NEWSLETTER OF THE AMERICAN ORTHOPAEDIC SOCIETY FOR SPORTS MEDICINE

sportsmedicine UPDATE

SEPTEMBER/OCTOBER 2013



CONSENSUS STATEMENTS

- Team Physicians
- Sports Medicine Management in Schools

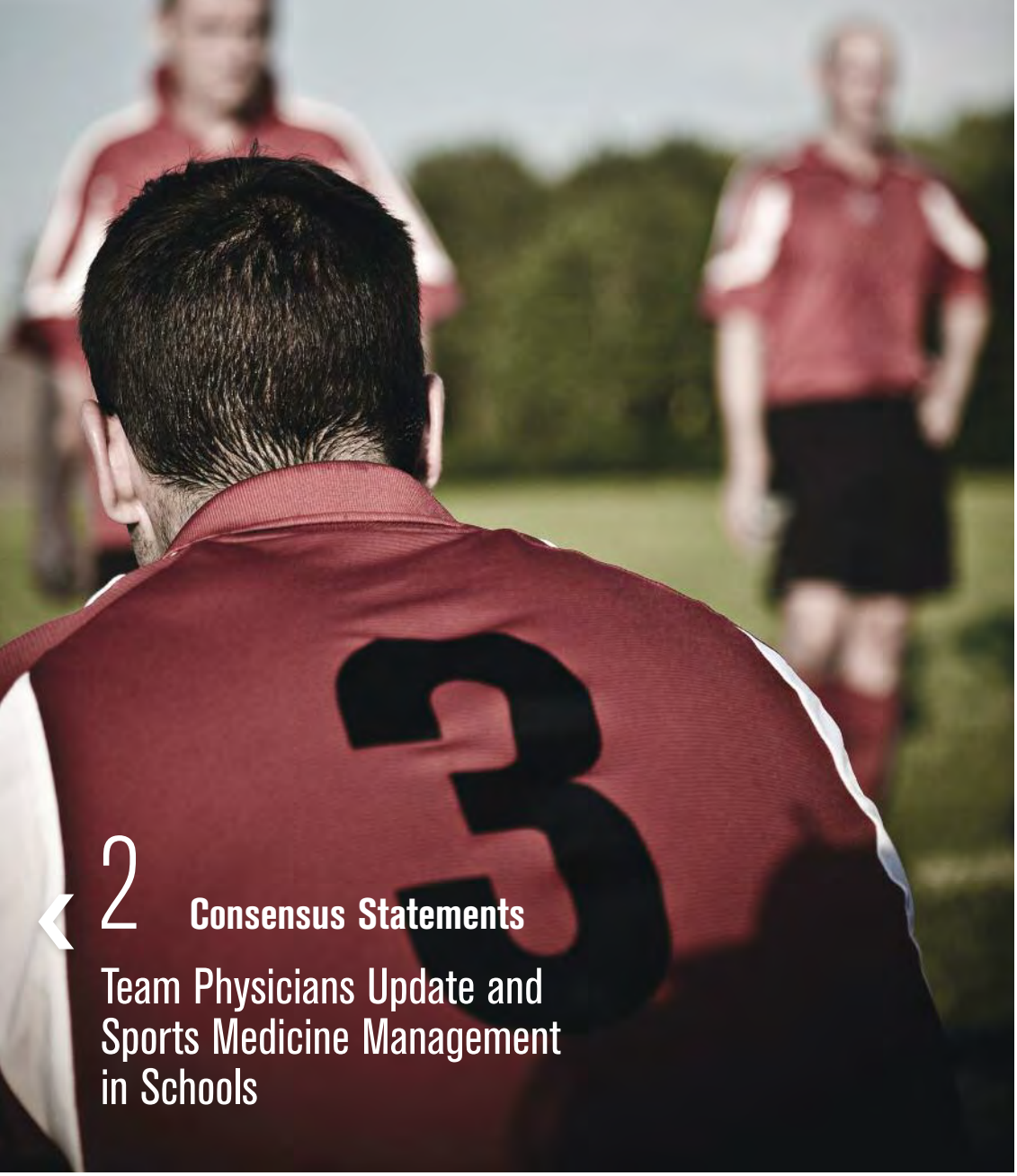
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SPORTS MEDICINE UPDATE is a bimonthly publication of the American Orthopaedic Society for Sports Medicine (AOSSM). The American Orthopaedic Society for Sports Medicine–a world leader in sports medicine education, research, communication, and fellowship–is a national organization of orthopaedic sports medicine specialists, including national and international sports medicine leaders. AOSSM works closely with many other sports medicine specialists and clinicians, including family physicians, emergency physicians, pediatricians, athletic trainers, and physical therapists, to improve the identification, prevention, treatment, and rehabilitation of sports injuries.

This newsletter is also available on the Society's Website at www.sportsmed.org.

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FROM THE PRESIDENT: INVESTING IN CHANGE BY GETTING INVOLVED



When perusing the findings from our 2013 Annual Meeting survey, I was pleased to see many positive remarks from those who attended the meeting. Along with the many kudos were constructive suggestions designed to enhance the meeting, including providing optional formats for viewing abstracts, outlines, and posters; increasing images of diversity in artwork; altering the agenda and schedule to increase the academic time available for podium presentations and discussion, and many others. The comments were wide ranging and they sometimes were diametrically at odds with each other. But the input was genuine and will be helpful as we prepare for our 2014 meeting in Seattle.

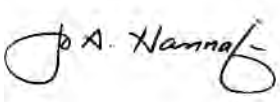
One of my priorities as president is to facilitate and integrate this broad cross-section of member input into all facets of our Society. The AOSSM has substantially evolved since I joined the Society in 1997, with a membership that is much larger and broader than ever before. I believe the breadth of members' perspectives, skills, expertise, and active involvement is the Society's most valuable asset. The input of a diverse cross-section of our membership is critical for AOSSM's achievements to continue to align with the needs of members. Providing meeting feedback is but one way for the Society to be responsive to your interests and concerns. The AOSSM will be sending out a member survey which will arrive shortly after this edition of *Sports Medicine Update.* Please provide your feedback as you have the opportunity and responsibility to help shape this organization moving forward.

The election of the nominating committee is another critical role that our members play. The members of this committee are both nominated by and elected by the membership and will be responsible for creating our next slate of officers for the AOSSM Board, including vice president, treasurer, secretary, and open at-large positions. We're asking all members to vote online, and the article on page 14 tells you about what the process entails.

The Traveling Fellowship provides you with yet another unparalleled way to get involved in the profession—either as fellow or as host—and to establish lifelong professional relationships in the U.S. and abroad. Next year the Society is offering tours to South America and Europe that will be led by outstanding godparents. Information about the 2013 tour and the process and deadlines for application for the 2014 tour are included on page 20.

Finally, in the November/December issue of *SMU,* we will be soliciting volunteers for committee assignments. There is no better way for you to become involved with the Society's activities than participating in a committee. We are fortunate to have many talented members of the AOSSM and I ask that you volunteer to serve on a committee in an area that matches your interests and expertise.

In early August, I had the pleasure of representing the Society in the groundbreaking ceremony for our new orthopaedic headquarters and Orthopaedic Learning Center. The Society is investing in this venture so that we have a facility that will serve our profession for years to come. As we build that new structure, it is equally important that we continue to invest in change as a Society so that we can remain a vibrant, effective profession. Your investment in the Society will help ensure that will happen.



Jo A. Hannafin, MD, PhD



Team Physician Consensus Statement

2013 Update, Special Communications

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Team physicians have the leadership role in the organization, management, and provision of care of athletes in individual, team, and mass participation sporting events. This document describes the definition, qualifications, education, duties, and responsibilities of the team physician fulfilling this role.

Goal

Since the publication of this statement in 2000, the roles and responsibilities of the team physician have evolved. The goal of this update is to outline the duties of the team physician to best serve athletes. To accomplish this goal, the team physician should possess, be responsible for, and/or understand:

- medical qualifications and education,
- medical and administrative duties and responsibilities,
- ethical issues, and
- medicolegal issues.

