Presidential Address of the American Orthopaedic Society for Sports Medicine

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Robert A. Stanton,* MD, *President, AOSSM*

Jimmy, thank you so much for your very kind introduction. It is an honor to follow you as president of this wonderful organization. As a kid growing up in the New York suburb of Great Neck, East Egg for you Great Gatsby fans, there was only one issue of significant concern. Who was the best centerfielder in New York? Mickey Mantle, Willie Mays, or Duke Snider. I inherited my love for the Brooklyn Dodgers from my dad, so my obvious choice was the Duke. The arguments were endless. We all had baseball cards with all the stats. I was certain that my future was to replace the Duke, a native of Southern California, who passed away this past winter. I gradually realized that I could catch anything, throw as hard and as far as the best, but I could not hit the curve ball.

It became obvious that a different direction was necessary, and here I am today unbelievably honored and humbled to serve as the 39th President of the American Orthopaedic Society for Sports Medicine.

How did I reach this position? I have always been fascinated by chance events and meetings, choices you make along the way, and how they influence where your life ends up. Let me recount a few of the people that I met early during my career, all of whom had a significant influence on me and helped me to achieve this position.

During the winter of 1971-1972, in my senior year of medical school at Columbia, I served an orthopaedic rotation at the University of Vermont. Two momentous occasions transpired that winter. Professionally, I met Past President Bob Johnson, just beginning his career at UVM. I was a member of the ski patrol at Mad River Glen and had some influence helping him start what has been a long-time UVM Clinic in the Mad River Valley. More significantly, I met Debby, my wife of 38 years, on New Year's Eve. That same year, for reasons buried in the fog of the past, I purchased a subscription to the *Journal of Sports Medicine*, now our flagship *American Journal of Sports Medicine*. I am proud to say that my library includes every issue ever published.

My oldest friend in orthopaedics is Bart Nisonson. I met Bart when I was a high school student working as a lifeguard. Bart was an orthopaedic resident at Columbia while I was in medical school and doing 2 years in general surgery. Bart left Columbia to run the Sports Medicine Service at Yale and I joined the orthopaedic residency. He gave me the opportunity to become involved in team care from the first day that I arrived in New Haven. I covered numerous games at his request. This was my first experience being on the sidelines; I was hooked. During that time I became friends with Bill Dayton, then Yale's long-time head athletic trainer. I have told many people over the years that I learned as much from Bill as I did from the orthopaedic faculty at Yale. My first piece of advice: befriend your athletic trainer. They are an invaluable resource and will make you a better sports medicine physician.

Bob Leach came to Yale to review the program while I was a resident. A 35-year friendship began. Bob is at a family event this weekend and could not be here in San Diego. I thank him for all of the insight and help that he has given me over the years. I volunteered as a physician for the Lake Placid Olympics in 1980. Bob was there working with the US Ski Team; he introduced me to Richard Steadman. A 30-year friendship and a position as physician for the US Ski Team followed. This position has given me the opportunity to meet surgeons from all over the world and greatly broadened my understanding of orthopaedic sports medicine. It is a great honor to me that my friends Otto and Traudl Muench have traveled from Garmisch-Partenkirchen to attend this meeting. Otto is an orthopaedic surgeon in Munich and physician for the German ski team. Traudl was a member of the German ski team and then the team's trainer for more than 20 years.

In 1975, while a resident, I registered to attend a knee and sports medicine course in Rochester, New York. There

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were travel issues in New York and our flight from LaGuardia was cancelled. There was another flight from Kennedy. As I was preparing to go get a cab, another passenger offered me a ride; he had a car and driver waiting. It was John Marshall, who was on the faculty. We sat together in the back of the plane. Dinner was a bag of peanuts that I shared with him. We became great friends. John came to Yale at my invite as a visiting professor. Sadly, John's talented career ended tragically in a plane crash in 1980 in Saranac Lake. John was flying to Lake Placid to stay with us and come out to the Olympic races at Whiteface. John was a brilliant clinician and researcher; he would certainly have been President of this organization. His influence on me during our short friendship was profound.

