

Presidential Address

Sports medicine—past, present, and future*

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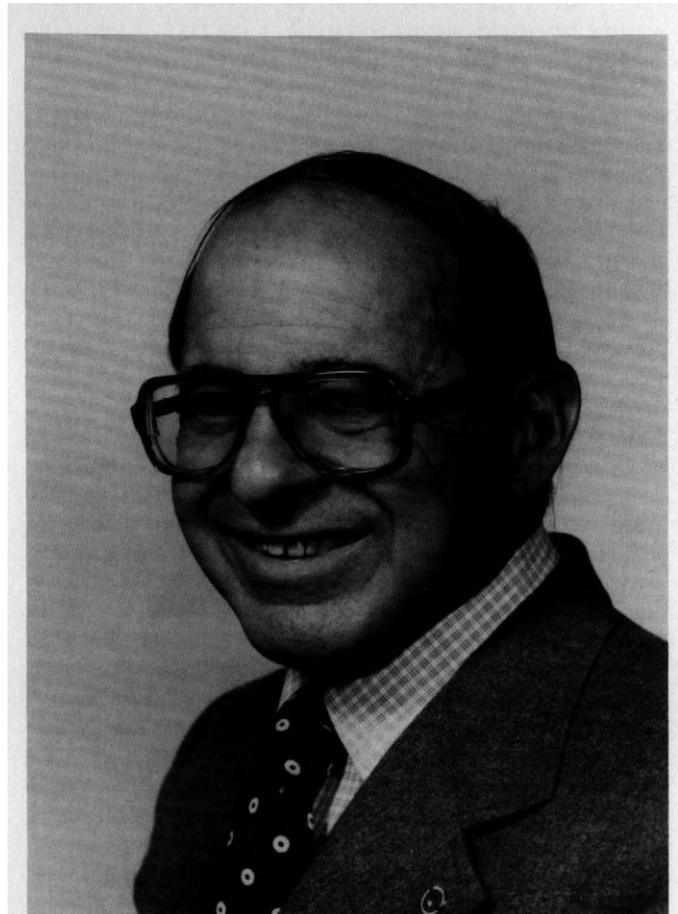
From The Institute of Sports Medicine and Athletic Trauma, Lenox Hill Hospital, New York

It is a great and privileged moment in my life to speak before you today as the president of this vigorous society. The American Orthopaedic Society for Sports Medicine (AOSSM) has played a key role in shaping how the vast field of orthopaedic surgery relates to sports medicine. I look back with amazement as well as pride at the impact of the AOSSM on the evolution of sports medicine over just the last 7 years.

Sports medicine did not receive attention during the Great Depression of the 1930s, through the Second World and Korean Wars. Yet, in the past 30 years, the science of sports medicine and fitness has developed into a multidisciplinary field which affects many facets of our lives. We have witnessed a fitness explosion in this country and the public has responded with a surging involvement in sports participation. We meet today as a testament to this growth, as scientists who must be experts in the disciplines of sports medicine, and as practitioners who must both treat athletic injuries and answer the array of fitness questions.

SPORTS MEDICINE IN 1930

I thought it would be useful to reflect on the past to give us a better understanding of how to direct the future. In 1930 there were 128 physicians practicing per 100,000 population. Today that number is 200 per 100,000. Medicine was concerned with survival, not prevention, as it is today. Polio, diabetes, bacterial infections, cancer, and tuberculosis ravaged our country with



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its population of 124 million, 100 million less than today. There was no AOSSM or American Academy of Orthopaedic Surgery (AAOS). In orthopaedics, fusions and osteotomies were the order of the day. Nonunions, septic joints, deformities, osteomyelitis, and rickets abounded.

For orthopaedic surgeons in 1930, there were no 5-year training programs, fellowships, or accredited peer review processes. No one had heard of continuing education credits. There were no classifications of knee instabilities, no specific diagnoses of herniated disk disease, or knowledge of spinal stenosis, bone scans, arthroscopy, replacements, or implantations, as are commonplace today.

