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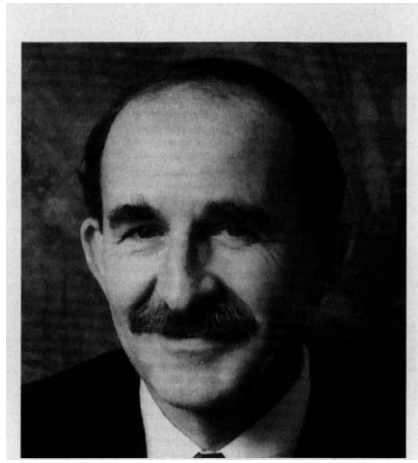

Presidential Address of the American Orthopaedic Society for Sports Medicine

Vicissitudes of Life and Medicine*

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Sitting here on an island off the coast of Maine gives one time to think about issues, both small and large, personal and professional, and of how few things in life progress in a linear fashion. Seemingly only the stock market of late goes straight up.

Certainly my life at sea, if you will, has not been a perfect success: although I usually arrive at my destination, my boat overheats on the way to the island and all aboard panic. During my first trip for mussels, my wallet disappears in the deep; on my second trip, in a 13-foot whaler, the steering fails so that I could only go in circles.

Hopefully, these are not reflections on my presidency.

My adventures at sea remind me how in medicine and life all can appear calm before wind and trouble strike, yet we usually find the right way. Both our Society and medicine in general are confronted by many forces, not all of which can we control.

This organization has meant a great deal to me because I have learned much and made many friends through my participation in it. My introduction to this Society was through the late Dr. John Marshall, who was the first director of sports medicine at the Hospital for Special Surgery. John was extremely enthusiastic and active in research and education; he encouraged Dr. Steven Arnoczky to join our staff in I believe the same year I returned to HSS (1979). Although he was not a founding member of this organization, John gave presentations at many meetings. He encouraged my involvement, which enabled me to develop my areas of interest in trauma and diseases of the shoulder and knee.

His sudden death following the AAOS meeting in 1980 was a shock to each of us. I will never forget receiving the call at 3 A.M. following his crash on the way to the 1980 Winter Olympics at Lake Placid. Subsequently, I was made head of our section and, with Steve Arnoczky, attempted to continue much of his work. John's great interest was the ACL; he was convinced of its importance after having seen so clearly the problems associated with it in the dogs he had treated as a veterinarian prior to becoming an orthopaedic surgeon.

Looking at today's program it is difficult to realize that there ever was a debate in this area, but there was an intense one during the 1970s on the importance of the ACL for knee function. Dr. Marshall believed that Ivan Palmer's work in the late 1930s was correct, but it took us nearly 40 years to accept it.

John's legacy to our program at HSS was to build an orthopaedic sports medicine section that played a larger role in our (HSS) academic center. Some of you may not recall but until recently, sports medicine in many academic orthopaedic departments seemed to have a slightly negative cast. It was thought that this field was not really "academic" or that it did not require any specific effort to obtain knowledge as in other given fields.

Actually, if one goes back two or three decades, this feeling is not very different from the attitudes of many in academics concerning the field of orthopaedics in general. I can still remember our chief of cardiac surgery attempting to talk me out of specializing in orthopaedics, noting that all those involved in that field really do is straighten broken

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bones. Both orthopaedics and the sports medicine component have come a long way since then.

This organization and its early founders—many of whom are here today—have played a major role in educating our members and those participating in orthopaedics at large, as well as promoting research and providing a forum for discussion. This aspect of your organization—acting as a forum for your presentations and discussions—is one of its greatest attributes. Each of you has important thoughts to offer; if you try, you can and will participate.

For me, this presentation-style approach to education has tremendously heightened my interest in getting involved. In fact, during the time I was in private practice in Lynchburg, Virginia (1973 to 1976), it was at one of these meetings in which I was in the audience listening to a Dr. William Clancy that I decided to try to participate at some level. Basically, "Billy" had been my intern on a surgical service in New York and I thought that if he could present a paper, anyone could! Just kidding, Bill. In any event this led to my seeking a fellowship with Dr. Charles Neer and returning to HSS.

Sports medicine, which to date has involved the community orthopedic specialist to a greater degree than those in academic centers, demonstrated the tremendous interest and need that was initially only being met by a few centers such as the Cleveland Clinic, then led by Royer Collins. Certainly there is a need for both community orthopaedic specialist groups, group practices, and academic centers to promote research and educational efforts. Each brings different advantages to the table: patient care issues can often be evaluated in community settings, but as research becomes more basic there is a greater need for centers to play a role. Creating a sports service and attempting to have it grow is more difficult in a center where space and personnel are often limited and there may be conflicting opinions. Also, funding becomes an increasingly difficult issue as the National Institutes of Health presently supports less than 10% of approved grants. This organization with its fundraising arm—the Foundation for Sports Medicine Education and Research (FSMER), in conjunction with the Orthopaedic Research and Education Foundation (OREF)—has helped in this area greatly, but often individuals are called upon to support their own ideas and research goals. We will ultimately need better funding on a national level if basic research is to improve in our field.

