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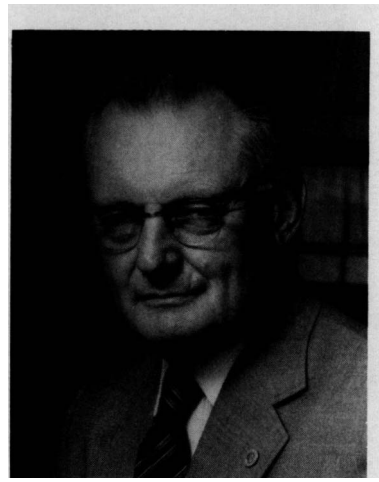

Presidential Address of the American Orthopaedic Society for Sports Medicine

Dreams*

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"We are such stuff As dreams are made on."

Eighteen years ago this quotation from *The Tempest* would have been an apt description of this organization. The dream was that of an organization of orthopaedic surgeons who had a deep and lasting interest in the care and prevention of injuries of the athlete. The substance was there as evidenced by the Committee on Sports Medicine of the Academy, but it took the vision and determination of a few men, and especially Don O'Donoghue, to see that something more was needed and to take the initial steps that led to the meeting in the Shoreham Hotel in Washington.

What happened to that dream? We have grown to an organization of about 1,000 members. We purchased and subsequently published a successful journal that is now recognized as a leader in sports medicine publications. Our interim meeting is far and away the best attended of the specialty societies at the annual Academy meeting. We have instituted instructional courses for both the orthopaedic surgeon and the nonorthopaedic surgeon. A special relationship with NATA has been established which parallels our individual relationship with our own trainers. With the help of Merck Sharpe & Dohme, the program of Traveling Fellowships with our counterparts in Europe was created. This year, with the assistance of American Airlines, we have started a similar Fellowship with the Pacific Rim countries. A Foundation has been established for the collection of funds to encourage research and education in sports medicine. I think if any of us at that organizational meeting had predicted that we would have accomplished these results in 17 years, he would have been told that he was a dreamer:

> "And, like the baseless fabric of this vision,...
> Yea, all which it inherit, shall dissolve
> And, like this insubstantial pageant faded,
> Leave not a rack behind."

This is the other side of dreamland. It is of this aspect that I wish to speak. Our organization is a young and vital group that has accomplished much in its short life. We must take care that it is not allowed to fade away and "leave not a rack behind."

Professor Alexander Tyler 200 years ago wrote that the world's great civilizations progressed through a sequence of bondage to spiritual faith to great courage to liberty to abundance to complacency to apathy to dependence and back again into bondage. Although this process does not apply specifically to our society, there is one section that does apply, and that is the middle portion of abundance to complacency to apathy and perhaps into bondage. I believe that we are in that crucial period of abundance and we must not slide into complacency. Today we have several threats

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to our specialty which, if ignored, can easily cripple it. Among these are fragmented health care, bureaucratic interference, and our own successful image. I wish to discuss these three by taking single examples and using them to illustrate the problem as a unified whole.

Fragmented health care can be a serious problem to the physician who cares for a high school athletic program. The team physician has gained the confidence and trust of the players, but has a problem when one of the athletes is injured but is a member of a local closed-panel HMO. The basic motive in the management of the HMO is cost. With all the rhetoric that abounds concerning preventive health, wellness, and holistic care, one would think that an HMO was an altruistic and philanthropic organization. We all know that it is not, and we know that the way an HMO survives is by cutting costs and treating the well young adult. HMOs have never made their point by treating the elderly, the indigent, or the sick. They set up the concept that only the family practitioner is capable of deciding when the patient needs referral to a specialist and even deciding how much treatment is necessary.

This is one side of the coin. As usual, there is another side. The cost of medical care is exorbitant, and any of you who has had a serious illness or injury in your family will understand that statement. Whether we like it or not, the HMO does offer a cheaper form of medical insurance, which is sometimes the only insurance that a young family can afford. Most of the physicians in an HMO are good conscientious practitioners who practice a good brand of medicine, and are prevented by the administrators from seeking consultation because of the cost.

The HMO theory is pernicious in three ways. Not only can you not take care of the patient, but the HMO doctor is dissuaded from seeking outside consultation because of the cost. Even though the athlete gets good care, it is not done in consultation with you, the team physician, and how many times have you been faced with an athlete who has been told that he may or may not return to a sport by a physician who does not know or care about the difference between a touchdown and a takedown? The easiest questions to answer are, Who are the eventual winner and loser? The answers, of course, are the HMO administration and the athlete.

Bureaucratic interference is probably the greatest and most difficult problem that we face. To use an example, I will take the DRG. Like the HMO its basic motivation is also cost, but in this instance the restriction is on how long we may keep the patient in the hospital or even if we can admit the patient in the first place. The administration is in the hands of nonphysician personnel who determine the stay by a cookbook approach using their manuals because they are unable or incapable of making a responsible decision in the matter on their own.