I must pay tribute to the great men who were instrumental in the development of sports medicine before this time. Perhaps the foresight of these men can be appreciated if we look back over the last 50 years and see how they enhanced development of this exciting field.

Physical diagnosis was emphasized in orthopaedics in the early 1900s. An example of how our early orthopaedic surgeons appreciated the substance of "sports medicine" can be seen in Dr. Whitman's 1903 text *Orthopedic Surgery*. In this book there is a description of "snapping knee," which we label today as "pivot shift." Furthermore, "loose and tight joints," "athletic performance" and "pathology" were all alluded to at that time.

In 1905 Gibney showed how to strap a "gamesman's" sprained ankle. In 1919, Robert Osgood, P.D. Wilson, and Gus Thorndike at Harvard established a fitness laboratory which was the first sports medicine facility in the USA. In the same year Dr. Bruce Gill presented a procedure for recurvatum in which the hamstrings and iliotibial tract were transplanted into the back of the knee by fasciodesis. Nine years later Putti introduced the posterolateral approach for treatment of knee instability and contracture caused by polio. We use this surgical approach today for anterior cruciate reconstruction in our iliotibial band pull-through graft procedure and in over the top repairs.

But what was going on elsewhere outside the United States?

The Germans pioneered a century of interest in sports medicine, but mainly in its nontraumatic and kinesiologic aspects. Indeed, the Weber brothers published a study of gait patterns as far back as 1833. Strasser, Last, and Lexer did original work in the 1900s on the mechanics of knee joint function. In 1910 *Hygiene des Sports* (a two-volume, 700-page text) was published and considered the "birth of scientific sports medicine." But when I reviewed this great work in French by Siegfried Weisbaum, I did not find a single page on the treatment of sports trauma.

SPORTS SCENE IN 1930

There was no discipline really responsible for the care of athletes, aside from a few people such as "bone-setter Reese," a trainer, and Dr. Robert Hyland, an osteopath who took care of the St. Louis Cardinals. Drs. Whitman, Wilson, and Speed all, however, wrote texts about what we deal with in our sports medicine practices today.

In 1930 there were two baseball leagues of 10 teams each. There were no national professional basketball teams. The heavyweight boxing champion was Max Schmeling. There

were 24 professional football teams spread throughout the country but none performed on the west coast due to travel constraints.

In golf, Bobby Jones won the US Open at that time with a score of 287, as opposed to 272 by Jack Nicklaus at Baltusrol this year. There were 10 teams in the National Hockey League, with Montreal, as usual, the winner of the Stanley Cup.

It is interesting to study the differences in performance then and now. The 1928 Olympics were held in Amsterdam. The 100-meter freestyle women's swimming meet was won by Albina Osipowich of the USA with a time of 1.11 whereas, in the 1976 Olympics, Karen Ender of East Germany won with a 0.56.65. In the track event Alberto Juantoreno ran the 800-meter in 1.43.50 in 1976, whereas Steve Little's time in 1928 was 1.51.8. Performance in the high jump increased by 16%, with King jumping 6 feet 4.3 inches in 1928, and Wszola reaching 7 feet 4.5 inches in 1976. Just about the same ratio of improvement can be seen in the women's performances between 1928 and 1976. Performance improved markedly and one of the reasons for this was the increased participation of sports medicine.

TODAY'S SPORTS MEDICINE

Today we have more injuries associated with recreational play than ever before. This is due to many factors including a greater population, more recreational time, more affluence, early retirement, and the injudicious attempt to play sports to augment health when risk factors are not protected against.

Many experts believe the physician shortage has been corrected; I think they are wrong because we don't have a sufficient number of physicians who know sports medicine to care for the large number of athletic injuries. Physicians have a chance to practice medicine as a whole rather than as a fragmented discipline when dealing with sports problems. Thus they are not endangered by tunnel vision. We are very short-handed in this area and our needs are growing in every direction. Your Board of Directors recognizes this need in the hiring of Tom Nelson and the development of a central office.