I attended my first AOSSM meeting in Williamsburg, Virginia in 1983. I knew only a few members at that point. I was warmly welcomed and immediately felt that I was part of the AOSSM family. It has always been my strong belief that if you join an organization, you should participate in its activities. My second message to you today is participate. Volunteer for a committee, present a paper or poster. This is your organization. To be a successful volunteer, you need to show up and do what you are asked to do. This point was emphasized by John Feagin in his presidential address in Sun Valley[8] in 1986, which was my first year on the newly formed Liaison Committee, chaired by Past President Fred Allman, and the predecessor to the Council of Delegates and my first volunteer activity. Walt Curl, in his presidential address,[7] made the same point about volunteering. John and Walt both continue to exemplify the principle of service and have eagerly volunteered their services to me and your organization this year. Walt was the Godfather for the SLARD Traveling Fellows trip this past spring. We can thank John and Werner Mueller for creating the Traveling Fellows program. I followed their advice and have volunteered for and served on numerous AOSSM committees, ultimately having the honor of serving as your president. Leadership in any organization is about service and responsibility. AOSSM involvement allows you to affect the direction of orthopaedic sports medicine. Your leadership strongly encourages all members to apply for service on committees; we make a significant effort to give all who ask a chance to serve. Currently, we have approximately 23 committees with 380 participants.

Let me shift gears and talk with you about an issue that has been a great concern for my entire career. The issue is ethics and sports medicine. When I opened my practice in 1977, sports medicine was in its infancy. There was a perception that the doctors who cared for athletes and did sports medicine were on the fringe of orthopaedics. The AOSSM had been formed to change this perception.

We are now in the mainstream of orthopaedics. More than a third of all orthopaedic residents pursue a Sports Medicine Fellowship. This growth in Sports Medicine has been paralleled by the rise of sports as a big business. Issues of ethics and morality have become commonplace. You cannot pick up the newspaper or watch the news without hearing about issues involving ethics: political scandals, Wall Street executives cheating, judges being bought, the relationship of some physicians to drug and device manufacturing companies, sports medicine care for sale. This last issue was discussed in a front-page article in *The Boston Sunday Globe* of March 27, 2011. Ethics in Sports Medicine is an issue and we must all consider it. Ethics may be defined as the moral principles or system of a particular school of thought. It defines the rules of conduct. My goal in the next few minutes is to raise questions and inspire thought. I am not here to lecture but to encourage all of you to contemplate these issues as you pursue a career in sports medicine.

We need to consider the following: the role of the team physician, confidentiality and informed consent, marketing and advertising, performance enhancement and use of drugs, return to play issues, and disclosure. These do not exist in a vacuum. The interrelationships are complex. Our individual integrity should define our actions. In his presidential address in 1977, our oldest living president, Les Bodnar, stated: "We must maintain our integrity."[5]

Sports medicine probably began with Hippocrates: "Do no harm." Galen, in the second century A.D., may have been the first team doctor, the doctor to the gladiators. In the 12th century A.D., Maimonides, the noted medieval rabbi, physician, and philosopher, wrote "not for profit in vision or reward." In 1495, Gabriel de Zerbia wrote "Physicians are to value integrity over fame and fortune." This rings true today. The Fédération International de Médecine Sportive was founded in 1928 by physicians serving as delegates to the second Winter Olympics. In 1997, FIMS published what is the most complete statement on medical ethics. Let me highlight a few of the principles outlined in this document, which I encourage all of you to review. "Always make the health of the athlete a priority. Never do harm. Never impose your authority in a way that impinges on the individual right of the athlete to make his or her own decisions. . . . Ethics in Sports Medicine should also be distinguished from law as it relates to sport. One refers to morality, the other to a set of enforceable social rules. Although it is desirable that the law be grounded in moral principles and that matters of moral importance should be given legal backing in many instances, not everything that is illegal is immoral and similarly not every immoral behavior is against the law. Thus when speaking of ethics in Sports Medicine, one is not concerned with etiquette or law, but with basic morality. The physician's duty to the athletes must be his or her first concern and contractual and other responsibilities are of secondary importance."[11]

Is it ethical for a university to demand that the team doctor buy advertising for the football program? What is the consequence of saying no? How would you feel as a parent of a college athlete, trusting the school to protect and nurture your child, if you knew that health care might be awarded not to the best doctor or institution but the one willing to spend the most money? We are all aware of teams, universities, and other organizations eventually putting the team physician position out to bid. Several professional leagues prohibit hospital and physician sponsorships that involve a commitment to provide medical service.

I am sure that most of you here today serve as a team physician at some level. Ethical issues increase proportional to the level of competition. Caring for a Pop Warner

football team is a labor of love. The same may apply to caring for a professional team, but economic and societal forces may create ethical conflict.

