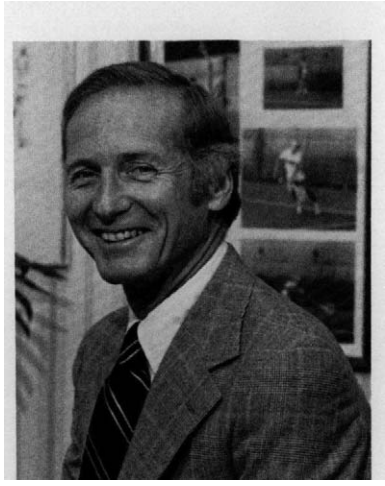
0363-5465/84/1206-0413$02.00/0
THE AMERICAN JOURNAL OF SPORTS MEDICINE, Vol. 12, No. 6



Presidential Address of The American Orthopaedic Society for Sports Medicine*

Robert E. Leach,† MD

President, AOSSM

It has been a distinct honor for me to serve as President of the American Orthopedic Society for Sports Medicine during this past year. It has also been a pleasure because members of this Society make it that way. The Presidential duties and the work of this Society could not be carried out without the help of many people who both work for the Society and within the Society. As a member of the Board, I look forward in the next years to working with Bill Allen and our succeeding Presidents.

I have entitled my Presidential Address, "The Nirvanian Challenge or Sisyphian Task." Nirvanian challenge is appropriate because there are so many challenges ahead of us and if we meet these successfully, we have the opportunity of molding the field of sports medicine into something we can all enjoy and cherish throughout our careers: a Sports Medicine Nirvana. Sisyphian task applies because some of the things ahead of us have been there a long time and look so formidable that one feels rather like Sisyphus. Instead of there being one big rock to push up that mountain, we have a series of small boulders which are ready to fall back as soon as we let up even briefly.

Past Presidents have listed the accomplishments of this Society, and rightly so. We can glow briefly in the reflected light of the accomplishments of many of our peers. But that should not be enough for this Society. Last year, Jerry O'Connor spoke primarily of establishing credibility in our field. He touched briefly on some problems and I would like to pick up on that note to discuss some of the challenges ahead in the field of sports medicine, particularly as they relate to the changing scene in American medical practice. It is my firm belief that there will be major changes in American medical practice in this coming decade, changes coming largely from within our own profession.

We are here in Southern California four days before the opening of the 1984 Summer Olympics, the acme of amateur athletic competition. There will be many athletes on the United States and other teams who will be competing not only because of their own skills, but because of the skills and knowledge of many people in the field of sports medicine. When one sees some of the athletic performances that are about to occur and reads in the newspaper about some of the wondrous medical recoveries due to surgery, medications, manipulations, miraculous machines, etc., one may have the feeling that all is certainly right in the field of sports medicine. But, there are problems here in Nirvana.

In Bloomington, Indiana, in the phone book under one MD's name, you will see family practice; sports medicine. In a small town in Connecticut under one doctor's name will be listed internal medicine and sports medicine. In the San Francisco directory in the podiatry section one sees podiatry and sports medicine. In Boston, Massachusetts, under orthopaedics and sports medicine, there are 15 names listed. What constitutes the field of sports medicine? Who practices it and who speaks for this field?

In orthopaedics, there is the worry that our field is becoming too fragmented. The Academy watches the growth of

* Delivered at Anaheim, California, on July 24, 1984.

† Address correspondence to: Robert E. Leach, University Hospital, 75 E. Newton Street, Boston, MA 02118.

specialty societies in orthopaedics fearing that orthopaedics may go the way of general surgery, gradually losing its collective clout to a series of smaller, less powerful organizations with special interest in their own area and less interest in the general field of orthopaedics. As orthopaedic surgeons interested in sports medicine, we deal primarily with the musculoskeletal system as it is affected by athletic activities. There are other people in medicine who are interested in sports medicine, but most of us do not deal on a routine basis with these internists, podiatrists, general practitioners, etc., who are in sports medicine. Few of these societies have yet banded together to form a sports medicine organization. The podiatrists have one and the American College of Sports Medicine encompasses people in many fields, doctors and nondoctors. There will be others. With this proliferation of organizations, including our own which came after the American College of Sports Medicine, there is some worry about the sports medicine turf. What will be the interrelationships between these various groups?