Summary

The Team Physician Consensus Statement delineates the qualifications, duties, and responsibilities of the team physician and provides guidelines to individuals and organizations in selecting team physicians. These delineations and guidelines provide a foundation for best practices in the medical care of athletes and teams. The team physician's education, training, and experience uniquely qualifies him or her to provide the best medical care for the athlete.

This document is not intended as a standard of care and should not be interpreted as such. It is only a guide and, as such, is of a general nature, consistent with the reasonable, objective practice of the healthcare profession. Adequate insurance should be in place to help protect the physician, the athlete, and the sponsoring organization. This document was originally developed as the first in the team physician consensus series, representing an ongoing project-based alliance of the major professional associations concerned about clinical sports medicine issues. The organizations are the American Academy of Family Physicians, the American Academy of Orthopedic Surgeons, the American College of Sports Medicine, the American Medical Society for Sports Medicine, the American Orthopedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.



THE TEAM PHYSICIAN

Must have an unrestricted medical license and be a medical doctor

Especially proficient in prevention and care of musculoskeletal injuries and medical conditions

Responsible for medical care of athletes at all participation levels

Clears athlete to participate and return to play



The Team Physician Defined

The team physician must have an unrestricted medical license and be a medical doctor (MD) or doctor of osteopathy (DO). He or she has the leadership role in the organization, management, and provision of medical care for individual, team, and mass participation sporting events. The most important responsibility of the team physician is the medical care of athletes at all ages and all levels of participation.

The team physician should possess special proficiency in the prevention and care of musculoskeletal injuries and medical conditions encountered in sports. The team physician integrates medical expertise with medical consultants, certified and/or licensed athletic trainers, and other allied health care professionals (athletic care network). Aided by the athletic care network, the team physician also educates athletes, coaches, parents/guardians, and administrators. The team physician is ultimately responsible for the clearance to participate and the return-to-play (RTP) decision.[5]

Medical Qualifications and Education

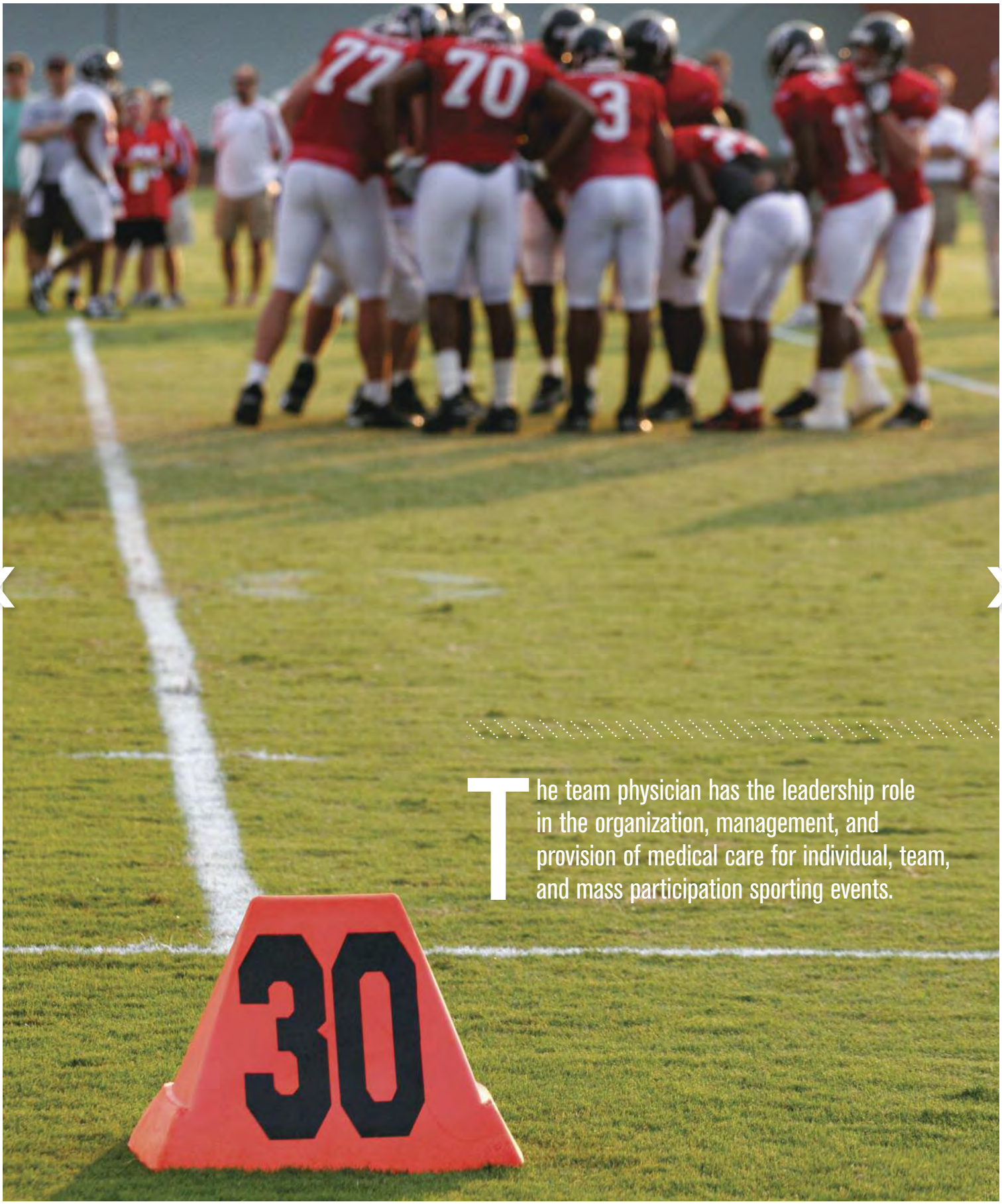
Since the primary responsibility of the team physician is to provide optimal medical care for athletes, the team physician must possess certain qualifications and education. Additional qualifications and education may be required for team physicians for some collegiate, national, and professional teams.

It is essential that the team physician:

- is an MD or a DO in good standing, with an unrestricted license to practice medicine;
- possesses a fundamental knowledge of on-field medical emergency care (e.g., concussion, cardiac emergencies, spinal injuries, heat-related illnesses);
- is trained in basic cardiopulmonary resuscitation and automated external defibrillator use;[4] and
- has a working knowledge of musculoskeletal injuries, medical conditions, and psychological issues affecting the athlete.

It is desirable for the team physician to have clinical training/experience, including the following:

- Medical specialty board certification
- Fellowship training in sports medicine
- Additional American Council of Graduate Medical Education (ACGME)/ American Osteopathic Association (AOA) certification in sports medicine
- A significant portion of clinical practice focused on sports medicine
- Continuing medical education in sports medicine
- Membership and participation in a sports medicine professional association or society
- Involvement in teaching, research, and publications related to sports medicine
- Training in advanced cardiac and trauma life support (ACLS/ATLS)
- Knowledge of medicolegal, disability, and workers' compensation issues
- Media training including communication skills and knowledge of social media



The team physician has the leadership role in the organization, management, and provision of medical care for individual, team, and mass participation sporting events.

Medical and Administrative Duties and Responsibilities

It is important for the team physician to be available and accessible and to maintain sport-specific knowledge and experience to provide medical care for the athlete. The team physician should also be involved in the medical and administrative aspects of team care.[4] Certified and/or licensed athletic trainers and other members of the athletic care network report to the team physician on medical issues. As in all areas of medicine, there are ethical and medicolegal issues that need to be identified and managed.