Let me quote from Teuscher et al in an article in *The Orthopaedic Legal Advisor*[12]: "What does it mean to be a team physician? Is a team physician's principal obligation to keep the athletes physically intact so that the team has a winning season? Can the team physician accomplish this objective ethically without compromising the short-term or long-term health status of an individual player? If the team physician's sole fiduciary obligation is to the player he or she is treating, then why is he or she called the team physician. Brings back memories of the old company doctors whose loyalty was to the corporation and not to the workers." To paraphrase our now deceased past president and my long-time friend and mentor, Dave Sisk, "I may be the team doctor but when you are injured, I become your doctor."

The AOSSM has issued a position statement with guidelines for selecting team medical coverage.[2] Jim Andrews spoke eloquently about this in his presidential address last year. "Therefore, the selection of a team physician should be based upon sports medicine capabilities through the best care available. The selection of team medical staff should not be based on financial incentives offered by the physician and/or his or her institution. The team should fully disclose any sponsorship, advertising, or financial arrangements that the medical staff or its institution have made with the team."[3] I encourage all of you to read this AOSSM document and share it with the schools and programs for whom you provide sports medicine services.

Marketing of sports medicine services is now commonplace. Go to Google or, for the older folks here, look in the Yellow Pages. Everyone wants to have the sports medicine moniker attached to their practice. Care for professional and college teams is all too often available for purchase.

Our founding member and past president Jack Hughston may have said it the best: "it is all bass-ackwards. How would you like to walk by a doctor's office and have him say, 'Here is 10,000 dollars, please be my patient.' I do not think you'd lie down real quick."[6] Tiki Barber, a former running back with the New York Giants, stated 10 years ago, "As soon as it becomes about money, I think the integrity and trust lessens. . . . He could be a good guy but it just doesn't feel right."[6] Our emeritus member, Thad Stanford, who is both a physician and an attorney, and who was very helpful to me when we were discussing Sports Medicine ethics a decade ago, wrote to me: "As regards the bidding for and purchasing of athletic teams, it has become an embarrassment to me. I would surmise that the athletes for whom the care has been provided assume that the doctors have been chosen solely for their expertise. This is not the case and is a form of deception. Indeed, when a hospital or HMO does the bidding and then advertises their doctors as the team doctors, the consumer is expected to assume that the team would not make that choice for any reason other than the physician's talents. The professional athlete, I assume, can go wherever he wishes for care and the team will pay for it. Not so for the college player. He or she is a captive and will make the assumption about excellence I have mentioned. Not honest."

The traditional relationship has always been between the doctor and the patient. Now the interests of the team are involved. There is a risk for decision making to be distorted. Coaches, trainers, athletic directors, administrators, parents, and the media are often interested parties. Our integrity is challenged and we must always do what is right for our patients, the athletes.

Those of us who work on the sidelines face an additional challenge, one truly unique to Sports Medicine. I am sure that all here today are aware of the basic principles of informed consent, the need to present all the facts that a prudent person would need to know to make an informed decision. This should be done in private and in a manner that is understandable. How do you handle this on the sidelines or in the locker room? Your star running back takes a brutal hit. He comes off the field under his own power slightly dazed. In a few moments, he seems normal. The dilemma is obvious. Should he return to play? While the guidelines for dealing with head injuries have become more explicit, you still need to decide. The fans are screaming, the coaches are probably asking if he can return. Even if you take him to the locker room, the correct action, the situation may not be much better. This situation is a constant in Sports Medicine and fraught with ethical pitfalls.

Is it ethical to inject Xylocaine or advise use of analgesics to allow for continued play? I recently participated in an online study being conducted by several sports fellows regarding use of IM Toradol. It is one situation to have a chat in a quiet exam room. What if the injury occurs in the first half and the only chance to have an informed discussion is in the locker room at halftime? The athlete is demanding injections so that he or she can return to play. Missing a game may affect athletes' status. They may have a professional career before them and short-term goals often cloud long-term judgment. Here the economics of sport often play a role.

What would you do with an athlete on your professional team who has a repairable medial meniscal tear? Fixing the tear is the best long-term choice; what if the athlete says that his contract is up this year and if he does not play, he may not get resigned? What if a college basketball player tears her medial meniscus with 3 weeks left in the season? The team is going to qualify for the national tournament. She is a senior and is going to medical school in the fall. Her dream has been to play in the NCAA tournament. She wants a partial meniscectomy so that she can play. You know that repairing her meniscus is best for the long-term health of her knee. Here you face the issue of patient autonomy. You and the athlete may have different goals. Should you respect her decision? How about external pressures? You are the team physician and there may well be implicit or explicit pressures from coaches, trainers, the press.