People do not become contentious over unsuccessful ventures. If we talk about taking care of the women's archery team at Boston University or the men's skin diving team at North Dakota State, it is unlikely that anybody would care or challenge our turf. When we talk about taking care of the New York Islanders Hockey Team or the USA Men's Basketball Team, there are many people interested. That is a problem in sports medicine. The field has become a success story in and of itself. Financially, there are many people making a living in sports and in sports medicine—athletes, coaches, trainers, owners in the professional ranks—and this same group except for owners in the college ranks, all receive financial return as do many orthopaedic surgeons, physical therapists, podiatrists, internists, psychologists, physiologists, massage therapists, acupuncturists, rolfers, etc. This success, which can be measured in financial terms and to some extent in fame, has led to competition within our specialty and within our medical and nonmedical groups.

As we mark our own turf boundaries, we must learn to interact with other groups. The AOSSM, with the help of Drs. Bodnar, Larson and O'Connor, has established working relationships with major groups such as the President's Council on Physical Fitness, the Olympic Council on Sports Medicine, the American College of Sports Medicine, and the NATA. It is vital that we continue to interact and maintain our presently established position in the field of sports medicine. As orthopaedic surgeons, we have one major advantage some of these other groups do not have—we take care of the people who are injured and frequently help them to return to athletic activities. We work hard at this task. A perceived disadvantage to other people is that we have an earning capacity well above what others who are interested in sports medicine will earn. We are sometimes seen as being more interested in the financial remuneration of taking care of injuries than we are in the prevention of such injuries. Although I believe this Society can be proud of the work it has done with regard to the education of athletes, trainers, coaches, and doctors in terms of preventing injury and, in particular, in the research work that has recently been established concerning epidemiological studies in many sports, it is essential that we assume the lead in the prevention of injuries.

More of our personal work with teams, our research work, and our teaching must be aimed at this prevention of injuries, not only with the professional and college teams but with high school, grammar schools, and particularly with post-school sports participants. To do this, we are going to have to raise some funds, particularly within this organization. The only way I see that we have of getting funding is by going to some of the companies that are involved in sports medicine and to other companies that want to project an image of promoting health and well-being in the United States. I believe we have to work to get funding for members of our Society to do research work, particularly aimed at the prevention of injuries and the maintenance of good health.

We must establish closer relationships with nonsurgical groups that are involved in sports medicine health care. I have heard criticism leveled at us because they feel we are less involved with the total care of athletes than we should be. Our aim must not only be the best care of the injured athlete, but the best care of the athlete. We need to increase our concern about the prevention of injuries by proper conditioning, by modifying equipment, by changing rules, etc. There are many members of this Society, such as Tom Peterson, who have made real contributions, and others who have been very active in this particular field, but it is one that we must continue to emphasize.

In the United States we are seeing changing patterns of private practice with, for the first time, perhaps too many physicians in this country. Soon there may be too many orthopaedic surgeons for the need. Competition is and will be keen. In law, an overpopulated profession, we see advertisements in local newspapers and magazines, some of which appear to be totally unprofessional, verging on unethical. In my area, I see numerous ads for emergency clinics and health maintenance organizations, etc., and frequently sports medicine or runner's clinics are mentioned in those ads as a come-on. In the next decade, physicians may not only have to be good doctors, but may be subject to American business methods in marketing and merchandising. Individual physicians will be competing with large clinics and the HMO's for patients.

How does this bear on sports medicine? Sports medicine is an area in which a physician and others involved may receive free and, what we have called ethical, advertising. By ethical advertising perhaps we mean that notice has not been sought out or paid for. An obstetrician delivering a thousand healthy babies, one of whom may go on to be a Nobel Prize Winner, famous writer, etc., is unlikely to be known to the public. However, if one of the members of our Society takes care of a Joe Namath, Tommy John, Larry Bird, or Gayle Sayers, this becomes news. If the final result is good, the physician involved will have ethically, but effectively, merchandised himself to the public. Thus, many people in the field of sports medicine find themselves with

an advantage in competing for the health care dollar. We must be careful in the manner in which we allow this to be done and ourselves to be exploited or to exploit.