Medical Care

It is essential that the team physician:

- establishes a chain of command for injury and illness management;
- coordinates the assessment and management of game-day injuries and medical problems;[4]
- makes the final decisions on clearance to participate, same-day RTP, and post-game-day RTP;
- understands the importance of the preparticipation examination (PPE);
- understands medical management and prevention of injury and illness in athletes;
- recognizes other issues that affect athletic performance, including strength and conditioning, nutrition, ergogenic aids, substance abuse, and psychological response to injury;
- recognizes unique issues in females, master athletes, adolescent athletes, and other defined athletic populations;
- integrates medical expertise with the athletic care network; and
- provides for documentation and medical record keeping.

It is desirable that the team physician:

- is familiar with the Team Physician Consensus Statement series (www.acsm.org);
- performs the PPE;
- reviews PPE performed by others to address identified conditions that may affect athlete health and safety;
- provides ongoing medical care beyond game-day/event coverage;
- is involved in injury and illness prevention;



- addresses other issues that affect athletic performance, including strength and conditioning, nutrition, ergogenic aids, substance abuse, and psychological response to injury;
- addresses unique issues in female, master, adolescent athletes, and other defined athletic populations;
- understands the effect of exercise and sports participation on medical conditions as well as the effect of medical conditions on exercise and sports participation;
- develops and participate in the selection of the athletic care network; and
- educates athletes, parents/guardians, coaches, and administrators.

Administrative Duties

It is essential that the team physician

- is aware of or involved in the development and rehearsal of an emergency action plan;[1,4]
- is aware of or involved in other aspects of sideline and event preparedness (e.g., environmental concerns, supplies, equipment, medication, policies, postseason review);[1,4] and
- develops an agreement of medical care and administrative responsibilities between the team physician and the organizing body, including a reporting structure from the athletic care network.[4]

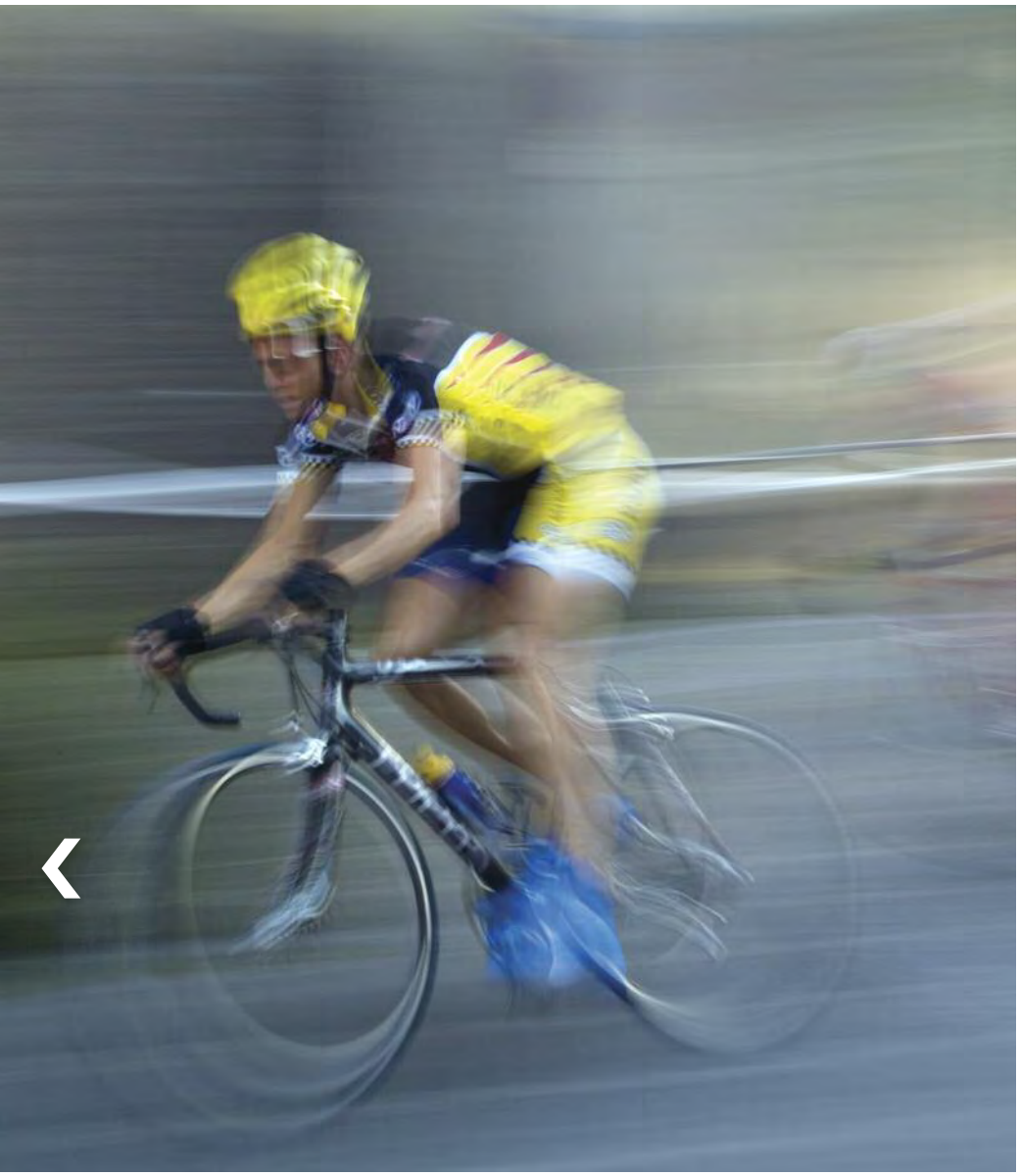
It is desirable that the team physician:

- oversees the development and implementation of the emergency action plan as well as other aspects of sideline or event preparedness;
- obtains a written agreement outlining medical care and administrative responsibilities;[4] and
- educates athletes, parents/guardians, administrators, coaches, and other interested parties.

Ethical Issues

Ethical challenges are present for all physicians, including team physicians. These challenges may have unique presentations in sports medicine. Examples of ethical challenges include the following:

- Confidentiality: respecting the rights of patients and safeguarding confidences within the constraints of the law. The confidentiality relationship with athletes may need to be clarified in advance. Examples include the following:
  - Information disclosure compliant with the Health Insurance Portability and Accountability Act (HIPAA) and the Family Educational Rights and Privacy Act (FERPA)
  - Athlete's medical and psychological conditions that affect participation and well-being[2]
  - Athlete's medical condition(s) that affects other participants
  - Drug testing results
- Informed consent: the content of information and the process of supplying information in order for the athlete and/or parent/guardian to make an informed decision.



Examples include the following:
- Discussion of all reasonable treatment options, including short- and long-term risks and benefits
- Athlete autonomy/desires versus optimal medical treatment
- Occasions and locations for which informed consent must be given in time-sensitive situations (e.g., training rooms, sideline)

- Conflict of interest: any factor that may compete or interfere with the physician/patient relationship. The disclosure and management of potential conflicts is essential. Examples include the following:
  - Financial relationships with industry
  - Financial relationships with a team/organization
  - Personal/professional gain versus welfare of the athlete
- Influence of third parties: implicit or explicit influence on medical decision making. Examples include the following:
  - Pressure from teammates, coaches, and administrators
  - Pressure from parents/guardians, community, media, and social media
- Drug use. Examples of ethical challenges include the following:
  - Pressure to supply/administer, hide use of or provide counsel regarding illegal, illicit, or performance-enhancing drugs
  - The use of local or systemic pain medications to allow participation
- Advertising/marketing/publicity. Examples of ethical challenges include the following:
  - Individual or corporate payment to the team to be a team physician
  - Individual, corporate, or institutional payment to the team for sponsorship or naming rights
- New products and technology. An example of an ethical challenge is as follows:
  - Endorsement, utilization, or prescription of treatments, medications, devices, and equipment without evidence of efficacy or safety.

The overriding principle for all physicians, including team physicians, in managing ethical issues is to provide care focused on what is best for the patient and only for the patient. An effective way to address ethical challenges is to obtain the greatest possible clarity regarding the team physician's relationship with all interested parties (athlete, parent/guardian, and club/team/organization) when the relationship is established. Disclosure and management of potential conflicts is essential.

