The Sideline Report

DECEMBER 2020

This grant provided funding to augment the MSK capabilities of a general regional medical clinic, Kumari, established in 2009 on a mountainside in the Himalayan foothills with an elevation of 9,000 feet and approximately 60 miles northeast of Kathmandu, very close to the Chinese-Tibetan border. This clinic serves Sherpa, Tamang, and

AMSSM NEWS

AMSSM 2021 Annual Meeting (Hybrid) – Come Together: Sports Medicine for Everybody

On behalf of the 2021 Program Planning Committee, we invite you to the AMSSM 30th Annual Meeting from April 13-18, 2021. The planning for this meeting has been shaped by our collective experience in the past year, a year of parallel crises of the COVID-19 pandemic and racial injustice. Our 2021 meeting theme is “Come Together: Sports Medicine for Everybody,” a meeting theme that demonstrates our commitment to meeting together and our dual clinical missions of promoting exercise as medicine for all people and providing sports medicine care to all people. As you will see in the program, we have a fantastic line-up of speakers from around the country and around the world that will inspire, energize and educate. With this meeting we aim to bring you the up-to-the-moment and in-depth sports medicine knowledge that you need, as well as the collegiality and community-building that is generated by coming together as a membership.

We will kick off the 2021 meeting with a focus on keys to Exercise 2020 AMSSM Foundation Global Humanitarian Service Project

In March of 2020, a team led by AMSSM Founder and Past President Doug McKeag, MD, and his son Ian McKeag, MD, journeyed to Kumari, Nepal as part of the 2020 AMSSM Global Humanitarian Service Project. The team’s goal was to provide MSK ultrasound course instruction, increased connectivity and numerous resources for Kumari, an isolated region of the Himalayas.

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The 2021 meeting will inspire all of us with his life story. Throughout the meeting, we will learn essential up-to-the-moment sports medicine knowledge from national and international experts. From the very latest on COVID-19 in athletes, to cutting edge research on tendinopathy, to shared decision-making in orthobiologics, to Food is Medicine, we have a lineup of topics that is clinically relevant and thought-provoking. We will be joined by experts who will teach us about The Throwing Athlete, Prevention of Sexual Violence in Sport, Reducing the Risk of Injury in Running and The Keys to the Physical Exam of the Hip to name just a few. You will be challenged to weigh in on cases, considering such questions as “Are you sure that is OA?” “Would you recommend that supplement to your patient?” and “What barriers to sports medicine care do your patients face in your community?”

We are also excited that for the 2021 meeting we will not only talk about physical activity, but we will do some activity! On day one, led by Lori Rose Benson and Dr. Olajide Williams from Hip Hop Public Health, we will learn about the science of behavioral change and then they will show us how this works (we can’t wait to see everyone do the Cross & Dip!). In between talks on the latest on tendinosis from an all-star panel on day two, moderator Kyle Goerl, MD will lead us in jumping jacks, hamstring stretches and planks. And back by public demand, both Monique Burton, MD, and Jordan Metzl, MD, will teach daily morning workouts.

As for the logistics of the 2021 meeting, we continue to hope and plan for an in-person meeting for those who are able to travel to San Diego, CA. We also know that many will be unable to attend the meeting in person, so we are planning to live-stream the meeting and to create a virtual experience that allows all of us to connect with one another. Whether you can attend in-person or from home, we are excited to see you, to catch up with you and to learn with you. We will continue to provide updates on logistics as we have them.

Sincerely,
Amy Powell, MD, FAMSSM
1st Vice President
Carlin Senter, MD
2021 Program Planning Committee Chair

AMSSM 2021 ANNUAL MEETING
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It provides complete primary care within its limits, including childbirth, acute care, chronic disease monitoring and public health initiatives. There is an X-ray machine on-site as well as an ultrasound machine, which are both gifts from a donor in Colorado. Neither is used much because of lack of skills in these areas. Short of diagnosing MSK injuries, there is little ability or equipment to treat such injuries. When such injuries arise, they must be transported back to Kathmandu by makeshift ambulance. Many injuries are just left untreated, regardless of how serious they may be. Kumari is an extremely isolated place, which until 2009 had never seen a physician. Both member leaders had been to Kumari several times, and both noticed the need for teaching, triage instruction, and equipment. Out of that realization came the application for the AMSSM Global Humanitarian Service Project Grant.

As the saying goes, timing is everything. Originally, 14 people were committed to go. As the COVID-19 pandemic loomed, that number dwindled to six. The group felt the importance justified going ahead with this project and included the following members: Drs. Doug and Ian McKeag, Aubrey Bridges (Physician Assistant), Eric Speck (Physical Therapist), Thomas Lasseter (Engineer) and Chris Wescott (Remote Internet Expert).

The goals of the team were to provide instruction and teaching to Kumari staff on a wide range of subjects, including MSK ultrasound training, physical therapy protocols, continued on page 3
AMSSM GLOBAL HUMANITARIAN SERVICE PROJECT
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MSK bracing and splints and women’s health procedures. The group also provided MSK patient care via an open free clinic each afternoon. To a small extent, these clinics expanded to general medicine when necessary, and the staff also saw a number of problematic MSK patients. Additionally, the team installed a remote broadband internet system to serve three purposes:
1. Connecting remote villages served by the clinic via telemedicine capabilities;
2. Setting up computer classrooms in village schools to teach students computer skills;
3. Connecting villages to the Kumari clinic for public health activities.

By March 5th, everyone had arrived. Staying overnight in Kathmandu, they left for the six-hour trip to Kumari the following morning. The road up the mountain was nearly impassable, but they arrived to an official Nepalese community welcome. Over the next four days, the four medical providers taught and then saw patients. The two computer engineers, with local help, installed antennae in remote villages. Telemedicine and schoolroom capabilities were established. Monitoring world news, the member leaders called a meeting of the group and decided to cut the trip short by one day. They returned to Kathmandu and caught individual flights home the next day. Actually, the last of our party left Nepal on Friday night - Nepal closed its borders at midnight on Saturday morning, but all participants returned safely to their homes.

Ultimately, the group accomplished all that it had hoped, and then some, and the staff was very grateful. The six team formed a wonderful work group and wishes to thank the AMSSM Foundation and the Halpern Family Fund for their support and cooperation. Global health is an area in which AMSSM and its members need to initiate an interest, and this project shows the skill sets of sports medicine physicians can help many people.
We have all had what is likely the craziest six months in our work and personal lives in recent memory. My life was turned upside down, as well, but I feel extremely fortunate that I have my work, my family’s health (despite some COVID scares), and the support of so many awesome people like all of you AMSSM members.

For those that know me well, you know that I love covering my teams. Sideline coverage is what I’m all about. On March 1, I was excited to go to Florida for a week to cover the Minnesota Twins during spring training. My Fellows were with me, and we had a blast covering practices, games, and giving many minor league physicals. The timing was perfect for me to see my youngest son Kobe play baseball with his college team in Florida for a few days before I was off to the Big Ten Basketball Tournament. I left on a flight for Indianapolis, covered our first University of Minnesota men’s basketball win, and was having a delicious dinner to celebrate. As I sat at dinner, the news of COVID spreading through the NBA and across the country was on every news feed. It felt like something bad was brewing.

That next day, the world seemed to change. Our Big Ten Tournament was canceled, and I was on a plane home that night to what seemed like a different world. Soon after I returned, my short-lived empty nesting stage was over, as my three college kids all came home for the next six months. I had many hard talks with my parents about sheltering in their houses and keeping their distance. My work, like many of us, was unrecognizable. I was on video visits, had work meetings that left the future in doubt, took pay cuts, and was stuck in my house. My family medicine side kept showing up for work, but they were some of the only times I ever went to work scared. I put on my mask and could only think, “There is no way I can do this.” I would come home, strip on my front steps (sorry, neighbors), bring my clothes to the laundry room, and hit the shower. I felt like I could do little to help the spirits of my family by the time I got home, so we just hung out. We got to know each other again. We talked, laughed, cried, and tried to keep my parents and stepparents safe. Slowly but surely, we started to get a little rhythm and hope back in our day-to-day life.

Then the unheard-of happened in Minneapolis. George Floyd was murdered by our own police officers. Certainly, this wasn’t something that happens in Minnesota. I couldn’t believe with everything already happening that we would now have to face racial unrest. I work in an urban, underserved clinic in North Minneapolis near the epicenter of unrest. I again had no answers for my patients, children or neighbors. I sat at my house in despair as I watched protests turn to riots and looting. Our beloved city was on fire! I knew change was needed and supported that. Nonetheless, it was hard to watch the city I love being destroyed.

Getting Through This Together

By David Olson, MD, Minneapolis, MN

Part of that destruction ended up being my clinic. Broadway Family Practice is one of the University of Minnesota Family Medicine Programs. I have worked there for 20 years and love the community. Our residents provide sports medicine coverage for two schools in the area. We are part of the community. Now, buildings were burned down and our clinic was looted, flooded, and destroyed. At least those that invaded were bad at starting fires. They tried to light it on fire twice but failed. Video showed these youngsters celebrating in our lab coats in our parking lot.

I was already fearful with the pandemic, and now this. The clinic I loved was destroyed. I had no idea what to do. As an African American male, I was already trying to explain all that was happening to my kids and their friends. I couldn’t honestly make

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GETTING THROUGH THIS TOGETHER

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sense of any of it. Still, we talked and tried to figure out a long-term plan. (This ended in my filing to run for city council this November.) We would go support peaceful efforts, get groups together to talk about what we can do to make real change, and honestly sit around my house a lot, scared for what might happen next. At the clinic, we did what we always do. We got in there, cleaned up the mess and started to bounce back — together. We weren’t going to let this stop us. People did what they felt like they needed to do, and now we were going to do what we need to do: be there for our patients and our community! We cleaned out all of the mess and got cleaners in to save anything we could. We set up a parking lot food, clothing, household goods, and medical supplies/medications drive. The entire community chipped in. On day one, we set out one table and passed out items. A week later, the parking lot was filled with people helping, dropping off items, and more volunteers than we could handle helped pass things out. This continued throughout the entire summer.