Your integrity demands doing what you think is in the best interest of the patient. The AAOS principles of Medical Ethics in Orthopaedic Surgery state,[1] "The orthopaedic surgeon should exercise all reasonable alternatives to ensure that the most appropriate care is provided to the patient.

If the conflict of interest cannot be resolved, the orthopaedic surgeon should notify the patient of his or her intention to withdraw from the relationship." Bernstein et al, in *Clinical Orthopaedics and Related Research* in 2000, wrote, "Patient autonomy trumps physician preference. The consensus is that the informed patient should be allowed to choose the medical approach that they see fit."[4]

Drugs and performance enhancement is a constant issue in Sports Medicine. It is worthy of a separate lecture and I encourage you to attend the talk by my friend Ed McDevitt on Sunday morning. He is an expert and his discussion on the ethics of drug use is superb.

Let me finish this part of my talk with some thoughts on disclosure and conflict of interest. This issue is not unique to sports medicine; it has become a national topic of conversation. Senator Charles Grassley, Republican from Iowa, has been looking into this issue for several years. He has encouraged professional organizations to post their corporate donors online. "Transparency, the public's right to know brings accountability," he said. A voluntary code of conduct created by the Council of Medical Specialty Societies requires groups to disclose industry support. Freddie Fu spoke about this issue in his presidential address 2 years ago.[9] Your Board had a lengthy discussion this past April about ethics and conflict of interest and agreed to develop guidelines including such key elements as transparency and full disclosure. The AOSSM has a long history of partnering with our corporate friends to pursue our mission of being a world leader in research and education. Many of you in the audience have a variety of relationships with the companies that make the products that allow us to care for our patients. A strong partnership with industry is critical for our mission, as well as theirs. The American Academy of Orthopaedics Standards of Professionalism, which were last revised in April 2007, clearly define the issue. "Orthopaedic surgeons must be mindful of potential conflicts of interest with patient care in pursuing academic and commercial ventures. A conflict of interest exists when professional judgment concerning the well being of the patient has a reasonable chance of being influenced by other interests of the physician. The self-interest of the physician may be financial in nature. The competing interests may involve fame and notoriety for the physician or time for the physician or the physician's family. When such conflicts exist, there is concern that care decisions may not be in the best interests of the patient. Disclosure of a conflict of interest is required in communications to patients, the public and colleagues. The benefit to the patient must be the primary goal and must not be compromised. Orthopaedic surgeons, like all physicians, have an ethical obligation to present themselves and the services they provide to patients in a clear and accurate manner. When an orthopaedic surgeon receives anything of significant value from industry, a potential conflict exists which should be disclosed to the patient. When an orthopaedic surgeon receives inventor royalties from industry, the orthopaedic surgeon should disclose this fact to the patient if such royalties relate to the patient's treatment. It is unethical for an orthopaedic surgeon to receive compensation of any kind from industry for using a particular device or medication."[1] The guidelines are specific and clearly the issue here is full disclosure. Our integrity is at stake, an issue passionately discussed by Freddie in his presidential address. In my mind, look at it this way; just do what you think is right as if no one is looking. Mark Twain once said, "Always do right. It will please some people and astonish the rest."

It is essential to the success of any organization to plan for the future. Your Board conducted a productive Long Range Planning session this past April. It was led by Tom Nelson, our first executive during the 1970s and the former AAOS executive director. Over my decade of service on the Board, Tom has led three of these. He has an amazing ability to organize thought, provoke discussion, and, most importantly, help us focus and visualize our future. Let me share with you our strategic plan.

Each initiative has specific staff with a timeline for Board review and decision. These add to our numerous ongoing initiatives.

Education

Our objective is to be the premier provider of orthopaedic sports medicine education for members and other sports medicine professions through collaboration. Two initiatives have been proposed:

1. Identify, develop and promote programs that facilitate member compliance with ABOS Maintenance of Certification requirements. Consideration should include a range of educational and practice tools designed for Parts II and IV, including publications, CME, self-assessment, practice improvement modules, and registries.
2. Thoroughly evaluate the Orthopaedic Sports Medicine Curriculum, AOSSM primary scientific meetings (Annual Meeting and Specialty Day), and members' perceptions of AOSSM educational meetings. Develop corresponding recommendations for ensuring the Society remains the pre-eminent CME provider for orthopaedic sports medicine.