Medicolegal Issues

Medicolegal issues are present for all physicians, including team physicians. Some ethical issues may also be viewed in a medicolegal context.[6] Medicolegal issues may have unique presentation in sports medicine. Some key areas of potential medicolegal liability include the following:
- Compliance with school and governing body guidelines, standards, policies, regulations, and rules[3,4]
- Compliance with local, state, and/or federal rules, regulations, and laws[3,4]
- Compliance with privacy laws (HIPAA and FERPA)
- Decisions made as a result of the PPE, clearance to play, waivers, and RTP
- Evaluation and management of significant on-field injuries and illnesses (e.g., concussion, cervical spine, cardiac, and heat-related illness)
- Medical record documentation

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Summary of the "Inter-Association Consensus Statement on Best Practices for Sports Medicine Management for Secondary Schools and Colleges"

DANIEL J. SOLOMON, MD
Past Chair, AOSSM Publications Committee

Recently the National Athletic Trainers Association led the Inter-Association Workgroup, including the American Orthopaedic Society for Sports Medicine, represented by Past President Peter Indelicato. Without a doubt, the consensus emphasizes the importance of physician-led athlete-centered care.

To review the complete statement visit: http://www.sportsmed.org/Publications/Other_Professional_Resources/Consensus_Statements/.

With more than 1.4 million high-school sports injuries and over 200,000 collegiate level sports injuries, the need to have well-organized and coordinated care remains critical. As we all know, caring for athletes can be tricky; pressure comes from the coach, athletic department, athlete, family, fans, etc. We must always keep the interest of the health and well-being of the athlete as the primary concern. To that end, the consensus paper was written "to help guide superintendents of schools, secondary school athletic directors, college/university athletic department administrators, athletic trainers, and team/school physicians by presenting the best practices in sports medicine management in the secondary and collegiate setting." This document outlines important considerations regarding:

- Duties and responsibilities of the athletic trainer and team physician
- Supervisory relationships and the chain of command within the sports medicine team members
- Decision-making authority relating to approval for participation of student-athletes, as well as injury management and return to sport participation status following injury/illness
- Administrative authority for the selection, renewal, and dismissal of related medical personnel
- Performance appraisal tools for the sports medicine team

Schools are recommended to have at least either an MD or DO physician director and an athletic health coordinator (preferably an athletic trainer certified by the NATA). This consensus statement defines the role of each key member.

The team physician should:

- Develop a chain of command (team physician should be highest with regard to any medical decisions and care)
- Plan for athletes' safe return to participation after injury or illness
- Coordinate pre-participation screening and evaluation
- Manage on-field injuries



- Provide for medical management of injury and illness
- Coordinate rehabilitation and return to participation
- Integrate medical expertise, as necessary
- Educate and counsel athletes concerning nutrition, strength and conditioning, ergogenic aids, substance abuse, and other medical issues which could affect the athlete
- Document and keep records
- Communicate among necessary parties concerning athletes' health
- Plan and train for emergencies
- Address equipment and supply issues
- Provide for proper event coverage
- Assess environmental concerns and playing conditions

The athletic trainer should:

- Provide injury prevention, recognition, diagnosis, referral, treatment and rehabilitation.
- Develop and implement a comprehensive emergency action plan
- Establish criteria for safe return to practice and play
- Establish and operate treatment facilities that follow standards of care
- Determine which venues and activities necessitate presence of the athletic trainer and/or the team physician
- Maintain/create guidelines for selection, fit, function and maintenance of athletic equipment
- Maintain accurate medical records
- Review design and implementation of strength and conditioning programs
- Establish a safe practice and playing environment (monitor environmental risks and meteorological conditions)
- Communicate with coaches in cooperation with the team physician (HIPAA/FERPA rules apply)
- Communicate with parents in cooperation with the team physician

Supervisory relationships vary because a huge range of school socioeconomic and budgetary factors exists, thus a wide range of staffing and resource options exist. Each of these have there own nuances. Team physicians are encouraged to understand their responsibilities to provide care and to evaluate and supervise athletic trainers even though

the athletic trainer may have a separate and unique employer. More details can be found in the complete consensus statement regarding these relationships.

There is no doubt that decision making and hierarchy factors, sometimes with intense conflict of interest potential, are omnipresent. Institutions are obliged to provide for the welfare of their athletes; they must establish a clear line of unchallengeable authority to the team physician and athletic trainer. This ability to act unencumbered allows the medical decisions to be made in the athletes best interest. However, all involved parties share responsibility for sports safety.

The consensus statement also discusses athletic trainer selection, retention and dismissal policy and procedure recommendations. Additionally, the statement includes sections on staff performance appraisal, program evaluation, teaching opportunities, and athletic training service metrics.



10 PRINCIPLES TO GUIDE ADMINISTRATION OF SPORTS MEDICINE-ATHLETIC TRAINING SERVICES

1. The physical and psychosocial welfare of the individual athlete must always be the highest priority of the athletic trainer and team physician.
2. Any program that delivers athletic training services must always have a designated medical director.
3. Sports medicine physicians and athletic trainers must always practice in a manner that integrates the best current research evidence within the preferences and values of each athlete.
4. The clinical responsibilities of an athletic trainer must always be performed in a manner that is consistent with the written or verbal instructions of a physician or standing orders and clinical management protocols that have been approved by a program's designated medical director.
5. Decisions that affect the current or future health status of an athlete who has an injury or illness must only be made by a properly credentialed health professional.
6. All aspects of the care process and changes in the athlete's disposition must be thoroughly documented.
7. Coaches must not be allowed to impose demands that are inconsistent with the guidelines and recommendations established by sports medicine-athletic training professional organizations.
8. An inherent conflict of interest exists when coaches or athletic program administrators primarily determine an athletic trainer's role delineation and employment status.
9. Administrative personnel who lack healthcare expertise must not primarily judge an athletic trainer's professional qualifications and performance evaluations.
10. Universities, colleges, and secondary schools should adopt an administrative structure for delivery of integrated sports medicine and athletic training services to minimize the potential for any conflict of interests that could adversely affect the health and well-bearing of athletes.



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Join the conversation on youth sports injury prevention with the STOP Sports Injuries Campaign's monthly tweet chats! Follow the #SportsSafety hashtag at 9 PM ET/8 PM CT on the following dates:

September 11, 2013
TOPIC: Return to Fall Sports

October 9, 2013
TOPIC: Rugby Injuries

November 13, 2013
TOPIC: Football Injuries

December 11, 2013
TOPIC: Safe Winter Play/Cold-Weather Safety

Questions, contact Joe Siebelts at joe@aossm.org.

New Supporting Organizations of STOP Sports Injuries Campaign

Sports Medicine Practices

All Star Orthopaedics
Irving, Texas

Center for Musculoskeletal Function
Palm Beach Gardens, Florida

Dr. John T. Cece, DC
Waldwick, New Jersey

Movement Logic Physical Therapy
Lambertville, New Jersey

One Accord Physical Therapy
Phoenix and Casa Grande, Arizona

Rachel Loeb Chiropractic and Wellness
St. Louis, Missouri

South Florida Health
Pembroke Pines, Florida

South Shore Orthopedics
Hingham, Massachusetts

Medical Institutions

Rothman Institute
Philadelphia, Pennsylvania

Yakima Valley Memorial Hospital
Yakima, Washington

Sports and Recreation Organizations

Fitness Solution 24/7
Lima, Ohio



STOP Sports Injuries thanks the following companies for their support of the campaign:

Arthrex

DePuy Synthes MITEK SPORTS MEDICINE COMPANIES OF Johnson & Johnson

smith&nephew





TOP: Irv Bomberger, Rosemont Mayor Stephens, Jo Hannafin, MD, PhD, and Freddie Fu, MD, toss the ceremonial first shovel of dirt during the groundbreaking.