We are now back in our clinic! We aren’t fully where we were before, but our patients can get what they need. The plans to be in a new building up the road in January are on track. We all have been through so much the last few months. My story is not unique, and it is not the worst story there is. I’m tired of having my face swabbed, I’m tired of false positive tests and quarantines. So many people have had to deal with job losses, deaths of loved ones, mental health crises, and so much more. All of us have had more Zoom meetings than we can stomach to discuss returning to clinic, school, and sports during the pandemic. We have all had to find balance again in our work, home, and hopefully some leisure time.

I’m not sure where this all is going or how this story ends. I do know I have learned a lot about myself and others during this time. AMSSM and its membership have been beacons of light during this time, supporting each other and making plans to help our patients/athletes get back to activities they love. Despite all we have been through on the negative side, I have also seen things that amaze me, small signs that give me hope in this dark time. I have seen people work together and boost each other when they are down. I have had moments these past few months that have given me new faith and hope in people and what we can do, where we can go. It will be a tough road for all of us, but we will get through this — together! ■

Check Out AMSSM’s Patient-Focused Resource Center On-Line, SportsMedToday.com!

SportsMedToday.com provides an easy-to-navigate, patient-centered resource center for parents, medical professionals and youth organizations interested in prevention and treatment of sports-related injuries.

Visitors to SportsMedToday.com will find a searchable database with a variety of sports medicine topics arranged by sport, medical condition (injury/illness) and body part, with topics being added and updated continually throughout the year. In addition, healthcare professionals can download tip sheets to share with their patients and partners.
Opinion: For me, a Green Card is the only good thing to come out of 2020

By Julia L. Iafrate, DO

The views expressed are those of the author and do not necessarily represent the views of the AMSSM.

I have been an attending physician at Columbia University Medical Center for the last three years. I feel lucky to have gained incredible mentors and created a niche in sports medicine about which I am truly passionate. I also happen to be an immigrant.

I am originally from Canada, but New York City is the first place that has ever felt like home to me. I love this concrete jungle. So, when the COVID-19 pandemic hit NYC in March 2020, I immediately volunteered to be redeployed to my hospital’s frontlines. Why? Because I protect my home.

Days in the ICU are still etched into my mind. The incessant beeping of ventilators, a sea of anxious eyes attached to otherwise unfamiliar masked faces, the sterile scent of disinfectant, and my gloved hands yearning to actually touch the fingers of the patients I was charged with caring for.

I made the decision to move to the frontlines so that someone else wouldn’t have to. Because I knew my chances of survival were better than my older colleagues. Because I trusted my medical training. Because I didn’t know how not to help.

I have lived, trained, and worked in the U.S. for nearly thirteen years on three different types of visas. Every time I moved for part of my training, my new hospital had to apply for a transition of my work permit. Any time it was in flux, I was not allowed to leave the country, or I would give up my rights to the visa and lose my job.

You can only spend so much time on a work visa before you need to apply for permanent residency or leave the country. The H1-B temporary skilled worker visa is valid for up to six years, but when applying for an EB-2 employment-based green card, you need to prove that you are an expert in your field. The government does not take into account “training time” for physicians, so my five years of residency and fellowship ended up working against me when it came to providing evidence of my expertise.

My 700-page green card application for employment-based residency was submitted in June 2019. I had letters of support from professional athletes I had treated, coaches, and my esteemed medical colleagues. It was a very strong application. Yet, amidst the uncertainty that came with the pandemic, the United States Citizenship and Immigration Services shut down, and on April 20th, a nationwide immigration ban was put into place. Eight days later, I received a notice that my green card application had been denied. After thirteen years, I was being deported.

The official reason for the immigration ban was to give Americans a chance to gain employment before citizens from other countries could be hired, but I hadn’t “stolen” anyone’s job. I was already working here, during a pandemic no less! I took to social media, and my story made national news.

After appearances on CNN, Fox5 News, and Toronto radio I received an outpouring of encouragement, including from my incredible colleagues at the AMSSM. President Dr. Tracy Ray immediately offered a letter of support on my behalf. Eventually, we were able to get the initial portion of my national interest waiver reopened for supervisor review. A few weeks later, the decision was reversed and ultimately approved. Gratefully, that meant I could at least return to work to take care of my patients.

On August 27, 2020, I was finally approved for my green card, and it was mailed to me on September 5. After thirteen years, numerous work visas, a pandemic, tens of thousands of dollars, and nearly being deported, continued on page 7
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I can finally say I’m a permanent resident of the United States of America.

Two million immigrants work in the US healthcare industry, and approximately 25 percent of physicians here are foreign. Over the years, an anti-immigration sentiment has focused on demonizing immigrants in an effort to seem “pro-American.” But immigrants and diversity are what make America great. We consider this our home, having driven stakes in the ground with our jobs, lives, and commitment to contributing to society. The immigration system in the United States is broken, and it is causing immigrant physicians to battle COVID in public but silently wage their own wars against an archaic system determined to break them.

Everyone here knows this pandemic is not over. Cases have risen in our efforts to rebuild the economy. And with that second wave, healthcare workers – both citizens and otherwise – will again be asked to don those painful N95 masks, gowns, face-shields, gloves and goggles. This is not the time to refuse admission for essential healthcare workers.

Yes, I can finally say that I am a green card holder. For me, it might be the only good thing to come out of 2020. I am beyond grateful for the support I received from many of you. Thank you, because I know my happy ending is not the story of all immigrant medical workers.

“Being adaptable...is going to be incredibly important for us.”
John DiFiori, MD, FAMSSM, CMO of the National Basketball Association

On December 2, 2020, Ashley Austin, MD, was able to meet with AMSSM past-president John DiFiori, MD, FAMSSM, for a discussion of the National Basketball Association’s “Bubble Season.” This interview has been edited for length and clarity. It can be heard in its entirety on the AMSSM/BJSM Podcast.

Austin: I am here with Dr. John DiFiori, MD, who is currently the Chief of Primary Care Sports Medicine at the Hospital for Special Surgery in New York City. He has worn many hats over the years, including being on various committees that set research initiatives, policies, and standards for player health and safety both nationally and internationally. He has worked with FIBA (the International Basketball Federation), NHL Players Association, and the Pan-American Games. Today, we are going to focus more on his work as Director of Sports Medicine for the NBA during the time of the COVID pandemic, where there has been great anxiety and uncertainty about the present and future of sports. We’ll sit down with him for a conversation pertaining to his role in the NBA after the successful completion of a bubble season. Dr. DiFiori, thank you for joining us today.

DiFiori: Thanks, Ashley. It’s a pleasure to be here, and I look forward to talking with you about these very interesting and difficult circumstances that we are all in.

Austin: This is quite the year we’ve had thus far! The first question is: what first intrigued you about this role of Sports Medicine Director for the NBA?

DiFiori: I am finishing up my sixth year with the NBA. When I was contemplating this opportunity, what encouraged me to pursue it was that in my interactions with people in the league and, at that time, the relatively new commissioner Adam Silver, I felt this was an organization that dealt with everything they did with high integrity, and that they wanted to do things the right way. They were putting forth an initiative on player health and safety. They also had an interest in youth basketball, which was of interest to me outside of the NBA. I think they had great plans to expand what they did from a health and safety standpoint including developing research, and not just the day-to-day player health in terms of injuries and injury prevention, but really a bigger vision of what they hoped to do. That’s what was probably the most important thing to me. I felt this was a group that really wanted to do this in the best possible way on behalf of players. That made me feel comfortable taking on what is quite a unique opportunity with the NBA.

Austin: I know sports fans like myself are quite excited for all athletes to have an opportunity to play and have the type of support they need to do it in a safe way, so it was exciting to see this season happen during a time that was pretty challenging for a lot of us. As you were constructing this NBA bubble, what were you most surprised about?

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DiFiori: There were an awful lot of people working really hard, seven days a week, sometimes twenty hours a day, trying to determine if we were going to be able to do it and if it was going to be safe, which was really our top priority. Could we do this safely from a player health and safety standpoint? Not only the players, but the coaches, the referees, all of the support staff. It was quite an endeavor, and we were learning week to week. It was very early at that time of the pandemic, and so information was limited. The virus had only been around a few months, so we were eagerly working with our colleagues in Europe, Asia, and Australia to gather as much information as we could and learn from them. What struck me the most after all the time, effort, and detail that went into setting things up for the bubble was the implementation of it. When I say implementation, I don’t mean just having the hotel space, meals, and medical support. All those things are pretty important, but once we got going, the players were very engaged in what we were doing there. They really took to heart the personal protection needed, even though we were testing every day in a closely contained environment. They understood what was necessary. They did that, and at the same time, they were so focused on competition. Those of us who watch and work with the League were really amazed at how focused they were on the games, on winning. That really made this whole thing shine even more. Yes, we were successful from an infection control standpoint, but the fact that the players participated and engaged and were so highly motivated from the health, safety, and basketball standpoints made it very rewarding at the end to finally have a successful completion of the season.

Austin: I imagine that is a testament to the trust the players have in the system you all created, that they could actually understand they were being well taken care of so they could focus on basketball during a time that was challenging both on and off the court, especially with all the social justice reforms that were going on as well.

DiFiori: Yes, there was an awful lot that was going on, and the credit goes to the players and the leadership and full time staff of the Players Association. It was a tremendously collaborative process. Really high level professionalism, with all the details that were needed, and I think because of that and the transparency of that process, the players felt comfortable moving forward and restarting the season.