OUR LEGISLATIVE INTERESTS—VERTICAL AND HORIZONTAL MOVEMENTS

Sports medicine today is characterized by a boom in the interest of the government, federal and state bodies, by legislators, administrators, and educators at every level. The intensity of interest in sports medicine by the government can be readily illustrated by the activity of the President's Council on Physical Fitness and Sports, of which I have the great fortune to be a member. You will hear Casey Conrad talk about this and you will have a taped message from President Carter in which he speaks on the importance of fitness. He demonstrates to what high imperative level the interest in sports and medicine has been mobilized. Participation of the Public Health Service, its Office of Health Information, the National Research Council, the National Academy of Science, and other national organizations, as well as the rapid development of state councils on fitness, signal the federal government's and its agencies' interest in medicine and sports.

In this light, orthopaedic surgeons interested in sports med-

icine must reevaluate their role, so as to increase their knowledge of fitness and learn the substance and composition of sports medicine programs, in this country, given by other disciplines. Such orthopaedists must be educated in exercise physiology, biomechanics, rehabilitation, kinesiology, injury prevention, psychology, and sociology to effectively treat sports injuries and to understand the athletic personality. Cardiology, family practice, orthopaedics, medicine, pediatrics, psychiatry, and many other specialties are all bound together in this endeavor, indicating the need for a team approach and team communication.

We are being besieged in our literature by sports medicine journals, abstracts, digests, transactions, videotapes, and instructional courses. We must continue to protect the merits of this development and not abuse or ignore it, for injuries to the musculoskeletal system are the second most common cause for hospital admission and disability today. These injuries result in a rapid *deconditioning process*, almost inevitably due to the length of convalescence in the repair of musculoskeletal injury. We must, as orthopaedists, know the composition of the *exercise response*, and the significance of deconditioning, and how to overcome it, as well as how to recognize it. For example, having a strong lower extremity will not suffice in a conditioning program in regard to what upper body fitness might be.

Who else can do this better than us? Who is in a better position to have expertise in orthopaedic surgery and, at the same time, take care of the athletes' wide-ranging musculoskeletal injuries? To this end, the Committee on Research and Education was structured in its tasks to actively meet this challenge. This Committee has the tremendous charge of defining what we should know about sports medicine, under the energetic hand of its chairman, Dr. Bernard Cahill. Its charges are comprehensive. I do not think a 15- or 18-man committee on sports medicine, as the Academy has today, can fulfill the increased responsibilities of these charges—requiring diversified expertise and time consuming study. I speak with experience in this regard, having been a member of that committee for 8 years.

Sports medicine differs from other forms of medicine. Attainment and maintenance of high levels of fitness in all athletic-minded people produces significant effects on the performer. The supernormal as well as the subnormal conditioned state is a task for all of us interested in sports medicine to learn about. But the demands of sports must be tailored to the individual. *The same injury which affects one person's performance may not affect another's* because the effect of such injury may not detract from the lower line performance. However, for the high level athlete with the same injury, there may be significant loss of performance at high cost to the athlete. Those of us in sports medicine are fully aware of those differences. Because of this, physicians practicing sports medicine or those who seek to take training in it, should have some field, gym, or stadium level of training to learn what *performance means at that level*, and mingle with individuals involved at that level. As orthopaedic surgeons we also have the task of defining what we and other disciplines should know about sports medicine and what we should teach. Bit by bit, gradually we must increase our participation at that ground level jungle in an

effort to counter widespread erroneous exploitation of our patients, because of inaccessibility to well-designed medical care for our performers.

HORIZONTAL VS. VERTICAL

For a better understanding of how wide-ranging interests and knowledge are becoming intertwined in the sports medicine world, I am going to introduce you to the concept of the *horizontal* and *vertical* structures of sports. It is important to understand this new conception characteristic of the sports world because it directly affects the growth of sports medicine, in all its ramifications, and it is necessary to understand lest we do fly in too many directions.

The horizontal movement of sports represents the specific sports and federations that govern each of these large numbers of largely professional and amateur organized sports. They have the charge to set up standards and guidelines for their sports. Such federations are capable of and are organizing sports medicine programs, as well as facilities, and attracting coaches and trainers to properly administer their sports. They need our support and input and, in many cases, our expertise will help them *develop quality assurance* in their programming so necessary to lasting success. *We must* give such educational programs our support and *our* educational expertise unstintingly.