LEFT: Past President, Freddie Fu, MD, Current President, Jo Hannafin, MD, PhD, and AOSSM Executive Director, Irv Bomberger pose with the "building orthopaedics together" bone during groundbreaking ceremonies.

NEW BUILDING BREAKS GROUND

On August 8, leaders from the AOSSM, AAOS, AANA, AAHKS, and the Orthopaedic Learning Center celebrated the ceremonial groundbreaking at the site of the all new orthopaedic building, which will be 180,000 square feet and house more than 25 specialty orthopaedic organizations and a state-of-the-art Orthopaedic Learning Center (OLC).

The new building, expected to be complete in 18 months, will be built on the northwest corner of River and Higgins Roads in Rosemont, Ill., on 2.2 acres of a 5-acre plot of land. The headquarters will be on the east end of the site, and a 155-room hotel is planned for the west end of the site.



Put All Your CME Credits in One Spot

The AOSSM and the AAOS have collaborated on transferring AOSSM CME credit to a comprehensive CME transcript in the AAOS Learning Portfolio. The AAOS Learning Portfolio helps you track CME credits you have earned. Now all of your AOSSM and AAOS CME certificates will be available in one location.

If you would like AOSSM to transfer your CME credit to your AAOS Learning Portfolio, please log in to www.sportsmed.org and select the "Get My CME Transcript" option in the drop-down menu, under My AOSSM. When your AOSSM CME Transcript opens, click the "Transfer My CME Credit" link. You'll be prompted to log in to the AAOS site using your AAOS member ID and password. Once you've successfully logged in, you'll receive a confirmation message.

When you opt in to the CME transfer, AOSSM will begin sending the AAOS your CME credits for the last 3 years. This time span matches the ABOS reporting timeline. Each time you complete an AOSSM CME activity, your credit will be transferred to your AAOS Learning Portfolio. Your AOSSM CME will remain on file with AOSSM and will be available at any time.

Questions, contact Director of Education, Susan Brown Zahn at susan@aossm.org.



New AOSSM Disclosure System Now Available

The next time you log into www.sportsmed.org to update your disclosure, request that your current disclosure information on record with the AAOS be shared with AOSSM. Just click the "Sign Up to Disclose through the AAOS Disclosure System" link! All of your current disclosure information as well as any subsequent updates you submit to AAOS, will then be sent to AOSSM for inclusion in educational activities and Board of Directors' meeting information per AOSSM policy.

Pay Your AOSSM Membership Dues Online

Invoices were sent in early August to all AOSSM members via e-mail. Please remember that dues are to be paid within 30 days of receiving your notice. Contact the Society if you have recently changed your e-mail or wish to have it sent to a different address. Any questions can be sent to Debbie Czech, Manager, Member Services, at debbie@aossm.org.



UPCOMING RESEARCH DEADLINES

AOSSM provides more than $250,000 of research money to orthopaedic sports medicine specialists each year. Deadlines for awards are approaching fast:

For more information and details visit www.sportsmed.org/researchawards and www.sportsmed.org/researchgrants.

Research Awards
November 1

Young Investigator Grant
December 1

Kirkley Grant
December 1

AOSSM Hall of Fame Nominations Around the Corner

Do you know someone who deserves to be inducted into the AOSSM Hall of Fame? Be on the lookout in November for an e-mail soliciting nominations. Questions, contact Camille Petrick at Camille@aossm.org.

Online Voting Available Soon for the 2013–2014 Nominating Committee

The election of the 2013–2014 AOSSM Nominating Committee will begin in mid-September and be online. Watch for an e-mail from AOSSM with an e-ballot link. To ensure voting is anonymous and secure, you will receive a second e-mail after you vote asking to confirm the ballot. **Your vote will not count until you confirm the ballot in the second e-mail.**

Peter Indelicato, MD, will serve as Chair of the 2013–2014 Nominating Committee with Past Chair, Robert Stanton, MD, Ex Officio. The seven nominees for the four Nominating Committee positions are:

- Michael Maloney, MD
- Eric McCarty, MD
- Edward McDevitt, MD
- Claude T. Moorman, MD
- Matthew Provencher, MD
- Scott Rodeo, MD
- Dean Taylor, MD

Watch for the e-mail, vote for four, and be sure to confirm your vote!

ARE YOU A FAN OR A FOLLOWER?

AOSSM, AJSM, and *Sports Health* are all on Facebook and Twitter. Join the conversation and learn about the latest news and articles from *AJSM* and *Sports Health.* Stay up to date on Society happenings and deadlines at AOSSM.

Facebook
www.facebook.com/AOSSM
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www.facebook.com/SportsHealthJournal
www.facebook.com/STOPSportsInjuries
www.facebook.com/TheOJSM

Twitter
Twitter.com/AOSSM_SportsMed
Twitter.com/Sports_Health
Twitter.com/SportsSafety
Twitter.com/AJSM_SportsMed



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FREE *AJSM, Sports Health,* and *OJSM* apps are now available! These apps present the cover-to-cover print edition in a mobile, user-friendly format. Readers can now mark "favorite" articles and download entire issues for offline reading. The *AJSM* and *Sports Health* apps are subscriber-only benefits and are already included in your subscription to the print journal. To set-up your password and download the apps, follow these simple steps:

1. Go to app.ajsm.org or app.sportshealthjournal.org and follow the steps to create your password (you must use the same password if you subscribe to both journals).
2. Go to the Apple App Store on your device and download the free *AJSM* and *Sports Health* apps.
3. For the *OJSM* app simply search for *OJSM* in the iTunes store.

Questions, contact Colleen O'Keefe at colleen@aossm.org.



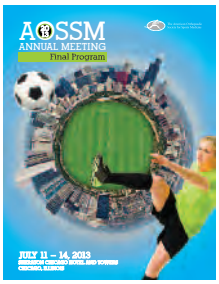
Are You Participating as a Health Care Provider for a Winter Olympic Team?

If you will be serving as a team physician, athletic trainer, or physical therapist at the upcoming Winter Olympics and are interested in serving as an expert for media calls we may receive, please send your name, contact information, and sport you will be assisting with to Lisa Weisenberger at lisa@aossm.org.



AOSSM Educational Resources

Did You Miss the AOSSM 2013 Annual Meeting? Go Online



Why take notes at a meeting when you can review the presentation online at your own pace? AOSSM records presentations at Specialty Day and the Annual Meeting and our sport specific meetings. You can purchase an annual subscription for $150. Online meetings are a great way to review presentations or share new research with colleagues and fellows. For more information visit www.sportsmed.org/onlinemeetings.

Need a Review? Purchase Self Assessment Today

Looking for a great review of sports medicine? The AOSSM Self Assessment is updated annually and contains 125 new questions designed to guide your review of diagnosing, treating, and rehabilitating common orthopaedic sports medicine injuries and conditions. Each question contains commentary and references to support your learning. Complete the exam and earn 12 *AMA PRA Category 1* ™ credits. Self Assessment can count toward your ABOS MOC Part 2 requirement, too. Visit www.sportsmed.org for more information.

Give Your Patients the Best Sports Medicine Tips– Send Them *In Motion*

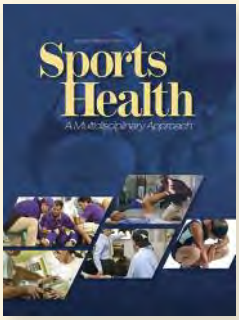
In Motion is now available to be personalized with your practice name and logo. For just $300, you will receive four personalized issues (Spring, Summer, Fall, Winter) and the high and low resolution PDFs to send to a patient's inbox, post on your Website, or print and place in your waiting room. For more information, contact Lisa Weisenberger, Director of Communications, at lisa@aossm.org.





Sports Health Call for Photographers!