Austin: As you alluded to a little earlier, it is one thing to design this bubble system, but it is another to actually insert people and see if what you created works, so having adaptability was key. Every week can look different than the next week.

DiFiori: That is a really good point. One of the key things that helped us is that we were collecting and analyzing data in real time. We were observing the experiential aspects and modifying on a day-to-day and week-to-week basis. We changed our testing and interpretation protocols within two weeks of using them because we began to see things that we thought we might see, but we weren’t sure of the best way to handle them, and we were being very conservative in management. We developed modifications that allowed us to handle those findings in a safe way and facilitate participation without risking infection. Everything was done in collaboration with the players and the Players Association, which required a lot of time and communication, but it really was very effective.

Austin: How do you think being in a bubble affected both the mental and physical aspects of the players? What kinds of things should be taken into consideration when constructing a bubble like this?

DiFiori: We certainly focused upon how we were going to support mental health in the bubble. It was uncharted territory. No one had gone through that kind of an experience before, and I think there were great pains taken by the League to ensure recreational opportunities and down time: nice environments, trying to support decompression time that everyone needs, and the ability to communicate with others and socialize to the extent you can with social distancing. We also had one of our NBA league psychologists onsite who was available to the players and staff. You can imagine if you are there, miles from home, testing every day, and all of a sudden you have a positive test, the anxiety that can create. Or if you are a player and your family is finally getting a chance to come in late August, and one of your family members tests positive and is in quarantine, you can just imagine the type of disruption and consternation that provokes. Some teams brought their own psychology and mental health support with them, but that was something we had anticipated, and it fortunately worked out really well. Players took advantage of the support, and partly as a result of that, that aspect went much more smoothly than we had thought.

Austin: I watched the games very continued on page 9
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differently from how I had watched
them before knowing all the things
that went into creating something
like this. Usually you are just kind of
“watching basketball,” but this was
more than that. This was a huge
collaborative effort on such a grand
scale. There were so many moving
parts and things that had to work
right. It is just incredible that you were
able to have such a successful season.
Are there any lessons you want to
take forward to the 2021 season if you
do have a bubble? Is there anything
you want to do differently?

DiFiori: Being extremely detailed
and doing it in a collaborative way
with the Players Association, and
the transparency, is foundational
to engendering success in a very
difficult circumstance. As we move
forward into the season, it’s more
of a challenge. We’re going to try to
play nearly a full season, seventy-two
games. We are setting out without
a bubble, and who knows what will
happen in the playoffs? We have to
be prepared to adapt. Unfortunately,
the pandemic still hasn’t reached
its peak and is at its worst point
since it started. We will continue to
emphasize the need for mask wearing
and social distancing and not letting
your guard down. This season is
just going to be a whole different
challenge.

We have learned a lot from our
colleagues in the NHL, Major League
Baseball, the NFL, and Major League
Soccer, who have all had great
success. People forget; Major League
Baseball did a great job. They had
some hurdles in the beginning, and
they adapted. They ended up having
a successful season. NHL did an
unbelievable job with their bubble.
Major League Soccer didn’t really
get recognition for being the first to
come out and do that, and again,
they had some challenges, but they
adapted. The NFL, obviously, has
even more of a challenge with the
size of their teams and the travel,
along with the escalation of the
pandemic during their season.
Being aware of the data and being
adaptable and implementing
necessary measures along the way
is going to be incredibly important
for us to have a chance to complete
nearly a full season.

Austin: I hope you all can do that.
I know you have enjoyed working
with amateur sports in the past and
creating policies and guidelines for
them. What aspects of the NBA’s
approach to their bubble season
might be applicable to amateur
sports?

DiFiori: People have to remember
that while testing is very important,
testing doesn’t prevent the infection.
What prevents the infection, as best
as we can, is mask wearing, social
distancing, and washing your hands.
It’s very difficult to be disciplined on
that for an extended time for anyone,
but I think it’s really important for
any organization that is trying to put
together competition. There has
to be consistent implementation.
In the professional leagues, there
are consequences beyond not
being able to play because you
developed the infection if you
are not following through on the
protocols. That is harder to enforce
in an amateur population, but it has
to be emphasized. You cannot rely
simply on your teammates or testing
to say, “You don’t need to wear a
mask.” That’s just not going to be a
successful competitive environment.
Testing is very important. PCR testing
is clearly superior, and point-of-
care PCR tests are being developed.
They are in relatively short supply
right now but will be in greater
supply as time goes on. They will
be very helpful in allowing not just
sports but businesses to function
in a close-to-normal fashion. The
technology is developing. Obviously,
we have the vaccines coming down
the road, but in the meantime, for
any sport, you really have to think,
“Can we implement this with proper
prevention measures? Secondly,
do we have the resources to do the
testing?” Without the resources to
do that, it’s just not going to be very
easy. We are already starting to see
where college basketball is running
into difficulty. It’s not anything against
anyone’s effort; it’s just a very difficult
challenge, and the resources involved
in trying to meet that are vast. Other
than professional sports leagues,
you wonder if anyone else has the
resources to be able to do it.

Austin: Hopefully our listeners [and
readers] are hearing the amount of
effort that is required just to have the
professional leagues. A lot goes into it,
and it is something to consider at all
levels of play. Thank you for the level
of detail you have given us. Thank you
for joining us; I know it is a busy time
of year for you, and the NBA is on
the cusp of another season. It is very
helpful to hear from you, and your
voice is important to us at AMSSM.

DiFiori: Thank you, Ashley. It is nice to
chat with you, and thank you for the
opportunity.
Mooney: It seems like our goal should be to intervene early and try to help our patients reach a normal BMI by adulthood. What is your approach to a visit with the obese child? Do you get referrals for obesity, or are you just seeing patients for musculoskeletal complaints?

Narducci: I’d say a bit of both. I have a low threshold to counsel on childhood obesity but also see referred patients. I begin by obtaining a detailed history of the child’s medical conditions, which includes details about medications that may cause weight gain such as glucocorticoids, psychotropic, and antiepileptic drugs. A child’s developmental history is important since a delay may indicate a chromosomal or genetic cause for obesity. Measuring the rate of linear growth and timing of puberty can help distinguish among the differential causes of childhood obesity.

Most children with lifestyle-induced obesity enter puberty at the appropriate age and grow at a normal or excessive rate. Sometimes, the obese child can mature faster and have bone growth that is advanced compared to their peers with normal body weight. When growth rate is diminished or pubertal development deviant, other causes of obesity such as hypothyroidism, excessive cortisol, growth hormone deficiency, diabetes, fatty liver, PCOS, and genetic syndromes should be considered. Also, don’t forget to use an appropriate-sized cuff; I always measure blood pressure.

We have not reached universal consensus on which laboratory tests to perform in children and adolescents with obesity. I often begin with a fasting lipid profile, fasting blood glucose or hemoglobin A1c and sometimes AST and ALT in children who have a BMI between the 85th and 95th percentile. These tests should always be done in children with a BMI ≥95th percentile. Sometimes serum leptin, reproductive hormones, and electrolytes can be useful. Thyroid, adrenal and growth hormone function tests might be needed. When concerned for genetic syndromes, karyotyping is appropriate.

When it comes to screening, there is a lot of controversy due to psychological effects and low predictive value. The USPSTF has found the harms of screening for childhood and adolescent obesity as small to none. In 2011, the U.S. National Heart, Lung, and Blood Institute expert panel recommended universal screening between 9 and 11 years of age and again between 17 and 21 years of age. The USPSTF concludes with moderate certainty that the net benefit of screening for obesity in children and adolescents 6 years and older and offering or referring them for comprehensive, intensive behavioral interventions to promote improvements in weight status is moderate. To date, there is no evidence found regarding appropriate screening intervals for obesity in children and adolescents.

Mooney: What about social history?

Narducci: We must assess a child’s physical activity, and this needs to be a detailed assessment. I often include questions about the child’s time spent in unstructured play, organized sports, school recess, and physical education as well as screen time with television, video games, mobile phones, and tablets. Pandemics certainly don’t help this situation!

Family dynamics are important; understanding how the family eats and functions physically is crucial. Don’t forget to collect details related to depression, peer relationships, sleep practices and disordered eating habits.

Mooney: At what point do you recommend intervening? What treatment options are there?

Narducci: Prevention is key, so ASAP! Interventions, even if they occur later on in one child, may help the family and therefore prevent obesity in siblings. Keep in mind that to be successful the recommendations must be understood by the child and family. I begin with setting weight goals for the child, which is determined by the child’s age and severity of obesity in addition to related comorbidities. The less severe cases may benefit from education and weight maintenance, whereas the severe cases will need a well-constructed weight loss plan and strict follow up visits. Although there is little evidence to support this practice, expert opinion suggests a weight loss of 1 pound per month is safe in children between 2 and 11 years of age whereas weight loss of up to 2 pounds per week is safe in adolescents with severe obesity and comorbidities.

Mooney: Once you determine the child’s weight loss goal, how do you move forward? Do you use the Expert Committee on the Assessment, Prevention, and Treatment of Child continued on page 11
CHILDHOOD OBESITY

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and Adolescent Overweight and Obesity staged approach to weight management in children?

Narducci: I am a huge advocate of the staged approach and have used it to create my own management strategy. I use the 3 M’s: Manners, Menu and Movement. Manners is for behaviors, Menu for nutrition, and Movement for physical and sedentary activity. I begin with educating the family and child about the importance of preventing the development of obesity. Knowledge is really power here. The intervention with the most promising results included motivational interviewing with parental participation.