I believe our Society should, in the next several years, take the lead in setting up a code of ethics that will deal not only with our aims in print, but with advertising and even the listing of sports medicine clinics. We must publish guidelines for sports medicine physicians, clinics, etc., but we must be aware that we will be competing with non-MD's in this same field who will not be bound by our rules. We must meet this competition and meet it ethically.

There has been some concern with how membership is determined in this Society. As a member of the Membership Committee and our Executive Board, I have been impressed as to how careful the Membership Committee considers each application. But we must remember that even membership in this Society may give a person a leg up in the sports medicine field, and it is possible that two competing physicians in the same area may both want to be members of the Society. If one is already in and the other trying to get in, there is the potential for a problem. Membership in our Society must be viewed as an educational and recreational vehicle and not as a merchandising or competitive tool.

A decade ago sports medicine was viewed by some people as being a fad, a small club, not a legitimate subspecialty of orthopaedics. We were then seen as not having serious academic ties. I find this of interest since Dr. Don O'Donoghue, the first President of the Society, was a Professor and Chairman of a major medical school orthopaedic department. Our meetings were sometimes referred to as "15 papers on the torn anterior cruciate and how many touchdowns they have scored since repair." This characterization is fading quickly. Our Journal, under the direction of Dr. Hughston and with the help of many others, has moved gradually into the forefront of sports medicine and is a well-recognized and academically sound educational vehicle. Throughout the country, there are a number of medical school orthopaedic departments whose Chairmen are members of this Society. In most departments around the country there are men holding the rank of Professor or Associate Professor of Orthopaedics who have a particular interest in sports medicine, and the names of these contributors are well known to all of you. We must continue to be represented in the academic area and in medical schools in the orthopaedic departments. There is no reason that someone should be particularly honored because he is an expert on how to reconstruct the anterior cruciate ligament or ankle ligament as opposed to being an expert on total hip replacements or back surgery. The worth of one man versus the other comes not from the individual patients, but from the perception of our worth by some of the academic leaders in orthopaedics. We should look carefully at our field and decide whether or not we feel sports medicine should be taught as an entity in schools. Should it be a section of orthopaedic surgery or a section in internal medicine? Is there, in fact, an entity of sports medicine or is it a subgrouping of orthopaedics or other specialties?

This brings to mind another area in which our Society has made progress, and that is the question of Fellowships. Fellowships in sports medicine often amount to preceptorships where a young orthopaedic surgeon works for six months or a year with some heavily involved sports medicine orthopaedic surgeon. He may or may not have a basic educational curriculum for that time. He may or may not be given a great deal of responsibility and the chance to make independent decisions and perform surgery. He may be a tool for that orthopaedic surgeon, another pair of hands who provides income. On the other hand, he may be well taught and come out of a Fellowship ready to advance the field. Our Society is dealing with this problem of Fellowships and will be making recommendations as to how these should be structured and policed.

To some orthopaedic surgeons we appear to be having too much fun in an interesting field. There is a tendency to believe that if persons enjoy their work as much as we do, perhaps it is not all that challenging or intellectual. The gradual development of research in our field and the funding of it ourselves, has done much to elevate the prestige of sports medicine. We must take pride in the accomplishments of our Research Committee under Dr. Frank Noyes and the work of such men as John Albright and others who are doing the epidemiological studies of sports injuries. We must continue to work in this field. Retrospective studies, while valuable, should gradually be replaced by prospective studies. The Sports Medicine Society can be justifiably proud of contributing its own monies to these studies, but we must raise future funds for people in research in our specialty. OREF has recognized us as an entity and a member of our Society, Dr. Robert Larson, is on their Board. Members have received funding from OREF, and we hope this will continue and increase.

One of our strengths has been the establishment of strong working relationships with certain other people in our field, particularly with trainers and physical therapists. We must enhance these relationships and learn from them as well as teaching them. We must be aware of the physiology and repair of injuries and of the rehabilitation phase. We cannot leave the period of rehabilitation of patients to therapists and trainers alone, but must be active in its direction and in its development.