The vertical system of sports treats sports from every level of society, such as government, schools, family, and individual sports performers. It deals with *each and every person*, lifelong, who is active in recreational sports. In studying how the vertical system affects sports, it is important to look at the recreational athlete in a multiple performance, physical and psychological level, on an *individual basis* rather than organized federated structures that exist, for example, in soccer, baseball, Pop Warner, Pee Wee, and other organized bodies. In the vertical system athletes can be classified as elitists, weekend, senior, prime age, junior, women, handicapped, ad infinitum. There is a spectrum of pedagogy that is associated with this. I call it the Seven P's.

THE SEVEN P'S OF SPORTS

In the vertical study of athletic activity we have, first, the *Performer*. He or she participates in recreation, be it on land, sea, or air, in hot or cold climates, in the farthest reaches of our country, and who indulges in the second P; namely, *performance*. Here the demand of each sport or activity in terms of agility, ability, balance, timing, coordination, tempo, discipline, and the demand of the environment in terms of playing conditions and equipment on this individual occurs every time the performer performs a sport. Because of the scientific advances that have enhanced our life span, and the emphasis on fitness, almost every one of us is included, even those with *pathology*, the third P, be it an elderly patient with cataracts, diabetes, arthritis, hypertension, or osteoporosis. *These three P's, the performance, the performer, and the pathology, are inherent components of sports medicine regardless of who, and/or what the athlete is today.* But there are more elements.

The *prescription* of play shows us *who* should play *what* sports, and for *what* duration and to *what* intensity, and *how* frequently. These questions are often only dimly perceived by

our fifth P, the *practitioner*, who must at one time or another be concerned. The practitioner can be a physician, parent, coach, teacher, lay person, chiropractor, politician, or priest—that is, anyone who gives advice about how to play, whether right or wrong—and that is part of our present-day problem. To acquire more speed, to acquire more endurance, to get more skill in sport requires a sixth P; namely, *practice*. To complicate matters, the performer who must run, jump, or throw, or whatever, may frequently be unaware of his or her pathology or the demands of performance, or what prescription is best for play. Out of all this we have the seventh and most focal of all P's, *prevention*.

A most important area for our Academy officers, then, to recognize is the comprehensive interest of our work as a society, specifically directed to these vertical and horizontal directions. I might add that Congress has already recognized the importance for the need of sports medicine research under Section 1907 of the Public Health Service Act which states "there shall be established a program of grants to conduct research into the problems of athletic injuries." But, at this time, the Public Health Service has not complied with the congressional mandate to establish this program and, perhaps, it should be the function of a different body.

INTERNATIONAL MOVEMENTS IN SPORTS MEDICINE

As a result, partly of the Olympics and the establishment of the United Nations, we are witnessing an international explosion of interest in sports medicine. New bodies of "coalitions," "councils," "federations," and "committees" have developed to represent their sports interests and are competing, each seeking to be the spokesman. There was a major meeting between eight such organizations in September 1978. The meeting was chaired by the United Nations Educational, Scientific and Cultural Organization, and it was recommended that an intergovernmental committee be set up to organize sports medicine and physical education programs.

An executive committee was formed and met in 1979. It was suggested that every member of the International Council for Sports and Physical Education was urged to bring their view to the attention of the institutions concerned with physical education, sports science, and medicine that existed in their countries.

Next week, July 10, 1980 to be exact, there will be a meeting of the general assembly as guests of the USSR Sports Committee before the opening of the International Sports Science Congress (July 10 to 16, 1980) at Tbilisi, Georgia, USSR. The program for the sports science congress includes sections with interests in philosophy, history, and sociology; pedagogics and psychology; and biology, biomechanics, biochemistry, medicine, and physiology. Under the latter heading of sports the age, health, and effects of the heart on one another, sports physiology, the biochemistry of sports activity, the biomechanics of sporting movement, the testing of the work capacity of the fitness of sportsmen, and nutritional and anthropometric foundations for sports mastership were to be emphasized.