I focus not only on the child’s but also the family’s behavior or ‘manners’ to assist me in making a structured weight management program. Programs will need to be individualized, and goals need to be precise, possible, practical, and proven. Depending on the severity and response to the structured weight management program, I will often utilize other health care professionals as needed including dieticians, psychologists, physical therapists and pediatric obesity specialists. As a last resort, I will use medications or surgical consults.

Mooney: How does diet play a role?

Narducci: Currently, we do not have a consensus on best dietary strategies for weight loss in children. I begin by determining where the excess calories are coming from: excessive intake, large portions, high calorie fluids, high percent of fat or carbohydrates. Reducing high-fat food, snacks and sugary beverages, in addition to increased intake of fruits and vegetables, have shown positive outcomes. Figure out if there is a knowledge deficit regarding nutrition or if the child and family are not ready for a lifestyle change, unable to monitor the child’s weight, or unwilling to adhere to a plan. Sadly, our current research has shown that these behaviors did not continue at long term follow up.

Mooney: What is the role of activity?

Narducci: Physical activity goals should be determined by the child’s age, personal preferences for the type of physical activity, and exercise tolerance. Various organizations have specific recommendations on how many minutes children should spend being physically active. Children should be active for at least 60-120 minutes a day with screen time less than 2 hours per day for children older than 2 years.

Encourage families and children to participate in organized sports or performance arts. If children struggle to find an activity that they enjoy, I recommend the trial-and-error approach which allows the child to be directly involved in the decision-making process. Don’t forget about strength-training programs for children and adolescents.

Mooney: In your experience, do children benefit more from organized sports, fitness class, or solo activities?

Narducci: I hate giving the politically correct answer, but it depends on what the child is interested in and financial and time constraints. Personally, I find value in organized sports, fitness classes and solo exercise, so if a child can do all three, imagine the social, emotional and physical benefits! I do want to mention that studies have found child and adolescent involvement in physical activity may be associated with positive alterations to certain brain structures. This can improve memory function and cognitive control. Think active recovery for concussions!

Mooney: When I was in residency, there was a program for obese adolescents to meet and exercise together with our obesity clinic. I had one patient love it as she was walking with them and didn’t feel self-conscious. However, I have not found a similar program in other locales. I wonder if we could make more of an impact with these kids if there were more recreational programs and less ultra-competitive programs which seem to be taking over youth sports. Any thoughts on this? Does gym class seem to make an impact?

Narducci: I believe the positive impact programs such as you have described can have is monumental. The barriers to physical engagement in our obese youth are complicated and can’t be overlooked. Physical barriers unique to obese youth engaging in exertional activities include difficulty breathing, joint pain, chest discomfort and general fatigue. Lack of education about how or why one should engage in sports or fitness activities can lead to avoidance and insecurity. Interpersonal considerations such as perceptions of feeling judged, low self-esteem, believing they are not athletic in nature, lack of motivation and other psychological factors such as depression and anxiety can cause children to avoid physical activity.

This will break your heart, but a study found that in regards to physical activity such as gym class in school, obese children were faced with verbal and physical bullying, social exclusion and stereotyping. Changes need to be made to help children and adolescents who are obese feel supported and comfortable, and I think sports medicine physicians have a gigantic role in making this happen.

Mooney: Can you summarize the evidence for interventions for childhood obesity?

Narducci: The 2019 Cochrane review on interventions for preventing childhood obesity?
CHILDHOOD OBESITY  
Continued from page 11

Obesity in children, which included 153 randomized trials, did a great job on this. The information wasn't very surprising, and the trials we have are limited, with only a few being long-term and only 8% of the studies going on for more than 2 years. Across all age groups, the use of dietary interventions alone failed to reduce BMI. Physical activity with or without dietary interventions are only modest at best, and we see a decrease in benefit from diet and exercise interventions from 5 to 13 years old.

Mooney: Is there a role for pharmacological therapy in the treatment of childhood obesity?

Narducci: Obviously, prevention and lifestyle interventions are the best course of action. The efficacy for medication use for childhood obesity has been disappointing. Orlistat is the only medication currently approved by the FDA for the treatment of obesity in adolescents twelve years and older. Metformin has been approved for Type 2 DM in children ten years and older, but when it comes to weight loss, the results are not promising.

Mooney: What about surgical intervention?

Narducci: There has been an increase in the number of bariatric surgical procedures in adolescents, but despite this, bariatric surgery is infrequently performed in this population. A large prospective study sponsored by the NIH called The Teen-Longitudinal Assessment of Bariatric Surgery found bariatric surgery to be safe and effective in adolescents with severe obesity. The American Society for Metabolic and Bariatric Surgery has guidance on how to select adolescents for bariatric surgery as criteria must be met before considering surgery for obesity in children.

Mooney: What do you think of counseling? Also, how often do you follow up with your patients when they are actively losing weight or in a maintenance phase?

Narducci: The USPSTF found that comprehensive, intensive behavioral interventions with a total of 26 contact hours or more over a period of 2-12 months resulted in weight loss. Interventions of more than 52 hours showed even more improvement. Interventions were provided by pediatricians, exercise physiologists or physical therapists, dieticians, psychologists or social workers, and other behavioral specialists. The interventions varied, but the most common behavioral strategies included sessions involving the parent alone, child alone and together. Family and group sessions about exercise, nutrition, understanding food labels and the need for limiting sedentary activities were used. Facilitating goal setting, self-monitoring, and problem solving activities, in addition to providing supervised instructional physical activity sessions, were also included. I believe that sports medicine clinicians should consider applying changes with every family, at every visit.
Executive Summary – Tensor Fascia Lata Syndrome

By Tyler Schmitz, DO

Introduction

The tensor fascia lata (TFL) is a poorly understood fibromuscular hip structure that may be involved in many disorders of the lower limb, pelvis, and spine. It has a complex anatomical relationship with the iliotibial band (ITB) and therefore cannot function in isolation. The TFL originates around the anterior superior iliac spine and inserts into the ITB just distal to the greater trochanter. Functionally, it is thought to help balance the non-weightbearing limb and act as a tension band for the hip, as the anterior fibers assist with hip flexion and the posterior fibers assist with hip abduction and internal rotation. Along with the gluteus medius and minimus, the TFL is innervated by the superior gluteal nerve which arises from the L4, L5, and S1 nerve roots of the sacral plexus.

TFL syndrome is a rare disorder that consists of low back pain associated with referred lateral thigh pain, specifically into the TFL and ITB. Dr. Frank Ober originally described a similar disorder in 1936; there was no mention of it again until 1988, which was the last time. In 1956, TFL syndrome was also described as a myofascial pain syndrome (MPS), producing a trigger point that was repeatedly found in the same location of the TFL and gluteus medius. Given the limited literature, it is unclear whether TFL syndrome should be considered within the spectrum of greater trochanteric pain syndrome or a proximal presentation of ITB syndrome. As such, this summary will discuss it as a separate clinical entity.

Affected Population/Incidence

Previous case reports have reported TFL syndrome to occur in two ways: traumatic origin with or without degenerative arthritis, or atraumatic origin with degenerative arthritis. Affected individuals range from age 22 to 77 years, with 46.2 years being the average in the traumatic group and 60.6 years being the average in the atraumatic group. TFL syndrome is more common in females with a 4:1 ratio. Risk factors include low back pain with L5-S1 nerve root impingement from trauma or degenerative arthritis with a tight TFL and ITB. The exact incidence is unknown.

In the context of trigger points, 30-85% of patients with musculoskeletal pain suffer from MPS, but it is unknown how many have a TFL or gluteus medius trigger point. The gender difference in incidence also remains unclear. The most common risk factors for MPS include acute or chronic mechanical stress such as trauma, ergonomic factors, or structural factors; however, systemic factors such as metabolic disease can also cause MPS.

Pathophysiology/Etiology

The etiology of TFL syndrome has not been described. Theoretically, weakness from a partial denervation of the superior gluteal nerve could lead to muscular imbalances at the hip and pelvis causing compensatory overuse, pain, and dysfunction of the TFL and ITB, although there is no literature to support this as the mechanism.

The exact pathophysiology of MPS is also unknown. One theory proposes that repetitive and prolonged activity can overload the muscle fibers leading to hypoxia and energy depletion causing increased intracellular calcium and inflammatory mediators which results in sustained muscle contraction and the development of painful taut bands. Other theories suggest neurogenic inflammation or sensitization and limbic dysfunction. Precipitating factors may be any continued on page 14.
Patients with TFL MPS present with a localized, persistent pain in a restricted area at the hip or on the anterolateral aspect of the thigh that may refer pain to the hip, thigh, and calf. They may also report decreased range of motion at the hip. Physical examination may reveal palpation of a hypersensitive bundle or nodule of muscle fiber harder than normal at the TFL or gluteus medius. This will elicit pain over the affected muscle and/or cause radicular pain in a specific referral pattern and local twitch response.

Diagnosis

TFL Syndrome is a clinical diagnosis based on history and physical examination. Both back pain and unilateral thigh pain with ITB tightness must be present concomitantly. This can be distinguished from sciatic radicular pain secondary to nerve root impingement by finding specific tightness, pain, and tenderness in the TFL and ITB. TFL and ITB pain should not be present in nerve root impingement, unless there is direct trauma to that area. Increased pain with or inability to cross the affected leg over the unaffected leg with hips and knees extended while in the sitting or reclining position can help support the diagnosis. Lumbar spine, pelvis, and hip radiographs can be used to assess for degenerative arthritis or exclude other pathology. Electromyogram (EMG) may demonstrate an abnormality at the L5 or S1 nerve roots. Diagnostic injection into the trochanteric bursa with corticosteroid and/or anesthetic may provide relief of pain in this area and may be helpful in establishing a diagnosis. The utility of ultrasound (US) and magnetic resonance imaging for this disorder is not described, but these modalities would potentially be valuable for assessment. Differential diagnosis includes lumbar radiculopathy, greater trochanteric pain syndrome, IT band syndrome, external snapping hip syndrome, piriformis syndrome, hip joint disease, iliolumbar ligament strain, lumbar somatic pain radiation, sacroiliac pain, femoral neck stress fracture, or osteonecrosis of the femoral head.