Sports Health: A Multidisciplinary Approach is looking for amateur photographers to submit action, sports-related photos, free of charge, to appear on the cover of the journal. Five different images are featured on the cover of each issue and with athletes of all ages competing in sporting-related events. You are invited to submit your photos to the editorial office for approval and potential use. Photos must be submitted as JPEG or TIFF files and at a resolution of 300 dpi to be considered. Color photographs are strongly recommended. Please submit your photos and direct any questions to Colleen O'Keefe at colleen@sportshealthjournal.org.



Got News We Could Use? *Sports Medicine Update* Wants to Hear from You!

Have you received a prestigious award recently? A new academic appointment? Been named a team physician? AOSSM wants to hear from you! *Sports Medicine Update* welcomes all members' news items. Send information to Lisa Weisenberger, AOSSM Director of Communications, at lisa@aossm.org, fax to 847/292-4905, or contact the Society office at 847/292-4900. High resolution (300 dpi) photos are always welcomed.









2013 AOSSM/APKASS TRAVELING FELLOWSHIP TOUR

By Matthew Smith, MD

AOSSM gratefully acknowledges DJO Global for their support of the Traveling Fellowship program.

Although our traveling fellowship to Asia officially began on May 21, 2013, our preparation began when we met as a group for the first time during the AAOS meeting in Chicago in March.

Our godfather for the fellowship was future AOSSM president, Allen Anderson, MD, from the Tennessee Orthopaedic Alliance. He is also the associate editor of the new online open access journal, *The Orthopaedic Journal of Sports Medicine.* The traveling fellows were Jay Albright, MD, Orlando Regional Medical Center (now with University of Colorado), Morgan Jones, MD, MPH, the Cleveland Clinic, and Matthew Smith, MD, Washington University in St. Louis.

Hiroshima, Japan

We began our trip in Hiroshima where we attended the Japanese Orthopaedic Association (JOA) meeting. Professor Mitsuo Ochi and Dr. Nobuo Adachi from Hiroshima University were our hosts. During our stay in Hiroshima we attended the JOA meeting for several days and learned about the outstanding research in cartilage restoration taking place at Hiroshima University. We also attended Professor Ochi's JOA presidential address which outlined the major Japanese contributions to sports medicine. Professor Ochi invited us to attend the presidential banquet, where we were treated to a performance by world-famous opera singer, Michie Nakamaru. Here, we also had the good fortune to interact with outstanding orthopaedic surgeons from across the world, including France, Belgium, Greece, Japan, Switzerland, Sweden, and the United States.

With the guidance of three gracious orthopaedic surgeons from Hiroshima University, Dr. Tomoyuki Nakasa, Dr. Masakazu Ishikawa, and Dr. Kobun Takazawa, we were treated to fabulous sites and experiences in Hiroshima. We visited the Hiroshima castle in the center of the city. We went to a traditional tea ceremony. We visited Shinto and Buddhist shrines on Miyajima Island. We visited the Atomic Bomb Dome, which was the only free-standing building that remained in Hiroshima after the atomic bomb was detonated. This building, which has not been restored since the atomic bomb, now serves as a symbol of peace for Hiroshima. Lastly, we toured the Hiroshima Peace Memorial which was a sobering experience for all of us.

Kobe, Japan

Next, we traveled to Kobe. When we arrived, we were met by two graduate students who showed us some of the famous sites. We had lunch at a restaurant where the sous chef was Iron Chef, Japan. In the evening we went to Kobe University



Hospital Department of Orthopedics for our academic session with Professor Masahiro Kurosaka and Dr. Ryosuke Kuroda and the Kobe University orthopaedic department. We met a Japanese Olympic volleyball player who allowed us to hold her bronze Olympic medal. After the academic session, we adjourned for an outstanding dinner at a shabu-shabu Kobe beef restaurant with the sports medicine faculty from Kobe University. The next morning we accompanied Professor Kurosaka and Dr. Kuroda to the operating room to watch Dr. Kuroda perform a revision ACL reconstruction. We also witnessed his research team gather data on the kinematics of the knee using unique image-capture software. After surgery, we went with Dr. Kuroda to the training room for the Kobe Steelers professional rugby team. We attended a Hanshin Tigers baseball game at Koshien Stadium near Osaka, Japan. The next morning we took the high speed train to Kyoto, Japan. Kyoto is one of the oldest and most traditional cities in Japan. We went to a famous Buddhist temple on the mountaintop overlooking Kyoto before departing for Tokyo.

Tokyo, Japan

Upon arriving in Tokyo, we were hosted by Dr. Toru Fukubayashi. Dr. Fukubayashi took us to the Japanese Institute of Sports Science and National Training Center. These facilities were built with the goal of increasing performance in the Olympics. The facilities were impressive with cutting-edge training equipment, including high altitude training simulators. They also had motion analysis cameras throughout the facility to help athletes work on technique. We also visited Tokyo University Hospital where we saw the first arthroscope used by Dr. Masaki Watanabe. We had an excellent academic exchange at Tokyo University Hospital where we gave our presentations and listened to outstanding presentations from their surgeons on topics ranging ACL reconstruction in elite athletes, fluoroscopic navigation of ACL tunnel placement, and management of Jones fractures. On our third day in Tokyo, we traveled to the Funabashi Orthopedic Hospital where we watched Dr. Hiroyuki Sugaya perform three shoulder surgeries: an arthroscopic labral repair, a bony Bankart repair with a remplissage, and a rotator cuff repair. We then had an enjoyable dinner with Dr. Sugaya and his colleagues from the Funabashi Orthopedic Hospital.

Beijing, China

We then traveled from Tokyo to Beijing, China where we met Dr. Hua Feng. Dr. Feng was a traveling fellow to the United States last year. Michael McBrayer, with DJO Global, met us in Beijing and accompanied us to the operating room, the academic sessions, and our tour of Beijing. On our first day, we hiked a

portion of the Great Wall of China, toured the Forbidden City, and visited Tiananmen Square. We also had a fantastic meal at the original Peking Duck restaurant in the heart of Beijing. The next morning we accompanied Dr. Feng to the operating room where we watched him perform a fast and elegant single-bundle posterior cruciate ligament reconstruction with Achilles allograft and a lateral collateral ligament reconstruction using bone-patellar-bone allograft. We also watched Dr. Chun-Yan Jiang skillfully perform an arthroscopic Latarjet and a rotator cuff repair. Afterwards, we attended an informative academic exchange on topics ranging from patellar dislocations, glenoid bone loss, hip arthroscopy, and elbow arthroscopy. We met Professor Guo-Ping Li, who is the director of sports medicine for the Chinese Olympic team. We toured the Chinese Olympic Training Center where we watched the Chinese gymnastics team and the Chinese volleyball team train.







Shanghai, China

We then were off to Shanghai where we were greeted by our hosts, Dr. Ji-Wu Chen and Dr. Shi-Yi Chen. We had an excellent traditional Chinese meal with our hosts and other sports medicine physicians at Huashan Hospital. The next morning, we traveled Hangzhou City, which is about 45 minutes outside of Shanghai by train. We toured the West Lake, a large lake in the city that feeds into the Yangtze River. There we met Dr. Lynn Chen, a knee surgeon in Hangzhou City. She escorted us to several shrines on top of a mountain overlooking West Lake and Hangzhou City. The next morning back in Shanghai, we visited Huashan Hospital where we watched an ACL reconstruction. After surgery, we went to an affiliated hospital to give our presentations and serve as lab instructors at an arthroscopy course for orthopaedic surgeons from all around China. Afterwards, Dr. Jessica Jiang took us to see the famous Chinese acrobats perform with the Shanghai Cirque. She also showed us the Shanghai Museum which houses ancient artifacts from Chinese culture, including stone sculptures and bronze from 3,000 BC. In the evening, we took a riverboat cruise along the Huang Po River where we enjoyed the majestic skyline of Shanghai.

