on both sides of the problem exemplify William's Law which states, "If enough data are collected *anything* can be proven by statistical methods."

We read of methods presently used which have been tried before, but now with a slightly different tack. Tissues through the knee joint more accurately placed in relationship to the anatomy of the cruciate ligament, better soft tissue covering to enhance blood supply and protect the transplanted tissues against the ravages of the fibrolytic effect of the synovial fluid, attempts to provide vascular transplants into the joint to substitute for the cruciate, different methods of rehabilitation and protected mobilization: all small variables which may or may not change the relatively poor results of our predecessors in their attempts to correct an anterior cruciate-deficient knee. Will these changes effect an improvement in our results, or are we merely spinning our wheels, going through that cycle of eager anticipation, through dismal despair, to realistic acceptance and back to eager anticipation? Certainly we welcome the enthusiasm of each new cycle. Though old methods are attempted again in slightly different ways, from some such attempts, threads of progress are produced into which eventually might be woven the material to provide a support onto which other threads might be added.

Several years ago, I had to give a talk which I entitled, "Compartmental Conceptualization." The message I tried to impart was that we tend to develop mental compartments which become closed to new ideas and new concepts. Mental blocks develop from preconceived ideas, by assumptions, or by emotional or expressive blocks that interfere with interpretation. For example, the assumption leading to a wrong conclusion is provided by the story of the man who visited Las Vegas and lost all of his money gambling in a casino. Destitute and penniless, he had to go down to use the men's room and found that they were all pay toilets. Swallowing all his pride, he went upstairs, approached a man at one of the slot machines, explained his predicament, and asked him if he could have a quarter. The man obliged and when the fellow went down to the men's room he happened to find one of the doors ajar and was able to use the facility without spending the quarter. When he went back upstairs to return the quarter to the stranger, he had left. So he thought, "Well, one quarter is no good." He put it in the slot machine and won the jackpot. With his small stake he started gambling, he won another small stake and left Las Vegas. He was able to go into business and became very successful. He became a millionaire and spent his later years traveling around the country lecturing on the evils of gambling, relating his experience in Las Vegas, and ending his speech with the comment that if he could ever find his unknown benefactor, he would gladly share his fortune with him. At one of his stops there was a man in the audience who remembered the incident and after the talk he approached the millionaire and told him "I'm the fella that lent you that quarter. I remember it was back in Las Vegas about 25 years ago, at the Flamingo Hotel." The millionaire looked at him and said, "Well, that's right but I don't mean you, I meant that fellow that left that door ajar."

The tremendous rush into arthroscopy and arthroscopic surgery may be an example of a compartmental conceptualization wash-out. A philosopher once said, "Unless our philosophers and our plumbers are committed to excellence, neither our pipes nor our arguments will hold water." The traditional methods of knee diagnosis and some of its surgery are being inundated by a wave of enthusiasm for arthroscopy so high that the conceptual compartments are flooded. We are now being challenged to see if the compartments do, indeed, hold water. I certainly feel that arthroscopy and arthroscopic surgery are making great strides and provide, particularly, the sports medicine physician with another tool in his constant quest for improvement and treatment. But to repudiate those who still use the tried and traditional methods, or to ignore these methods when they are less costly and often as effective, is to also become conceptually compartmentalized. Let us not become so blinded by the dazzling light of the arthroscope that we cannot see the knee as a functional unit designed for many tasks, and believe its only pathology is related to an internal derangement correctable by an arthroscopic approach.

On the other hand, arthroscopy and arthroscopic surgery, primarily by the impetus of sports-related injury, is showing a spin-off in providing benefits to those with nonsports-related knee problems, such as arthritis, as well as in investigation of other joints. This has been true in other aspects of sports medicine investigation—knee ligament reconstruction used in motor accident and industrial injuries; the impetus toward physical fitness as a prophylactic measure

against obesity, hypertension, chronic fatigue, mental tension, and backache; and the value of jogging and exercise in the treatment of those with heart disease, to mention but a few. The field of sports medicine should be proud of its contribution to a healthier life, not only for the athlete, but for all. We can be proud to be part of sports medicine as an orthopaedic society providing the clinical expertise to mesh with others in the field of sports medicine. Certainly, we want to be a leader, but our strength lies in our abilities to care for the athlete in prevention, treatment, and rehabilitation, and in our willingness to share our knowledge by educational activities with other sports medicine and ancillary groups. We need not be the loudest voice in every sports medicine endeavor, but should be, by example and our demonstrated productivity, the model to which other sports medicine organizations look.

Toward this goal, our Liaison Committee, under the chairmanship of Les Bodnar, has developed official liaisons with over 40 sports- or sports medicine-related groups or organizations. A representative of our organization in each state to serve as our spokesman is being developed. In this role, many are serving or work with the Governor's Council on Physical Fitness and Sports in that state. We are encouraging states that do not have a Governor's Council on Physical Fitness and Sports to develop such councils and are offering our support and expertise in their formation. These liaison representatives are to keep our Society informed as to the sports medicine activities of that state or of those organizations to which they act as a liaison member. They are to offer our help in projects of mutual interest. Our objective, as stated in our bylaws, is to foster education in sports medicine, especially the orthopaedic aspect, both preventative and therapeutic, to extend sports medicine interests in the direction of science, research, fitness and health. Many of you have been asked, and many more will be needed to help in this effort.

An example of one of our liaisons is with the Ladies' Professional Golf Association, for whom we are providing local contacts to provide medical coverage for their tournaments. They have also approached us to present a symposium on golfing injuries at their national meeting. Such associations with the elite of the sports world must not, however, detract from our goal of the improvement of care for the benefit of all athletes. These associations *do*, however, provide a public relations benefit for our Society toward our educational efforts.

The broadening activities of our Research and Education Committee has been nurtured by Bernie Cahill into a vital and dynamic portion of our society. With our new affiliation agreement and our expanding goals, it has been necessary to divide this committee into two committees—a Continuing Education Committee and a Research Education Committee. The Continuing Education Committee is developing an ambitious effort of educational programs to enhance the knowledge of nonorthopaedists about orthopaedic sports medicine and to continually renew our knowledge on nonorthopaedic sports medicine topics. An example of one such activity is the development of an instructional course on sports medicine for The American Academy of Family Practice.

Our Research Committee has several projects presently underway, including a Society survey on weight-training injury and a shoulder injury survey related to swimming. The restructuring of our Research Committee to foster and promote research in orthopaedic sports medicine, to accomplish funding for such research, and to educate the AOSSM members on relevant research, is being actively developed.

The American Journal of Sports Medicine with Jack Hughston as its editor is becoming a leading journal in the dissemination of sports medicine information.

As we all know, sports medicine is on the crest of a wave. The increasing popularity of sports makes for the increasing popularity of sports medicine. As a quotation from *The Art of Scientific Investigation* states, "If when the tide is falling, you take out water with a two-penny pail, you and the moon can do a great deal." So let us not lose our perspective. Our task is to improve the care and treatment of athletes, to aid in the prevention of such injuries, to promote and enhance the physical fitness of our citizens, and to provide knowledge for their safe pursuit of athletic and recreational activities. With our dedication to all athletes, be they competitive or recreational, young or old, male or female, friend or foe, our Society cannot help but continue to prosper and give us all a feeling of accomplishment and contribution to fitness and sports.

I should like to thank the Society for the privilege of being your President for this past year.