Another major challenge which I see before us is the question of ethics in dealing with athletes, coaches, athletic directors, and other people related to athletes, including lawyers, owners, etc. There are about 11,000 professional athletes in the United States who daily receive more notice than do all of the physicians together in the country. These professional athletes form a tiny portion of the people we are taking care of who have sports medicine injuries, but they receive a major part of the public notice. The ethics of dealing with members of teams who are in competition for championships, money payments, etc., may be difficult. The relationship established between team doctors, players, coaches, and owners, must be carefully defined. Our cardinal rule must always be to think of the athletes first and cause

no harm. In principle, this is easy. In practice it is not as simple. Sometimes the athlete himself may be the leading proponent for freezing an ankle, removing a splint, or taking some medications which will mask pain. This is a problem not only in the professional ranks but in college and high school. College scholarships represent a great deal of money and the coaches, athletic directors, and players themselves are under pressure to produce and even sometimes play with injuries. We must be scrupulously honest in dealing with the athletes and recognize our obligation to them. We must recognize the privacy of an athlete of note who is injured. There is doctor-patient relationship here, but do we consider this information privileged? What are the ethics involved when the public or press wants to know what has happened to an injured athlete? Does the known athlete forfeit his or her privacy rights? In dealing with athletes who are moving from team to team we must be careful in preserving their privacy in restricting access to information if the athlete does not give permission.

All of us must worry about the long-term effects of athletic participation on athletes, particularly in those sports that have a high injury potential. What are we to tell our 20-year-old football players who have had reconstructions of their ligaments with regard to the potential for future injury? What do we say to the linebacker with both meniscii out and an incompetent anterior cruciate and a will to play who is still functioning well enough to play? In the State of Massachusetts it has been determined that former professional football players who have had injuries and whose careers have ended partially due to these injuries but partially due to the fact that they have become older and less able to compete, are eligible for workmen's compensation. If the team is held responsible for injuries incurred on the job, will the doctors be later held responsible for chronic problems? Are we responsible for the development of degenerative arthritis 25 years ahead in a person who has a torn meniscus and slight laxity of the knee? Will the myrmidons of the legal profession have more to say about what we tell the players than what we actually think should be told?

One problem of several years ago has become less of a problem. Our ties to the American Academy of Orthopedic Surgeons have become stronger as the affiliation agreement has been dropped and we have established a simple working relationship. One past President of the Academy, Dr. Bill Fielding, and the present President, Dr. Charlie Rockwood, are members of our organization. I consider it essential that the members of the Sports Medicine Society recognize that they are orthopaedic surgeons first and sports medicine physicians second. As a special interest group that receives much notice, we can be helpful to the Academy and in my opinion, would only hurt ourselves if we were to loosen our ties to the American Academy of Orthopedic Surgeons. I have been delighted with the events of the past several years, which have included several joint ventures which we have entered into as equal partners with the Academy.

Finally, as I look at what has been accomplished in the past decade and I have put it into juxtaposition with the 1984 Olympics where we will see the elite athletes from multiple nations involved, I wonder what our role can be in helping to develop better athletes and better methods of playing sports so that people can perform them for longer periods of time with less potential for injury. Should we not be more involved with the biomechanics of these sports so we can help to increase performance and decrease injury? Should we not know more about the psychology of these sports to help everybody, not just the elite athlete, reach his or her performance potential? Are we paying enough attention to the conditioning of athletes so we can help people reach their potential and have a long-term career? I am not interested in just the four years in high school and the four years in college, but I mean for people in their 60s and 70s so they can play sports literally all of their lives.

As I was putting together this address, I thought of these challenges and it appeared to me to be, indeed, a Sisyphian task. As I consider the people with whom I have worked in the field of sports medicine and look at the orthopaedic surgeons in this audience and listen to the papers that have been given here during this meeting, I realize that this is a challenge worthy of our efforts. You as individuals and as a Society are equal to this challenge.

It has been a thrill for me to be your President during this past year. It is an exhilarating experience to stand before you as the President of such a dynamic organization. I sincerely thank you all for this opportunity and for this moment which I will truly cherish forever.