Please note that the word or subject, pathology, was never mentioned, nor epidemiology, training methods, drugs, nor

either the substance of the vertical or horizontal systems of sports. Although I think this movement is a good start, it does not give us the role that we as orthopaedists are best qualified to do—handle the musculoskeletal pathology from pediatrics to old age, to relate pathology to medicine, and to embrace total rehabilitation of sports to the highest levels for treatment and prevention.

What are the implications of this continuing program? It reflects the lack of *coordinated effort among all* the major bodies in sports medicine. It established communication media and information exchange at an international level. It ignored the primary role of biologic science in sport and especially the specialty of orthopaedic surgery, as it is concerned with fitness of an athlete at the various levels, and the limiting factors at these levels. It made no mention of those with lower levels of fitness such as the handicapped, the aged, and the ill. It dealt with biomechanics and physiology without dealing with pathology, nor did it provide a mechanism for quality assurance in these sciences.

It is elitist-oriented to the 50 nations in the Olympics and represents as such a coalition approach rather than a consensus approach. Moreover, because of political problems, it does not represent the large number of bodies who are not going to Russia in July. It is a physical education-oriented group which is limited in scope.

Under the limits of licensure they cannot perform the medical aspects of sports without an MD, but in this international endeavor they may be assuming a role beyond their legality. Fitness is a primary goal not only to the physical educator, but also to the medical practitioner, and for all our population at all levels. The conception of the sports scientists and the sports specialists in this explosive movement is not sufficiently visionary to meet the problems of educating those who need it most, that whole system of people who see the athletes at play. I submit this information to you because I think you should understand the directions and pressures on our interests in sports medicine at all levels that we have to be aware of. We have to define our own relationship also to the American College of Sports Medicine which self-avowedly seeks to be the "spokesman for sports medicine," as well as with the American Medical Association, and the Olympic Council on Sports Medicine and other bodies.

As a matter of fact, Marcus Stewart represents us at the executive board in the USOC and assures us of cooperative emphasis in developing leadership. I know John Bergfeld, as Vice President in the American College of Sports Medicine, will keep in mind our own need to participate in a leadership role as sports medicine evolves in our country.

CONTRIBUTIONS OF OUR PAST PRESIDENTS

I would like to tell you how the leaders of our own society, with all of their powerful contributions as orthopaedic surgeons, have also contributed gigantically to the development of our society to what it is today and the directions which it is taking. Starting with Dr. O'Donoghue, who founded our society in 1972, we have had Joe Godfrey implement the constitution, Jack Hughston develop *The American Journal of Sports Medicine* together with the late Joe King, who set up our

Committee on Research and Education, Les Bodnar who reanalyzed our by-laws, Marcus Stewart who brought us our liaison with the Olympic Committee, and Jack Kennedy who initiated our Academy affiliation discussion. All of these men, to whom we are all so deeply obligated, have each taken the challenge of moving our society step by step to what we are today. Certainly, they are inspirations for us all in the wisdom and fulfillment of their goals. We are most grateful to them, and to all of you, who are members of the committees which have been expanded by the hard work of these men who have nobly labored so hard for our society. We will, with such talent, meet some of the problems I have alluded to with experience and wisdom in the future.

COMMITTEE WORK IN THE AOSSM AND THE LIAISONS

So you see, sports medicine for the American Orthopaedic Society today includes not just how to repair knee ligaments and football stars, but also includes sociology, the political scene, women in sports, profiles, organizations, and the process of affiliation and liaison with other organizations. There is so much to do. For example, in regard to disability in sports, there are a number of organizations with which we must have some active liaison relationship, to name a few, including the International Sports Organization for the Disabled, the International Cerebral Palsy Society, the International Wheelchair Games, the National Camps for Blind Children, the Amputee Skiing Program, and the Special Olympics Program for the mentally handicapped. Les Bodnar is in charge of our liaison committee. Not only is he working diligently in this area, but also on the political relationship our group must have with bodies such as the Red Cross and Boy Scouts.