TFL MPS is also a clinical diagnosis. EMG and US can be used to confirm the diagnosis and exclude other musculoskeletal disorders. EMG may demonstrate end-plate noise and US may display trigger points as more hypoechoic areas compared with surrounding muscles. Pain relief from saline injection into a trigger point can also be diagnostic. Differential diagnosis includes tendinopathy, bursitis, arthritis, nerve entrapment, and fibromyalgia.

Treatment/Management

Treatment of TFL syndrome should be conservative with physical therapy, rest, and local injection, where appropriate. Physical therapy should focus on stretching and strengthening the TFL and ITB. Failure to respond may warrant surgery of the ITB and/or low back. One described surgical technique for lateral thigh pain is partial transection of the TFL with excision of the greater trochanteric bursa to relieve any snapping, tension, or irritation of the tissues, as it projects over the greater trochanter and lateral aspect of the femur. The patient is then progressed to weight-bearing as tolerated.

Management of TFL MPS involves pain relief and correction of precipitating factors, including stretching and ergonomic modification. Nonpharmacological measures may include trigger point injections with local anesthetic or saline, acupuncture, dry needling, osteopathic manipulative treatment, massage, therapeutic US, heat or ice, diathermy, or transcutaneous electrical nerve stimulation. Pharmacologic measures may include nonsteroidal anti-inflammatory drugs and analgesics, muscle relaxants, antidepressants, or neuroleptics. Trigger point injection has been shown to be one of the most effective treatment modalities to inactivate continued on page 19
UPDATE FROM THE AMSSM SMFC (SPORTS MEDICINE FELLOWS COUNCIL)
A Sports Medicine Fellows Interest Group Led by AMSSM Fellowship Members

On behalf of the Sports Medicine Fellowship Council and the current fellow class, I would like to wish everyone and their families much happiness and health during the upcoming holiday season and New Year! The current COVID-19 pandemic has certainly led to a very unconventional start to the first half of the academic year, but I am so proud of how the current fellow class and Sports Medicine Fellow Council have adapted to these unprecedented times.

In July, an exclusive fellow’s community, Sports Medicine Fellow Council, was created on AMSSM Collaborate to help the current fellow class connect and support each other. I am so appreciative of all the contributions from the Sports Medicine Fellow Council members as well as the current fellow class. The community has served as a fantastic place for the current fellow class to connect, and I encourage each of the fellows to continue participating in the discussions. I also highly recommend subscribing to a daily email digest to stay up-to-date on the latest happenings in the community. Please feel free to reach out to any of the officers with any specific questions or ideas you may have to become more involved.

In addition to the exclusive fellow’s community, a new “Ask-a-Fellow” community was recently launched on AMSSM Collaborate. This community provides a platform for residents and student members to interact with current fellows and ask questions about applying to sports medicine fellowships. It is my hope that this community will foster mentorship and serve as a pipeline for students and residents interested in pursuing a career in primary care sports medicine. I truly appreciate all of the current fellow’s participation in the discussions and look forward to the continued development of this great community for trainees.

Lastly, the National Fellow Online Lecture series continues to run strong thanks in large part to efforts led by the members of the Online Fellows Educational Subcommittee. Recent talks have highlighted MSK ultrasound techniques, the female athlete triad and RED-S in sport and exercise induced bronchospasm. The lectures have been well received and had some amazing speakers. You can view the most recent lectures on the AMSSM YouTube page.

Again, wishing you much happiness and health during the holiday season. I look forward to hopefully seeing everyone in 2021 at the Annual Meeting!

Nicolas Hatamiya, DO
Fellow Class Representative to the Fellowship Committee
Sports Medicine Fellow, UCLA
Primary Care Sports Medicine Fellowship Program

Resident & Student Members – Join “Ask-a-Fellow” on AMSSM Collaborate to get answers to these questions as well as other questions:

- Are you wondering what to include on your C.V.?
- Need tips/advice on interviewing with a fellowship program?
- What suggested activities/recommendations can I do now to match in a sports medicine fellowship?
- Need to know potential questions to ask during the fellowship interview?
- Need tips and advice on matching into the sports medicine fellowship program?

After posting your question(s) on “Ask-a-Fellow”, current fellows will respond to your question(s). It is completely voluntary and will be an impactful program for current fellows that just went through the Match to have an opportunity to share their tips/advice as they mentor to residents and students looking to match into a sports medicine fellowship. Nicolas Hatamiya, DO (Fellow Class Representative to the Fellowship Committee) and Stephanie Carey, MD, MPH (Fellow Liaison to the Membership Committee) will be Co-Moderators/Co-Leaders of this community group.
President’s Message

Chris Cornell, MS, ATC
Touro University of Nevada
DO Candidate 2021

Aloha All!

2020 is almost in the books! Turbulent year to say the least, but I hope everyone is safe and that those affected by the virus find strength. Weird year in sports medicine as well, with many student observation opportunities being shut down for safety concern. The best I can say is that this is a great opportunity for us to show our perseverance and creativity on our path to what we want to become. Find an interesting way around a difficult problem. Look for the silver lining in whatever challenge lies ahead. Make 2021 the start of something new!

Continuing the “Day in the Life” Primary Specialty MSIG Webinar Series

In November, the “Day in the Life” series kicked off with two really great discussions. Panels discussed their role and duties in sports medicine as it pertains to them from both Orthopaedics and Emergency Medicine. On December 3rd, we had another great event with the most common route into a sports medicine fellowship, Family Medicine. Webinars will continue in the new year January 5th with our Internal Medicine Speaker Panel and January 14th with our Pediatrics Speaker Panel. On January 25th we will wrap the series up with our Physiatrist Speaker Panel. The remaining webinars all begin at 8:30/7:30pm (EST/CST) so make sure you make it there with all your questions! Our goal is to highlight each path to help you gain perspective in what specialty fits your lifestyle best.

Also, if you are not able to watch any of the webinars live, remember you can always watch these recordings and all of our other previous MSIG webinars on the AMSSM website. The links to playback the webinar recordings are posted on the Student page (must be logged in to view).

Become an Active Student Member

In my final month as 2020 MSIG President, I want to again encourage all Student members to become active participants in the MSIG as we continue to expand. This year we continued on page 17

Officers of the AMSSM MSIG for 2021

Melissa Jackels, BS, PSM ................................. President
University of Hawaii - John A. Burns School of Medicine
(Class of 2022)

Sonal Singh, BA ................................. Vice President
St. George’s University School of Medicine (Class of 2022)

Evan O’Malley, BS ................................. Secretary
Ohio University Heritage College of Medicine - Cleveland Campus
(Class of 2022)

Alex England Akman, MS ........................ At-Large Member (MS2)
Georgetown University School of Medicine (Class of 2023)

Amelia Hummel, BA ........................ At-Large Member (MS2)
University of Hawaii - John A. Burns School of Medicine
(Class of 2023)

Landon Morikawa, MA ........................ At-Large Member (MS1)
University of Hawaii - John A. Burns School of Medicine
(Class of 2024)

Renee Zhao, BS ........................ At-Large Member (MS1)
David Geffen School of Medicine at UCLA
(Class of 2024)

Chris Cornell, MS, ATC ........................ Immediate Past President
Touro University Nevada (Class of 2021)
AMSSM NEWS

UPDATE FROM AMSSM MSIG

Continued from page 16

have laid the groundwork for regional-based community pods to build our active membership from the bottom up. I encourage Student members to “Like” and “Follow” on the MSIG Facebook Page to connect with the AMSSM and the new MSIG Officers. If you are a President of your local interest group or a Faculty Champion, we’ll be contacting you soon about your school’s goals for 2021! Our goal is to create a more collaborative environment for local chapters to exchange ideas.

Do you have an idea or topic your sports medicine group would like to share with other interest groups? Has your local sports medicine interest group found new ways to connect with your community during COVID-19? Send an email to AMSSM_MSIG@amssm.org with your update, question, or suggestion – we would love to chat!

Students: Connect with the MSIG

Like and Follow on Facebook

AMSSM Student Members Elect the 2021 MSIG Officers

12 AMSSM Student members ran for leadership positions within the AMSSM MSIG (Medical Student Interest Group) and the two-week Election of Officers just concluded in early December. All of the candidates were outstanding and ran in a close Election! The month of December will give the outgoing and incoming MSIG Officers time for transitioning in their leadership roles. All of the “newly elected” MSIG Officers are excited to serve and become more involved in AMSSM. The newly elected 2021 MSIG Officers are posted on the Student page of the AMSSM website.

MSIG Webinar Series, “Day in the Life” for Each Primary Specialty (via Zoom)

The AMSSM MSIG is excited to announce their new 6-part Webinar Series, “Day in the Life.” Each webinar will feature a Speaker Panel of AMSSM members from one of the primary specialties where each Speaker will share their unique perspective of their “Day in the Life as a Physician in their Primary Specialty.” Each speaker will share their training background, how they decided to choose their primary specialty, any impactful decisions along the way in their career path, what is their typical day, share their interests in sports medicine (what they are passionate about), impact of COVID-19 Pandemic in their practice and how they made adjustments and offer recommendations to the residents and medical students as they plan their own career path. Each webinar will include a Q&A segment where residents and students can ask questions to the Speaker Panel to address. It will be a great opportunity for members to engage with Resident and Student members.

Make Plans to Attend Now!

The complete list of this Webinar Series is posted on the Student page of the AMSSM website (must be logged in to access the link to access the webinar).