Research

Our objective is to be the pre-eminent facilitator of research in orthopaedic sports medicine. Two initiatives have been proposed:

1. Identify methods and metrics for prioritizing, supporting, and funding basic science, translational, and clinical research. Utilize those metrics in assessing the effectiveness of past and future research endeavors.
2. Cultivate and expand the society's research network. Work with NIAMS, OREF, and the research community to facilitate collaboration in identifying research priorities, continuity in establishing and evaluating grants in support of those priorities,

funding to support those initiatives, and the development of research at the individual and institutional level.

Publishing

Our objective is to continue to be the pre-eminent worldwide publisher of orthopaedic sports medicine research and education. Two initiatives have been proposed:

1. Work with external resources in identifying and evaluating modifications to our publishing activities that provide a) diversification of content, b) relevance to the changing print and electronic publishing environment, c) additional revenue streams, and d) expanded opportunities for organizational collaboration and individual contribution (nationally and internationally) for AOSSM publishing interests.
2. Develop specific product recommendations to complement publishing activities, including open access publishing, online blogs, interactive products, collaborative opportunities such as Ortho Portal, and repackaging/repurposing current content.

Communication

Our objective is to disseminate information about AOSSM and its programs to our members, collaborative organizations, and the public. Two initiatives have been proposed:

1. Develop a business plan for the STOP campaign. Identify strategic objectives and metrics of success that allow the Society to prioritize activities and assess their effectiveness. Variables for consideration should include a) depth of member involvement, b) breadth of organizational collaboration, c) reach of educational activities, d) impact of effort on youth sports, and e) financial sustainability.
2. Expand non-print communication activities. Utilize digital communication vehicles to effectively reach the professional and lay communities through the AOSSM Web site, social networking, mobile applications, and other IT program development.

As I ride off into the sunset, I need to say thank you to several special people. Seven years ago, Clarence Shields called me as I was carrying my skis to the lift at Beaver Creek. As chair of the Nominating Committee, he offered me the position of secretary. He elaborated by saying that I was now in the Presidential line. I thanked him for the honor of being secretary and truly thought that this would be my last service to the AOSSM. Clarence, I always knew you were smarter than I. Four years later, standing on a street corner in San Francisco during the AAOS meeting, Bill Grana called and asked me to become Vice President. I expressed to him my belief that he must have the wrong number. He asked me quite forcefully, "Do you accept?" Yes was my answer.

Both of these Past Presidents have been great friends, mentors, and supporters. I have learned from them and every other Past President of this society. Bill spent a good part of his Presidential address discussing stewardship, expanding on Tom Wickiewicz's address of the previous year. *Steward* is derived from 2 French words that mean house and warden—so the warden of the house, Bill said. "As a steward, the leader of the AAOSM assumes the responsibility for the welfare of the organization."[10] Bill, I hope that I have lived up to this responsibility.

We are blessed to have an outstanding staff. I spent a day in the office in April meeting with each of our staff. They are uniformly enthused about and engaged in the work that they do for the AOSSM. I told them then, and repeat today, that I know that I would not be standing here if not for their help, support, and advice. Our executive director, Irv Bomberger, and managing director, Camille Petrick, are the glue that keeps the AOSSM focused and moving forward. I will greatly miss my weekly call with Irv and my nearly as frequent communications and meetings with Camille. I count both of them as friends for life.

To the Board of Directors, thank you so much for your support and guidance. You have made my job easier and guided the organization towards a bright future. The AOSSM is lucky to have my long-time friend Pete Indelicato as the next president. I know that he will be a superb steward, as will our future leaders Chris Harner and Jo Hannafin.

This outstanding program could not have occurred without the hard work and dedication of my program chair, Marlene DeMaio, and the program committee. Marlene, I can never thank you enough for saying yes to my request.

It is impossible to ever thank one's family enough. Debby, my wife of 38 years, never fails to guide me in the right direction (and I can be very stubborn) and provide me the support that has allowed me to achieve the honor of serving as President. I am so proud that my son, Jim, could be here today. He has given us two great grandsons—Jack is 2½ and Ridley's first birthday was on Wednesday. Thank you for choosing to be here. Traveling across the country with them would have been a major challenge, so Christina and the kids are enjoying some time at the family house in Northeast Harbor. Debby and Camille have organized a great family night at The Children's Museum tomorrow. We look forward to seeing you there.

Be sure to be here tomorrow to listen to my Presidential Guest Speaker, Frank Deford. Thank you.

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