Hong Kong, China

Our last stop was in Hong Kong where we were hosted by Dr. K. M. Chan. Upon arrival, he took us for a trail hike on top of Victoria's Peak overlooking Hong Kong. The next morning, we toured Prince of Wales Hospital and watched Dr. Patrick Yung perform an arthroscopic AC joint reconstruction. The research faculty gave outstanding presentations on the use of motion analysis and muscle stimulation to prevent ankle sprains, methods of measuring rotation of the knee, and techniques to enhance graft healing in bone tunnels after ACL reconstruction. In the evening, we toured the Hong Kong Institute of Sports and gave presentations to the Chinese University of Hong Kong Department of Orthopedics. Dr. Chan also arranged for a day trip to Macau where we met with Dr. Chan Wai Sin. We toured the sites in Macau and visited the Macau Sports Medicine Center. Back in Hong Kong the next day, we watched the annual Dragon Boat Races on the Shing Mun River. We had lunch at the Sha Tin Jockey Club and watched horse racing with Dr. Chan. In the afternoon, we went to local antique stores in Hong Kong where we browsed through very old and traditional antiques from Hong Kong and mainland China.

On the last night of our trip, we had dinner at our hotel where we reflected on the things we had learned, new friendships



"The AOSSM/APKASS Traveling Fellowship was an exceptional personal and professional experience for us all."

we had made, and the unbelievable experiences we had. The AOSSM/APKASS Traveling Fellowship was an exceptional personal and professional experience for us all. We are grateful to the AOSSM, APKASS, and DJO Global for sponsoring the Fellowship, and the Traveling Fellowship Committee for selecting us. The Japanese and Chinese hosts were amazing and the carefully planned travel arrangements were perfectly executed. There were many excellent, informative, and provocative scientific exchanges, which undoubtedly deepened our knowledge and ultimately will improve the care of our patients. More importantly, we developed many friendships that will serve as a bridge between the United States and the Pacific Rim countries. These friendships will continue to provide an exchange of ideas which will benefit us all.





Traveling Fellowship Applications Due Soon

Applications are now being accepted for the 2014 AOSSM/ESSKA and AOSSM/SLARD Traveling Fellowship Tours.

Dr. Rick Wilkerson of NWIA Bone, Joint & Sports Surgeons, Spencer, Iowa, has been selected to be the godfather for the AOSSM/SLARD Traveling Fellowship tour. The tour will tentatively take place for three weeks starting around June 1–22, 2014. The AOSSM/ESSKA tour will be April 24–May 17, 2014, with godmother Elizabeth Arendt, MD, University of Minnesota.

Applicants must be orthopaedic surgeons currently practicing in North America, who are 45 years of age or under, board certified, and are either an AOSSM member or completed an accredited sports medicine fellowship. Applicants must be interested in fostering a meaningful exchange of scientific information, stimulating research, and developing friendships with sports medicine colleagues.

Download the application at www.sportsmed.org, under the About tab and then click on Traveling Fellowships. All applications must be received by the Society no later than October 31, 2013. For more information, please contact Debbie Czech at Debbie@aossm.org or 847/292-4900.



DATES

AOSSM/SLARD Traveling Fellowship Tour Dates
June 1–22, 2014

AOSSM/ESSKA Tour Dates
April 24–May 17, 2014

Applications Due
October 31, 2013

Host Applications Due
November 30, 2013

AOSSM gratefully acknowledges the support of DJO Global for the Traveling Fellowship program.

Host the Traveling Fellows

The Traveling Fellowship Committee is currently seeking volunteers to host the Traveling Fellows for next year's North American tour with the Asia Pacific (APKASS). Tentative tour dates are June 19–July 9 followed by the AOSSM Annual Meeting in Seattle. The Traveling Fellowship Program serves as a vital link between the Society and its counterparts in Europe, Asia Pacific, and Latin America. More than 200 individuals have participated in the program, which most report that the experience has had a positive impact on their careers and personal lives.

Each year, the Society hosts three young and promising orthopaedic sports medicine specialists and one senior surgeon who acts as godparent. These four Traveling Fellows usually tour six sports medicine centers in North America and attend the AOSSM Annual Meeting during their three and a half week stay.

Individual hosts are responsible for the costs of lodging, meals, local transportation, entertainment, and associated costs of the fellows. The Traveling Fellowship Committee also encourages members to "group host" with several institutions in one area sharing the hosting duties and costs, thus adding to the diversity of the tour.

If you are interested in hosting the Traveling Fellows in 2014, please visit www.sportsmed.org for more information and to download the application. All hosting applications need to be submitted to Debbie Czech by **November 30, 2013.** Applications received after the deadline will not be accepted. Please be sure to indicate which three- or four-day period between June 19 and July 9 you will be ***unable*** to host the fellows.

WASHINGTON UPDATE

By Jamie Gregorian, AAOS Senior Manager, Specialty Society Affairs and Research Advocacy

The Senate went into recess August 1, and a day later the House did the same—both will return after Labor Day. During that time, congresspersons and senators will spend time in their home states and districts, much of it listening to constituents. On those constituents' minds will assuredly be the fate of health care. Prior to adjourning, the House passed its 40th attempt to repeal all or part of the Affordable Care Act, and the House Energy and Commerce Committee sent a rare bipartisan bill to repeal SGR to the full House, albeit without a plan of how to pay for it. A few members of Congress sought to repeal the in-office ancillary services exception to the Stark Laws, and the RUC continued to take hits.

ACA Repeal

Immediately before leaving for the August recess, the House voted 232–185 for a bill that would bar the IRS from any role in carrying out the Affordable Care Act or in collecting taxes to help pay for it. Four Democrats (Jim Matheson, Utah; Colin Peterson, Minnesota; Mike McIntyre, North Carolina; and John Barrow, Georgia) voted in favor, as did every Republican. Like most of the previous 39 repeal attempts, this bill is expected to go nowhere in the Senate. There have been seven revisions (such as the 1099 repeal) that were signed into law.

Despite the fact that the bill will almost assuredly now die, the GOP can use it as part of their August campaign strategy. The National Republican Congressional Committee is expected to hit the IRS in August with television ads, piggybacking health reform onto reports that the IRS targeted conservative groups for investigation. The theme is that the IRS should not have any role in administering the health law.

"This legislation would cripple the ability of Americans nationwide to pay for health care, undermining the health and economic security of the middle class. A vote for this bill is a vote to put insurance companies back in charge of Americans' health. I wish my colleagues would spend as much time working on growing the middle class as they do holding pointless votes and posturing. Enough is enough. Let us stop the political games and act now to put people back to work," said Rep. Rosa DeLauro (D-CT).

SGR Repeal

On July 31, the House Energy and Commerce Committee unanimously approved a bill that would replace the SGR with one that rewards providers for overall high-quality care—a measure that had broad bipartisan support. The 51–0 vote by the Energy and Commerce Committee sends the bill, titled the "Medicare Patient Access and Quality Improvement Act," to the House this fall.

In principle, all sides like what they see, but there is a major caveat: the pay-for. As of right now, the bill offers no way to pay for repealing the SGR, which the nonpartisan Congressional Budget Office estimated earlier this year would cost about $139 billion over 10 years—much lower than in previous years due to the decline in Medicare cost growth. The pay-for part undoubtedly will involve a fierce battle among healthcare industry sectors, none of whom want to be nicked. When you add in the fact that there will be five years of patches before the repeal actually takes effect, many observers expect the cost to be in the $200 billion range. While this is a relative bargain compared to other estimates, it is still a substantial sum of money.

Because the costs are still significant, there is something of a "rob Peter to pay Paul" fear that prevents much of medicine from getting fully behind the legislation. For example, the bill directs CMS to identify services it overpays and reduce those payments by 1 percent each year from 2016 to 2018. Usually when CMS undertakes this task, it redirects those reductions toward other codes, and this bill just keeps the cut without redirecting the savings back into reimbursements, thus removing savings realized from RVU reductions out of the payment pool. So those are monies saved at the moment, but it's an effective Medicare cut in a bill that is supposed to save Medicare. Still, optimism is probably higher than it has been in a very long time.