These webinars will be recorded for playback (must be logged in to access the link to access the webinar).

Is Your Sports Medicine Interest Group Connected with the AMSSM MSIG? If Not, Connect Now as a Charter Medical School

53 Charter Medical Schools are currently connected with the AMSSM MSIG and are listed on the Student page of the AMSSM website. If your medical school sports medicine interest group is not listed, become a Charter Medical School.

Please contact the AMSSM MSIG Officers if you would like your medical school’s interest group (must be a Charter Medical School) featured in an upcoming edition of The Sideline Report at AMSSM_MSIG@amssm.org.

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<tr>
<th>Date/Time</th>
<th>Title of Webinar in Series</th>
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<td>Tues., Jan. 5</td>
<td>“Day in the Life as an Internal Medicine</td>
<td>Sameer Dixit, MD, FAMSSM</td>
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<td>Physician”</td>
<td>Nancy Gritter, MD</td>
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<td>David G. Liddle, MD, FACP</td>
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<td>Katherine H. Rizzone, MD, MPH</td>
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<td>Carlin H. Senter, MD, FACP</td>
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<td>Thurs., Jan. 14</td>
<td>“Day in the Life as a Pediatrician”</td>
<td>David T. Bernhardt, MD</td>
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<td>(7:30pm – 8:30pm CT)</td>
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<td>Nailah Japera Coleman, MD</td>
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<td>Mon., Jan. 25</td>
<td>“Day in the Life as a PM&amp;R Physician”</td>
<td>Mark E. Halstead, MD, FAMSSM</td>
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President’s Message
Jeffrey Fleming, DO (PGY3)
Family Medicine Resident
Rowan University School of Medicine

2020 has undoubtedly been a year unlike any other. The coronavirus global pandemic not only affected the world of sports, but also the world of sports medicine. Throughout this time of uncertainty and constant change, the AMSSM has proven to be a guiding light for sports medicine physicians everywhere.

As part of the AMSSM, the Sports Medicine Resident Council (SMRC) strived to provide the same caliber of leadership to its own resident constituents. While this year has certainly provided its fair share of unprecedented obstacles, the SMRC has hopefully lived up to the AMSSM’s preeminent standard.

Our group started the year off strong with the Virtual AMSSM 20th Annual Meeting in the spring. Here, we hosted the first ever “Resources for Residents & Students” lecture. The session focused on informing student and resident members about many of the wonderful, learner-directed resources AMSSM has to offer. Over 250 trainees attended!

The lecture gave us the opportunity to receive feedback from YOU, the AMSSM resident member. Thanks to your responses, we were able to tailor some of our future projects toward addressing the most pertinent needs of tomorrow’s sports medicine physicians. One such need was the request for more sideline coverage experiences during the pandemic. Highlighted at the end of this article is information about a document we’ve developed with suggestions to gain sports medicine experience during this challenging time.

In addition to this project, we have also prioritized streamlining our communication with residents across the country. We utilized our SMRC Facebook page to provide followers with real-time updates and information related to the annual AMSSM conference and fellowship application deadlines. Our goal is to continue the conversation by bolstering our presence within the new AMSSM Collaborate website.

While maintaining an open discussion with residents will always be a top priority, the SMRC has also worked to represent the AMSSM itself. Our Communications Representative Giorgio Negron, MD, helped our continued on page 19
The COVID-19 pandemic has dramatically changed the landscape of sports across all levels. With the implementation of testing protocols and social distancing mandates, sports medicine physicians have led the charge in keeping athletes safe while competing. However, many sport seasons have been postponed or outright cancelled in order to assist with further reducing viral transmission. The precarious nature of the sports world has not only affected athletes, but also the physicians that care for them. The pandemic has presented several challenges to residents and medical students seeking careers in sports medicine. Posted on the website, this article provides medical students and residents with a “How-To” guide for obtaining meaningful sports medicine experiences during the uncertain times of a global pandemic.

Residents...Our Presence Is Growing...Get Connected

AMSSM Resident Members Elect the 2021 SMRC Officers
The two-week Election of Officers concluded in early December with 40 candidates running for leadership positions within the AMSSM SMRC. All of the candidates were exemplary. Over the next several weeks the outgoing and incoming SMRC Officers will transition in their leadership roles. The newly elected SMRC Officers are honored to represent residents of their respective primary specialty and excited to take a leadership role within AMSSM. The SMRC Officers are posted on the Resident page of the AMSSM website.

References
Note from the Editor

We have all been there, either competitively or as medical support, when our team enters overtime. The players are worn out and beat up, physically, mentally and emotionally. The contest should have been over by now, but for a multitude of reasons, the fight goes on, the score tied. What happens in the next few minutes will decide whether you go home in triumph or tragedy. Now is the time to dig deep and decide: how do we finish this?

In many ways, it feels like we are in overtime of the COVID-19 pandemic. The turning of the year, the promise of vaccines, and the ongoing development of useful therapeutics and prevention tools give the sense that the end is in sight. However, for so many of us, the battle still rages hotly. You may feel tired and worn, wondering if you can make it across the finish line. Please know that as a profession, a Society, and as colleagues and friends, we stand together to encourage each other until the final buzzer sounds. Hang in there. Lift the person next to you. We’re going to make it through.

In this vein, we present the latest edition of The Sideline Report, designed to uplift and revitalize. This edition contains inspiring messages from Drs. Julia Iafrate and David Olson, as well as the latest installments of the World of Sports Medicine and Executive Summaries. We will also share Part 2 of Dr. Caitlyn Mooney’s interview with Dr. Dusty Narducci regarding the sports medicine physician’s role in treating childhood obesity. The continuation of our CMO Corner series brings a conversation with AMSSM past-president Dr. John DiFiori as he discusses the completion of the 2019-2020 NBA season in the Orlando Bubble.

I hope this message finds you well and happy. I hope you have a blessed holiday season and are able to take some time to recharge and regroup, because overtime is upon us. Read this edition, then buckle up your chinstrap and head back in there. Show them what you’re made of, and make them remember you.

Jacob Miller, MD
Arthroscopic Partial Meniscectomy Tied to Radiographic Knee Osteoarthritis Progression

By Jesse Charnoff, MD

Arthroscopic partial meniscectomy (APM) is one of the most common surgeries performed world-wide. Recently, Dr. Teppo Jarvinen and his group at the University of Helsinki released results from their study entitled “Arthroscopic partial meniscectomy for a degenerative meniscus tear: a 5 year follow-up of the placebo-surgery controlled.” After five years, there were no relevant differences between APM and placebo surgery for three primary outcomes reported by patients: Western Ontario Meniscal Evaluation Tool (WOMET), Lysholm knee, and knee joint pain following exercise. Furthermore, five years after surgery, 72% of the APM group and 60% of the placebo surgery group had at least one Kellgren-Lawrence grade progression in radiographic tibiofemoral knee osteoarthritis (adjusted absolute risk difference of 13%). Dr. Jarvinen stated, “In addition to not providing symptom-relief, APM seems to cause harm in the form of slightly accelerating the progression of knee osteoarthritis.” The study included 146 adult participants with degenerative meniscus tears confirmed by magnetic resonance imaging (MRI). These participants were randomized to receive either APM or diagnostic knee arthroscopy that served as a placebo surgery. The authors noted several limitations, which include the unblinding of many participants due to persistent symptoms (11% APM vs. 12% placebo), as well as the subjective nature of radiographic assessment of knee osteoarthritis. However, this study highlights that sports medicine physicians should recommend this procedure with caution.

Further reading | Original article

Should We Wear Masks During Physical Activities?

By Manoj Poudel, MD

The rate of COVID-19 transmission may be higher at group sporting activities, enclosed spaces, and secondary to wider spread of droplets during exercise. The possible respiratory effects of wearing a mask during exercise are increases in dead space CO2, flow resistance and respiratory effort and lower oxygen saturation level. However, our knowledge on safety and the physiological effects of mask wearing during physical activity is limited. Recently, Epstein et al performed a multiple cross-over, self-control trial to assess the physiological effects of masks during short-term moderate-strenuous exertion. Sixteen healthy male adult volunteers (mean age 34 ± 4 years and mean BMI 28.72 ± 3.78 kg/m2) performed exercise on a bicycle ergometer (started at 25 watts; cycling rate of 55-65 revolutions per minute) with increment of load until exhaustion in 3 settings — without a mask, wearing a surgical mask, and wearing a N95 respirator. Data was analyzed using descriptive statistics, repeated measures of analysis of variance (ANOVA) and partial eta-squared. Differences in time to exhaustion, respiratory rate, heart rate, blood pressure, oxygen saturation, end-tidal carbon dioxide (EtCO2, surgical mask vs. no mask) levels, and perceived exertion did not reach statistical significance. The EtCO2 was slightly higher at rest and during exercise with N95 respirator versus without a mask. Hence, the short-term moderate-strenuous aerobic physical activity with a mask in healthy subjects was feasible, safe, and associated with only minor changes in physiological parameters. This study sets the stage for further research on the physiological effects of mask-wearing during exercise.