The idea of the DRG may not have originated in the minds of economists or politicians, but there is no doubt that its eventual form appeared in Congress. Its proponents will point with pride at the shorter hospital stay and hence the lower cost. I personally think that the shorter stay is due more to advances in techniques such as arthroscopic surgery and the increasing cooperation of hospital administrators that allowed us to start such innovations as surgical day care units, preadmission laboratory work, and admission on the morning of surgery. I must also agree that it was probably the threat of DRGs that spurred this cooperation and probably stimulated us out of our inertia to develop these innovations. As an example, the 1971 fifth edition of *Campbell's Operative Orthopaedics,* in discussing the postoperative care of a patient who has had a removal of a Baker's cyst, recommends starting quadriceps exercises on the second day. The patient is allowed up on the seventh day, and starts crutch walking on the tenth postoperative day.

The third complication is one that we in some respects have fostered and abetted. Our own success and our increased public image has made sports medicine a very popular field in the mind of the public. Dr. Robert Leach in his Presidential Address pointed out the rise of the "followers" in the Boston area with the proliferation of sports medicine specialists. These included professionals, semiprofessionals, and would-be professionals, but one of my concerns is what I call the spurious "sports medicine clinic." By this I mean a group of nonphysician personnel who form a group, call themselves a sports medicine clinic, and then proceed to diagnose and treat athletic injuries without physician supervision. They may include physiotherapists, exercise science graduates, nutritionists, psychologists, and sometimes a podiatrist. They usually proclaim a holistic approach to medical care. The end result is of course delay in obtaining treatment if the patient is fortunate and aggravation of the condition if the patient is not.

There are other problems which beset our practice of sports medicine, but I have used these three as examples of the three basic threats that I mentioned earlier. These can be tolerated as there are benefits in each of them, but we must not become apathetic or lose sight of their relationship to the practice of sports medicine. DRGs are part of the law of the land. The HMO will not go away, and the independent physiotherapist can still be utilized by us to further the rehabilitation of the athlete. Our task is to determine how we can ethically and legally protect our practice from being eroded by these potentially malignant growths.

The first and primary step in combating these forces is to practice good medicine. We must maintain our good judgment in the care of the athlete and avoid the efforts of outside forces that would influence us against our better judgment. We must temper our inclinations to perform surgery when conservative therapy will suffice and at the same time recognize that at times surgical therapy is the conservative treatment.

Secondly, we must continually promote education for both ourselves and our nonorthopaedic compatriots. Our own education is paramount, as we must stay in the forefront of knowledge in both sports medicine and orthopaedics. By personal contact we can help to educate our students and residents and also those nonorthopaedists who are involved

with us in this field. Do not forget that we can also learn much from them which will make us better physicians. We must continue to sponsor continuing education programs for ourselves and our colleagues. It is in this aspect of education that our society must take the lead, for it is in these programs that the healthy exchange of ideas and the learning of new techniques take place. This problem has already been addressed by Dr. William Allen in his Presidential Address, and it still merits reading today.

One of the major thrusts of this organization is research in our chosen field. With the encouragement and influence of my immediate four predecessors and our research and education committees, FSMER, the Foundation for Sports Medicine Education and Research, is now a viable entity under the chairmanship of your recent President, Bernard Cahill. Some of us are experienced researchers and some of us have no interest in doing this type of work. There are many here, however, who would like to take on a project or have an idea but who lack the expertise or means to carry it through. Your foundation is the means by which this may now be possible. It can provide the help and the training to get started and can also be the source of funds to subsidize the project. It is your foundation and it needs the team approach to be successful. A better job can be done by the whole than by the individual, and just as a team needs the quarterbacks it also needs the linemen. After all, if the center does not snap the ball the back is going to have a difficult time running with it. FSMER therefore needs the support of each and every one of us as it will be a major force in maintaining our viability. One additional caution. Our research must go beyond the treatment of the anterior cruciate ligament although I admit it is still our number one problem. We must, however, promote basic science research in bone and especially cartilage research as well as investigating newer and better methods of treatment.

Political action is a task that many of us including myself find distasteful. I find that dealing with many politicians is a very frustrating experience. It is however a necessity because, as Winston Churchill said, democracy is a poor and inefficient form of government but it is still infinitely better than any other alternative. It is here that your organization is of immense importance. Benjamin Franklin stated that if we do not hang together we will surely hang separately, and this concept surely applies to us. Through your Liaison Committee you can have a powerful voice to influence the future of sports medicine, and in this committee there is room for any of you who wish to serve this society.

These are the means which we must use to further our self-appointed task of caring for the athlete, but there is one thought that I have hinted at and I think sums up the problem. It concerns me the way the term "sports medicine" is used. We, the physicians, are the ones who practice sports medicine. Psychologists, chiropractors, and other nonmedical personnel do not practice medicine, and it is up to us to put the term "medicine" back into "sports medicine."

To return to Professor Tyler's words earlier in this presentation, I am emphasizing the complacency to apathy to dependence part. I am not particularly worried about the AOSSM becoming complacent, but history is rife with tales of dominant civilizations, social orders, football teams, and any organization that you wish to consider, that became complacent and lapsed into apathy. The major threats to our practice mentioned earlier are basically caused by nonmedical people, and if we get complacent they will gradually erode our practice and blindside us with restrictions so that one day we will wake to find "Othello's occupation's gone!"