In the past, much of our work has been anatomical, with an emphasis on function and clinical results. The basic science has been more on structural issues and there has been little focus on biology. We are very much behind some fields in this regard, but we are improving rapidly. Academic centers need to play a larger role in the cell biology component of soft tissue and sports medicine research because a significant support staff is often necessary.

Our goal is to increase our basic science knowledge to improve our patient care. As we learn more about how cells migrate in response to injury and repair, we may learn how to further strengthen or replace tissues or even how to avoid some injuries. Certainly some individuals appear prone to certain types of injuries and their repair is more problematic. If defects can be identified in collagen, then genetically altered cells may be able to correct the defect.

The future of sports medicine presents opportunities and challenges. Your Society has had difficult times and has weathered the storm. As recently as the late 1980s, significant financial problems led to a balance of only $7,000 in our account. After a close scrutiny of accounting principles, we have progressively improved so that we presently have a reserve of close to 1 million dollars, representing a little over 1 year's expenses. Your Board, over the past 6 years, has worked hard to improve this financial picture to the point where it is.

Your Board acts mainly by consensus and attempts to find solutions to problems put forth by the membership and the Council of Delegates. It attempts to develop initiatives in areas of future concerns. The Board attempts to act in the long-term interests of you as a group. For instance, CAQs (certificates of added qualification) is such an issue that has been discussed at some length in the past. The CAQ, while having pros and cons, was put forth as having ultimate value for membership. Your Public Relations Committee, in response to the Council of Delegates, is attempting to add value to membership by improving name recognition and making AOSSM synonymous with sports medicine.

With success can come problems. These relate particularly to size: as we grow we have lost much of our ability to function as a small family-oriented meeting. To date we have retained the partial-day programming that we all enjoy; however, an increasing number of abstracts places pressure on the program committee.

Some have raised questions as to our membership criteria. Should they be more or less strict? Should team coverage be deleted as a requirement? Personally, I believe that team coverage is one of the main criteria that separates us from being a technical group, and that losing this as part of membership criteria would be a step backward. Although we are surgeons, many of our real skills are in deciding when not to operate and how to return individuals to play safely.

Medicine itself has its own vicissitudes that depend to some degree on research advances, economics, and politics. Many are concerned that the great success of the past 50 or more years is about to cease, that medicine as we have known it will disappear, that individualism will be lost and we will be employees of one large HMO, if not your government.

Yes, this is a time of change. Costs have gotten out of hand and change is occurring rapidly, whether we like it or not. With change will come opportunities and problems. Managed care supporters tend to think little about research or education and more about the bottom line, and hopefully, patient care. Research education—the training of residents and fellows—and caring for those without the ability to pay are not their main interests.

On the other hand there are some positive effects that occur when a system is stressed. We have seen the rate of medical inflation cut drastically to about 5.5% from about 12%. Certainly each of us has thought twice about using an

extra shaverblade while performing an ACL reconstruction. If you have not yet, then you will in the near future, because cost effectiveness as well as quality of care are both going to control patient activities.

Although I am concerned, I do not believe that all patients will give up their rights to choose their physicians. Our task is to provide choices and to help educate our patients about the importance of choice.

The success of HMOs in the New York area is often based on providing POS (point of service contracts). If this is removed, lost, or given up, we need to educate our patients about its importance and encourage them to use plans that offer POS.

In addition, we should not give up on the concept of orthopaedics, and particularly our field of sports medicine, as being primary care providers. Certainly our team coverage is primary care and the reason why we need to stay active as a leader in team care.

We need also to help patients realize when their self-interests are not being served by an HMO and what to do about it. These HMOs will listen to their clients better than us. Probably the best recent example of this is in the field of obstetrics, where several states, including New Jersey, have given back to the patient and doctor the right to decide if the patient should stay in the hospital for 48 hours after delivery and the HMO has to pay the hospital bill.

Our future is bright, as the need for musculoskeletal care and preventive programs will only increase as our society ages and leisure time and recreation increase. Our goals need to address how athletics and conditioning lead to a healthier individual who can delay the effects of aging.

Our future of improved patient care, if soundly based on good research and outcome studies, will ultimately succeed. I encourage each of you, particularly our younger members, to set goals for yourself, to ask good questions, and to participate in this American Orthopaedic Society for Sports Medicine. We need each of you, your enthusiasm and your energy.

The trip is well worth the effort.