Our Committee on Research and Education has also been charged with the responsibility of functioning at all levels and in dealing with the nomenclature program and a professional and public education program. We also are devoted to the encouragement of research as well as to the cataloguing of it. Our new O'Donoghue Research Award is a serious contribution in this direction from our young researchers. Incidentally, I might state that there is more research money being spent in sports medicine by private funding than total government spending in the USA. Total government funding for exercise, physical fitness, and sports medicine research amounted to \$5,011,440.00 in 1978, with the bulk of it being on cardiologic research as it relates to sports. In my own Institute of Sports Medicine we conduct an annual survey on the state of physical fitness and sports research in the USA. We found that over \$10 million was being spent for sports medicine research and education *outside* of the government level by private funding. Therefore, our research and education committee has been charged with performing a greater in-depth analysis of this, to decide where we will be going in the future. Other problems which our Committee on Research and Education must consider include resource coordination, human resource development, program development, the development of safe facilities, public information methods, and the nature of needs for coverage for event sponsorship.

Results will stem out of such analysis. We must take time to

teach those who need it most and we must find out by what means. Among other problems that the committee must define are training personnel for knowledge of sports medicine. This is a hard task; I know they will try to succeed. We have a duty as a society to participate in programs to educate both paramedical and ancillary care personnel as well as fulfill the needs of our own specialty. We must continue to cooperate with allied medical disciplines wherever possible in every aspect.

To this end, we must rearrange our affiliation agreement with the Academy so that it meets both our own needs—and the Academy's charges. It may not be possible to stay within the Academy's affiliate status, for reasons I have brought out. It is perfectly possible that we have reached maturity in this regard and may have to strike out on our own, because *our society is growing so rapidly and has been geared to meet expanding charges and responsibilities* with the enlargement of our executive office. We look forward to our discussion with Bob Wells and others of the Academy in the coming year to see what is best for both organizations in the future. One thing is certain, we do want to give instructional courses as we see fit and to continue our interim meeting with the Academy, just as the Hand Society and the Orthopaedic Research Society do. We recognize the importance of our parent body, the Academy, in our overall educational experience and are most grateful for the past support of the Academy since it recognized sports medicine in 1965 with the formation then of the Committee on Sports Medicine.

THE FUTURE

I would like to make some concluding remarks about my conception for a blueprint of the future. I foresee a coalition developing in the leadership of sports medicine over the next decade. Such a coalition can be predicted when we consider the roles and aspirations of organizations such as the American College of Sports Medicine, the Olympic Council on Sports Medicine, American Medical Association, the President's Council on Physical Fitness and Sports (which I think should be the coordinating body), perhaps the American Association for Health, Physical Education, Recreation, and Dance, and our own Society. It is essential that the American Orthopaedic Society for Sports Medicine (AOSSM) play a strong role, along with other bodies, in a federated movement.

I imagine a pentagon-like group structure of federated parent bodies, each with its own satellites of responsibilities, and a structured communication at the top for the interchange of ideas. The responsibilities will challenge all of us in each discipline of sports medicine. Some of our responsibilities will be in the area of education, others in programs for lifetime adult fitness and still others in epidemiology and research for medical advancements. I would like to offer some specific predictions that concern us in this organization.

In the area of education, new continuing education programs will need to be developed for home videotapes and worldwide application through Telstar. Part of continuing education will be the responsibility of each parent discipline in the federation as it relates to its membership. The parent coalition will provide videotapes or educational programs that relate to its expertise. Resource coordination will be necessary to develop curricula

which we can incorporate into degree offerings for allied health personnel, ranging from trainers to therapists to PhD programs. The orthopaedic surgeon can offer courses in sports medicine for medical school, residency, and fellowship programs as well.

Learning objectives in medical education will continue to stress injury prevention, injury treatment, conditioning, exercises, and physical fitness as well as biomechanic and psychologic aspects of sports. An ongoing mechanism should be developed whereby one can review, evaluate, and revise sports medicine curricula throughout the country.