In Office Ancillary Services

Rep. Jackie Speier (D-CA) introduced the H.R. 2914, the "Promoting Integrity in Medicare Act of 2013" in the House of Representatives on August 1. The bill would close the in-office ancillary services exception to the Stark Laws that allows surgeons to provide advanced imaging, anatomic pathology, radiation therapy, and physical therapy in their offices. The bill was introduced once before and attracted only four co-sponsors, and this time only has two co-sponsors. The radiation oncologists praised the bill effusively, as did the physical therapists. AAOS and allies in the surgical community are confident that the bill will be as unsuccessful as the first attempt, but will fight it vigorously nonetheless.

Stuck in the RUC

A July 20 *Washington Post* investigative article found that the AMA/Specialty Society RVS Update Committee (RUC) has overvalued many procedures by overstating the amount of physicians' time required to perform them. Also, *Washington Monthly* also published a critical article about the RUC in July, effectively calling the RUC a secret cabal of specialty physicians that overvalues services and fixes prices. The AMA offered a sharp rebuttal, asserting among other things that the allegations that relative values have primarily increased since 2003 leading to an increase in Medicare spending are false.



Orthopaedic Sports Medicine and Arthroscopy Match

AANA and AOSSM are pleased to announce the following sports medicine/arthroscopy fellowship programs are participating in the Orthopaedic Sports Medicine and Arthroscopy Match for 2014. The Match, administered through the San Francisco Matching Program (www.sfmatch.org), provides an orderly, equitable selection process for applicants and fellowship programs. For the most current match information, please visit www.sportsmed.org/fellowships.

Sports Medicine/Arthroscopy Fellowship Programs

Allegheny General Hospital Program
Sam Akhavan, MD
Pittsburgh, PA

American Sports Medicine Institute (St. Vincent's) Program
Jeffrey R. Dugas, MD
Birmingham, AL

Andrews Research and Education Institute Program
James R. Andrews, MD
Gulf Breeze, FL

Aria Health Program
Arthur R. Bartolozzi, MD
Langhorne, PA

ASMI/Trinity/Lemak Sports Medicine Program
Lawrence J. Lemak, MD
Birmingham, AL

Aspen Sports Medicine Foundation Program
N. Lindsay Harris, Jr., MD
Aspen, CO

Atlanta Sports Medicine & Cartilage Reconstruction Fellowship Program
Scott D. Gillogly, MD
Atlanta, GA

Banner Good Samaritan Medical Center Program
Anikar Chhabra, MD, MS
Phoenix, AZ

Barton/Lake Tahoe Sports Medicine Fellowship Program
Keith R. Swanson, MD
Zephyr Cove, NV

Baylor College of Medicine Program
David M. Green, MD
Houston, TX

Beacon Orthopaedic Research & Education Foundation, Inc. Program
Timothy E. Kremchek, MD
Sharonville, OH

Boston University Medical Center Program
Robert Nicoletta, MD
Boston, MA

Brigham & Women's Hospital, Harvard Medical School Program
Scott D. Martin, MD
Chestnut Hill, MA

Brown University Program
Paul D. Fadale, MD
Providence, RI

Children's Hospital (Boston) Program
Lyle J. Micheli, MD
Boston, MA

Cincinnati Sports Medicine & Orthopaedic Center Program
Frank R. Noyes, MD
Cincinnati, OH

Cleveland Clinic Foundation Sports Medicine Program
Mark S. Schickendantz, MD
Cleveland, OH

Congress Medical Associates Program
Gregory J. Adamson, MD
Pasadena, CA

Detroit Medical Center Program
Stephen E. Lemos, MD, PhD
Warren, MI

Duke University Hospital Program
Dean C. Taylor, MD
Durham, NC

Emory University Orthopaedic Sports Medicine Fellowship Program
Spero G. Karas, MD
Atlanta, GA

Fairview Southdale Hospital/ MOSMI Program
Christopher M. Larson, MD
Minneapolis, MN

Henry Ford Hospital/Wayne State University Program
Patricia A. Kolowich, MD
Detroit, MI

Hoag Orthopedic Institute Sports Medicine Fellowship Program
Carlos A. Prietto, MD
Irvine, CA

Hospital for Special Surgery/ Cornell Medical Center Program
Scott A. Rodeo, MD
New York, NY

Hughston Foundation Program
Champ L. Baker, Jr., MD
Columbus, GA

Indiana University School of Medicine Program
Arthur C. Rettig, MD
Indianapolis, IN

Jackson Memorial Hospital/ Jackson Health Systems Program
Bryson P. Lesniak, MD
Miami, FL

Kaiser Permanente Southern California (Orange County) Program
Brent R. Davis, MD
Irvine, CA

Kaiser Permanente Southern California (San Diego) Program
Edmond Pai Young, MD
El Cajon, CA

Kerlan-Jobe Orthopaedic Clinic Program
Neal S. ElAttrache, MD
Los Angeles, CA

Lenox Hill Hospital Program
Barton Nisonson, MD
New York, NY

Massachusetts General Hospital/ Harvard Medical School Program
Luke S. Oh, MD, MS
Boston, MA

Mayo Clinic (Rochester), College of Medicine Program
Michael J. Stuart, MD
Rochester, MN

Mercy Hospital Anderson/University of Cincinnati College of Medicine Program
Denver T. Stanfield, MD
Cincinnati, OH

Methodist Hospital (Houston) Program
David M. Lintner, MD
Houston, TX

Mississippi Sports Medicine & Orthopaedic Center Program
Larry D. Field, MD
Jackson, MS

New England Baptist Hospital Program
Mark E. Steiner, MD
Boston, MA

New Mexico Orthopaedics Program
Samuel K. Tabet, MD
Albuquerque, NM

Northwestern University– McGaw Medical Center Fellowship Program
Michael A. Terry, MD
Chicago, IL

NYU Hospital for Joint Diseases Program
Orrin H. Sherman, MD
New York, NY

Ochsner Clinic Foundation Program
Deryk G. Jones, MD
Jefferson, LA

Ohio State University Hospital Program
Christopher C. Kaeding, MD
Columbus, OH

OrthoCarolina Sports Medicine, Shoulder & Elbow Program
James E. Fleischli, MD
Charlotte, NC

OrthoIndy Program
Jack Farr, II, MD
Greenwood, IN

Orthopaedic Research of Virginia Program
John F. Meyers, MD
Richmond, VA

Penn State Milton S. Hershey Medical Center Program
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State College, PA

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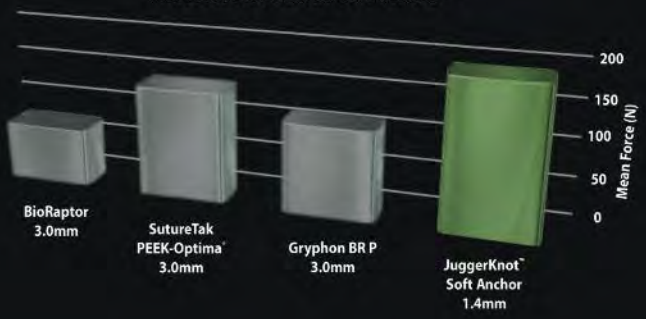
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1. Barber FA, Herber MA, Beavis RC, and Oro FB; "Suture Anchor Materials, Eyelets, and Designs: Update: 2008." Arthroscopy Vol. 24, No. 8 pp 859–867, 2008
2. Barber FA, Herbert MA, Hapa O, Rapley JH, Barber CA, Bynum JA, Hrnack SA.; "Suture Anchor Update 2010." Arthroscopy 2010; In Press.

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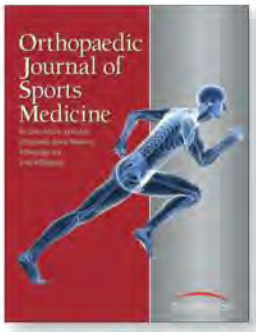
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