Inspiratory and Lower-Limb Strength Importance in Mountain Ultramarathon Running. Sex Differences and Relationship with Performance

By Gregory Walker, MD

A recent study published in Sports by Basel et al enrolled 47 participants (29 male and 18 female, median age 41 +/- 5 years) intending to complete the Penyagolosa Trails CSP Mountain Ultramarathon held in the province of Castellón, Spain. Participants were recruited to perform a series of lower-limb strength tests (squat jump test, ankle rebound test and an isometric maximal voluntary contraction (IMVC) test in half-squat position) and pulmonary function testing including maximal inspiratory pressure (MIP) 2-4 weeks before the race. Of the 43 starters (four participants withdrew prior to the race secondary to injury), 32 runners (19 male and 13 female) completed the entire race. Performance levels were heterogeneous with average finish times 174% and 157% of the men’s and women’s winning times, respectively. Results of the study illustrated a positive correlation between finishing time and the ankle rebound test, IMVC, and MIP. Interestingly, there were not significant sex differences in the ankle rebound test, IMVC, and MIP. The male subjects had the strongest correlation between MIP and performance, whereas female subjects had the strongest correlation between the ankle rebound test and performance. The two principle conclusions were that strength training and assessment in athletes completing mountain ultramarathons should focus on lower-limb isometric strength and reactive ankle strength and that coaches and athletes should consider adding inspiratory muscle training exercises into their training regimens. Limitations of the study included the absence of lower-limb muscle endurance testing. Overall, this study is novel in its examination of the growing sport of mountain ultramarathon running.

Disclaimer: The information provided in this section does not necessarily represent the official view of AMSSM but is nonetheless available for consumption and consideration of the membership.
News from the Board

President’s Corner: An Update from the Presidential Task Force on Training for Future Sports Medicine Physician

By Tracy Ray, MD, FAMSSM

In late 2018, then-AMSSM President Chad Asplund, MD, FAMSSM, appointed me to chair a Presidential Task Force with the charge to evaluate our current educational model for producing sports medicine physicians and evaluate and recommend possible changes (if needed) to the current model.

This task force is composed of a diverse group of members, most with extensive experience in training residents and fellows in sports medicine. It includes Chad Asplund, MD, MPH, FAMSSM; Chad Carlson, MD, FAMSSM; Mederic Hall, MD; Ken Mautner, MD, FAMSSM; Jim Moeller, MD; Rebecca Myers, MD; Fran O’Connor, MD, MPH, FAMSSM; Amy Powell, MD, FAMSSM; Tracy Ray, MD, FAMSSM; and Mark Stovak, MD, FAMSSM. Over the past two years, this task force has carefully analyzed the issues related to training of sports medicine physicians, with no preconceived outcome. The task force divided its work amongst seven working groups that were formed to study the issues in a more in-depth way.

PRESENTING POSSIBLE WAY FORWARD

In April 2020, I presented a brief summary to Fellowship Directors during the Fellowship Forum as a possible way forward to consider expanding Fellowship curriculum, faculty and, therefore, length of Fellowship training to better meet the needs/gaps identified by the task force and working groups. Understandably, there were concerns raised by Fellowship directors, since the virtual forum didn’t allow for an opportunity to go into more detail regarding the findings of the task force and recommendations from the working groups. In May, the task force shared a 110-page document with Fellowship Directors, providing further background and insights regarding the recommendations. Below are highlights from the seven working groups’ work:

- **Limitations of the Current Training System** – The research that came out of the Branding and Marketing Task Force in 2017-18 indicated that our membership continues to struggle with our identity as Sports Medicine Physicians. Our differing backgrounds in five primary specialties and the variable training that exists in our one-year fellowships make it difficult to communicate “who we are” and “what we do” in a marketing campaign for our specialty. This diversity also became a barrier to our ability to provide a consistent product when we describe what we do in our Scope of Practice document. The task force concluded that the problem of identity and consistency has its roots in our education and training.

- **Stakeholder Advisory** – This group discussed the growing educational requirements and needs of the sports medicine fellowship. They were supportive of the broad training in primary care with current residencies that support sports medicine fellowships, while also being supportive of an extended fellowship-

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PRESIDENTIAL TASK FORCE
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training period of two years that could occur in several different formats.

• Curriculum Development
  – Developed an all-inclusive curriculum that would reflect the current Scope of Practice and Standards of Excellence documents (noting that the current ACGME sports medicine requirements set a low bar that has allowed marked diversity amongst the fellowship programs). It was strongly felt that one year was not a sufficient time-period. The ideal curriculum estimate was 36 months. This included large portions of time for curricula such as cardiology, nutrition, ultrasound, mental health, exercise & wellness medicine and orthobiologics.

• SWOT Analysis – Considered the following options and submitted a SWOT analysis for each model. A 1-year Fellowship (current model): a 1.5-year Fellowship; a 2-year Fellowship; a 3-year Fellowship; a 1-year Fellowship plus 1-year Sub-Fellowship in a sub-specialty area (e.g. cardiology, US, procedures, etc.); a 1-year Fellowship plus 1-year Jr. Faculty or Clinical Instructor employment model; a Sports Medicine Track in residency (6-12 months of sports training in place of usual primary specialty training) followed by 1-year Fellowship Sports Medicine Residency Program.

• Funding Issues – Evaluated the costs associated with training expansion. Sports Medicine Fellowships are funded by a wide variety of mechanisms including CMS funding, fellow billing, athletic department funding, grants, departmental funding, and even DME monies. Funding is seen as a major concern of extending training beyond one year, but a barrier that could be overcome with sufficient foresight and planning. The funding issues would be much larger for starting new sports medicine residencies than they would be to extend the length of fellowship training. Resources are another concern for training expansion. Faculty with the required expertise would be necessary in each community or region to meet the training requirements in all of the areas of the curriculum. The new AMSSM Fellowship Online Lecture and Ultrasound Education Series will help programs that do not already have these resources.

• Accreditation Concerns - Evaluated issues surrounding the processes of expanding current program requirements for Sports Medicine Fellowships through the current specialty societies review committees (Ex. FM-Rc) versus innovations needed to pursue a stand-alone specialty with its own residency program in Sports Medicine through the American Board of Medical Specialties. Fellowship expansion seemed like the most logical next step at this time.

• Future Healthcare Needs
  - Evaluated the value of sports medicine physicians to employers, insurers, hospitals and patients. This working group concluded that a move to expand fellow training in the future allows for a better trained future sports medicine physician who, in turn, will be able to treat a wider variety of patients and control costs for health care systems that are going to have to reduce costs in the future. The threat to our medical specialty of sports medicine by other healthcare providers seeking to expand their scope of practice is very real. They are cheaper to employ than we are as physicians, and they are cheaper to train. Their scope of practice is expanding, and we must continue to separate ourselves as sports medicine specialists.

Thank you for the hard work and thoughtful consideration provided by the Task Force and the following members who served on these working groups - Irfan Asif, MD; Fred H. Brennan, Jr., DO, FAMSSM; Kevin Burnham, MD; Kevin Burroughs, MD; Jeffrey Bytomski, DO, FAMSSM; Peter Carek, MD; Jay Clugston, MD, FAMSSM; Alex Diamond, DO, MPH, FAMSSM; Sam Dixit, MD, FAMSSM; Jon Drezen, MD, FAMSSM; Bert Fields, MD, FAMSSM; Jeff Fleming, DO; Jon Finnoff, DO, FAMSSM; Margaret Gibson, MD; Mike Henehan, DO; Eliot Hu, MD; Julie Ingwerson, MD; Hamish Kerr, MD, MSc; Morteza Khodaei, MD, MPH, FAMSSM; Jennifer Koontz, MD, MPH, FAMSSM; David Liddle, MD; John Lombardo, MD, FAMSSM; Doug McKeag, MD, FAMSSM; Melissa Novak, DO; Rick Okragly, MD, FAMSSM; Jim Puffer, MD, FAMSSM; Ashwin Rao, MD, FAMSSM; Jeremiah Ray, MD; Jeff Roberts, MD, FAMSSM; Matthew Silvis, MD; Siobhan Statuta, MD; Michael Swartzon, MD; Jim Tucker, MD; Verle Valentine, MD, FAMSSM; Brandee Waite, MD; Craig Young, MD, FAMSSM; Jason Zaremski, MD. The working groups also sought input from colleagues from other international societies including – Dr. Mark Batt; Dr. Peter Brukner; and Dr. David Humphries and sought input from Dr. Sam Jones.

GATHERING INPUT

The task force and AMSSM Board of Directors are in the process of gathering more information from Fellowship Program Directors, recent graduates and future fellows before further considering these recommendations.

• Phase 1 - To gather input from Fellowship Program Directors, ten Regional Town Hall Meetings were organized. These town halls were hosted between September and November 2020. The summaries from these 10 Regional Town Halls have been compiled and are being closely reviewed by the task force and the Board of Directors, with some recurring themes, concerns voiced, with advantages and disadvantages of the task force recommendation being discussed. Thank you to the strong participation from approximately continued on page 24
NEWS FROM THE BOARD

PRESIDENTIAL TASK FORCE
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150 different Program Directors who participated and the following members who served as hosts - Irfan Asif, MD; David Bernhardt, MD; Anthony Beutler, MD, FAMSSM; Suzanne Hecht, MD; Michael Fredericson, MD; Andrew Gregory, MD, FAMSSM; James Kinderknecht, MD; Andrew Monseau, MD; David Webner, MD, FAMSSM; Ramon Ylanan, MD.

• Phase 2 - Our next step will be building separate surveys that will allow us to more accurately measure thoughts and opinions of fellowship program directors, recent graduates, and future fellowship candidates. We anticipate utilizing outside survey expertise to ensure that bias is eliminated in the survey process and that we appropriately gather the information needed. Thank you to the following working group helping me develop these three distinct surveys - Carly Day, MD; Paul Gubanich, MD, MPH, FAMSSM; AJ Monseau, MD; Amy Powell, MD, FAMSSM; Ashwin Rao, MD, FAMSSM; Mark Stovak, MD, FAMSSM; Adam Tenforde, MD; and Kristina Wilson, MD, MPH, FAMSSM with support/guidance from AMSSM Research Director Stephanie Kliethermes, PhD.