Sports medicine committees should be serving in both the specific horizontal and vertical systems to provide an integrated system for teaching and delivery of service. Mass participation will demand the establishment of regional fitness centers. These centers can develop in existing colleges and universities and can facilitate research in sports medicine. I foresee a network of sports medicine facilities spanning the country, providing a network of care for the recreational athlete of the highest order. These facilities will serve all ages of athletes involved in a wide range of sports. Liaisons will be established with major coalition bodies to achieve the best in sports medicine and the AOSSM will be active in these liaisons at every level of professional expertise demanded of us.

The essence of any major sports medicine effort will be a public and private partnership with industry and business working with the government. The economic impact of the sports and fitness industry cannot be ignored. It is regarded as a high growth industry and as a result will perpetuate and promote increased participation in a variety of sports.

New sports will develop, new facilities will be created, and new health and medical problems will have to be solved. Orthopaedists will be obligated to participate in the safety of sports inasmuch as this is a \$3 billion industry in New York State alone. At present we do not know the national figures, but I estimate it is over \$40 billion.

Mass participation and the emphasis on lifetime fitness and lifelong involvement in sports, will require the implementation of physical fitness programs by both the private and public sectors. This will demand quality assurance and inventories of services nationwide. There should be certification procedures to identify individuals, ranging from doctors to volunteer coaches, who have had specialized training in sports medicine from experts, so that only those who qualify will be placed in positions of responsibility.

There should be an integrated sports information system available statewide with data secured by private to and from polling such as AC Neilson or Columbus QUBE (Ohio) surveys, as well as from sports committees from the horizontal and regional fitness/research centers. An epidemiologic data base should be established with standardized nomenclature for injuries. Data on injuries from all over the nation, from recreational to professional levels, can be collected and analyzed. The information from such data should be coordinated by each coalition parent body and disseminated. As a result, physical education programs will be modified and researched and volunteer coaching programs throughout the country will be developed on the basis of need.

Sports medicine on an international level will promote the exchange of ideas and stimulate research. We must become versatile with a large number of topics, beyond and above our own orthopaedic world, in which we have a vested interest. Guidelines for preparticipation examinations, and qualifications for specific sports must be developed. An understanding of the risks of contact sports as well as knowledge of the movements of sports will come as all the specialties involved work together.

The individual's ability to perform in relation to his pathology and somatotype should require special expansion of our knowledge in cardiovascular fitness programs. But, as orthopaedists, we are in the best position to integrate a cardiovascular program into musculoskeletal programs on the basis of musculoskeletal pathology. These can involve individualized strength-endurance programs for the upper and lower body with emphasis on other performance factors such as balance, coordination, tempo, rhythm, and agility as well. A selection classification program based on maturation should be part of our science. Preventive physical fitness testing and programming should become part of our daily medical practice.

In the future there should be quicker diagnosis and the use of new modalities for contact and overuse injuries. Chronic lesions brought on by overexertion causing periosteal alterations, stress fractures, and chondropathy with microalterations in blood flow in the surrounding muscles and tendons will be diagnosed readily by new techniques such as scans, ultrasound, and fiber optics. The effect of localized areas of pathology will be related to the fitness of the body as a whole. With all of this, records in performance will continue to be broken, techniques and facilities will continue to improve, and coaching and medical treatment will improve and the health of the nation will improve at great cost-saving.

CONCLUSION

The future of sports medicine is bright. It is a science that involves all of us. I have spoken about our Society's role and leadership charges. The coalition must develop if we are not to shirk from our responsibilities. The AOSSM has a vital role in meeting all the needs of such a movement. This will require the energies and efforts of all our membership.

It is for this reason that I humbly give this statement of my position today, for when one looks at the task ahead and looks back to our beginnings, one finds it almost impossible to comprehend the progress. But this is as it should be in medicine, for progress depends on recognition of responsibility and the implementation of our work to fulfill our responsibility.

We can all agree, I think, as members here, without prejudice, that our Society is meeting its responsibilities, but we have much to do in the future. We can all agree, too, that our Society will participate in such progress. We can all agree that education for ourselves will provide leadership for others in sports medicine.

Thank you so much for the privilege of allowing me to speak to you and for the wonderful memories that this association have given my wife, Kiki, and myself—and for your friendship.