PREPARING FINAL RECOMMENDATIONS
The outcomes from these surveys in combination with the feedback gathered from the Regional Town Halls and the original work of the task force will allow the task force to solidify recommendations to present to the AMSSM Board of Directors for consideration. We anticipate that ACGME will put out a call for major revisions to Fellowships sometime in 2021, though COVID-19 has delayed the review processes for other specialties. Ultimately, AMSSM’s final suggestions will be submitted and vetted through a complex process of the ACGME prior to implementation. AMSSM will continue to work within the ACGME system to play its role in effecting positive change in the future training of sports medicine physicians.

I appreciate your support and patience as we work our way through this important process. I am quite confident that everyone involved in the training of sports medicine physicians desires the very best experience for all trainees.

Membership Committee Update
By Nailah Coleman, MD

As we approach the end of 2020, the Membership Committee is pleased to report that AMSSM membership continues to have steady growth with 5.8% increase in total membership compared to last year with increases in almost every membership category.

Total Membership: 4,361
MD 74% | DO 26%
Male 72% | Female 28%
MEMBERSHIP COMMITTEE UPDATE
Continued from page 24

Initiatives advocating for the physician that are developed and implemented by AMSSM leadership continue to sustain our organization but it is the energy and enthusiasm of each member that is the driving force that enables AMSSM to continue to thrive. We want to thank our fellowship class liaisons and class representative, MSIG and SMRC Officers, committee members and AMSSM leadership. On behalf of all the Membership Committee members, I want to thank Marci Goolsby, MD, for her leadership over the past four years chairing the Membership Committee and for her support as we transitioned our leadership roles. Through her intuitive nature and vision, she started the six Focus Area Work Groups within the Membership Committee for members to share ideas, evaluate current goals and set new goals for each of the Focus Areas.

The Membership Committee oversees:

- **Scholarship Review:** Resident Scholarship, Galen Medical Student Scholarship and Notre Dame/South Bend Resident Scholarship (led by Nathaniel Jones, MD) and the Jason Davenport Memorial Scholarship (co-led by Diversity Special Interest Group Leaders: Shelley Street Callender, MD; Membership Committee Vice Chairperson and Nailah Coleman, MD; Membership Committee Chairperson).

- **Annual Membership Survey:** Led by Steven Poon, MD; this subcommittee works diligently on reviewing and implementing the Annual Membership survey. The survey response rate is typically 30-35% of the membership each year. Highlights of the survey results are included in this committee short.

- **FAMSSM Designation:** This subcommittee is chaired by Marci Goolsby, MD. The Fellow of AMSSM (FAMSSM) Designation serves to recognize sports medicine physicians in the AMSSM membership who have demonstrated an ongoing commitment to lifelong learning, the advancement of the profession, service to AMSSM and leadership in their communities. There are currently 113 AMSSM members who have achieved the designation, with additional designees selected each year through an application/review process. FAMSSM Designation Class of 2021 will be announced in January.

- **Fellow Liaison:** Stephanie Carey, MD, MPH, is our 2020-2021 Fellowship Class Liaison for the Membership Committee. She serves as the co-leader of the “Ask-a-Fellow” community group on AMSSM Collaborate where Resident and Student members can post a question to current Fellowship members about matching into a sports medicine fellowship and also works with the SMRC and MSIG on various projects. Her focus is working on encouraging fellow communication especially on AMSSM Collaborate.

- **Medical Student Interest Group (MSIG):** The MSIG Officers have hosted outstanding live webinars for Resident and Student members in 2020. In addition to the current six-part webinar series, “Day in the Life” where each webinar focuses on one of the primary specialties and features AMSSM members on the Speaker Panel sharing their story about their career, why they chose their specialty, how COVID-19 has affected their practice and insight/advice they can give to the residents and medical students. Earlier this year, two other webinars were presented, “Sport Specialization – The Past, Present and the Future of Single Sport Training” presented by Neeru Jayanthi, MD; AMSSM Member and Stephanie Kliethermes, PhD; AMSSM Research Director that was followed by a Twitter feed after the webinar concluded and “Being the Best Sideline Physician: Developing & Implementing an Emergency Action Plan (EAP)” featuring Steven Cole, MS, ATC; Christopher Hogrefe, MD; and Michael Petrizzi, MD. Links to these webinars and all of the past webinars are posted on the Student page of the AMSSM website for all members to view (must be logged in). MSIG Officers make posts to engage Student members and expose medical students all over the country to AMSSM and the field of sports medicine on the AMSSM MSIG Facebook page (currently with 98 likes|106 followers). Congratulations to the newly elected 2021 MSIG Officers.

- **Sports Medicine Resident Council (SMRC):** The SMRC Officers have been working on initiatives dedicated to supporting resident members as they complete their residency training. During the Virtual 2020 AMSSM Annual Meeting, the SMRC Officers led by Jeffrey Fleming, DO (President) and Giorgio Negron, MD (Communications Representative) hosted the first ever “Resources for Residents & Students” lecture. The session discussed all of the resources AMSSM has to offer Resident and Student members. During the virtual session, participants were polled on various topics which provided important feedback to the SMRC Officers. The SMRC Officers also continue to look for updates to the Fellowship Program listings on the AMSSM website. The SMRC Officers are also creating a document/article with ideas and suggestions on how to get coverage opportunities during COVID-19. The AMSSM SMRC Facebook page (currently with 195 likes|214 followers) continues to continued on page 26
MEMBERSHIP COMMITTEE UPDATE
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engage current resident members and introduce residents all over the country to AMSSM. Congratulations to the newly elected 2021 SMRC Officers.

• Rookie Report: This is an e-newsletter published throughout the year that features short articles of interest for Student and Resident members. The Editorial Board is led by the Giorgio Negron, MD; SMRC Communications Representative.

• Mentor Program: Led by David Wang, MD and Joan Brown (Membership Manager). Beginning now at the end of 2020, the Mentor Program has been expanded to be a year-round program. The ultimate goal is to be longitudinal through a natural evolving process where the mentor-mentee (protégé) relationship would continue to develop and sustain over a longer period of time. A Mentor-Protégé Blueprint was created with detailed information about the program. The Mentor Program is committed to continually build a core group of mentors in each primary specialty called Mentor Group Leaders. Their primary role is to serve as a mentor resource and to offer support and advice to the mentors in their group periodically. Mentor Group Leaders: Emergency Medicine – Christopher Guyer, MD; Family Medicine (Allopathic) – Marci Goolsby, MD; Yaowen Eliot Hu, MD, MBA; Siobhan Statuta, MD; and David Wang, MD; Family Medicine (Osteopathic) – Jacklyn Kiefer, DO and Jason Smith, DO; Internal Medicine – Claudia Dal Molin, DO; Pediatrics – Cassidy Foley Davelaar, DO; PM&R – Lauren Elson, MD and Jonathan Napolitano, MD; and Diversity – Janeeka Benoit, DO and Oluseun Olufade, MD.

• Special Interest Groups – A few highlights of discussions below:

- Academics (Steven Poon, MD). Session held at the 2020 Virtual AMSSM Annual Meeting with a great Q&A Panel led by Matthew Silvis, MD; Mark Stovak, MD, FAMSSM; Kimberly Harmon, MD, FAMSSM; and Irfan Asif, MD.

- Diversity (Shelley Street Callender, MD): • The Jason Davenport Memorial Scholarship award supports an underrepresented minority member that is presenting a case or research abstract and helps defray the expense of attending the Annual Meeting with a $500 cash award and plaque. Giorgio Negron, MD was selected as the recipient for 2020 (Award/plaque will be presented at the 2021 Annual Meeting along with the 2021 scholarship recipient. • Working on improving diversity in mentorship • Evaluating research ideas for diversity in sports medicine (ex. women in sports medicine positions, head physician designation status).

- Emergency Medicine (Christopher Guyer, MD): • Discussed EMIG listserv and invited members to sign up for this useful tool. • Members broke into work groups and developed action plans for each area (education, Annual Meeting/ICL topic development, fellowship, research, practice development).

- Internal Medicine (Claudia Dal Molin, DO): • Discussed ABIM/MOC Certification – possibly online MOC opportunities for ABIM credit • Discussed COVID Era Updates – Check ABIM site for most up-to-date information • David Liddle, MD, presented update on Internal Medicine MSK Curriculum • Sameer Dixit, MD, FAMSSM presented an update from the ACP.

- Military (Chad Hulsopple, MD; Nathaniel Nye, MD; and Julie Creech, DO): A new Special Interest Group approved by the Board of Directors. Excited to have the opportunity for military members to begin unique collaboration through AMSSM.

- Pediatrics (Mark Halstead, MD): • Peds sports curriculum is pending in publication • No COSMF Meeting this year • Virtual PRISM Meeting is this January - hoping to springboard some stuff there before the AMSSM Annual Meeting • Concerns raised again about discrepancy in cost for sports medicine boards for pediatricians compared to other primary disciplines and discussed as a continued issue with ABP.

- PM&R (Melody Hrubes, MD): • Pleased with significant participation at the 2020 Virtual Annual Meeting • Concern from trainees about oral boards being delayed and application for CAQ • Great representation at AAPMR Annual Meeting from AMSSM members • Would like to build a list of AMSSM members (especially younger faculty) to present on MSK medicine at PM&R meetings.

- Private Practice & Employed Practice (Michael Swartzon, MD): • Presented updates to interest group members during the Virtual 2020 AMSSM Annual Meeting.

- Resident/Student (David A. Ross, MD): Session held at the Virtual 2020 Annual Meeting on member engagement in AMSSM and about applying and preparing to match in a sports medicine fellowship with a Speaker Panel answering questions raised by residents and students attending the session.

Focus areas were formed at the 2019 Membership Committee Meeting and discussions ensued among committee members on evaluating current goals continued on page 27
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MEMBERSHIP COMMITTEE UPDATE
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and generating new ideas for each focus area: **Member Engagement** (David Ross, MD); **Infrastructure** (Shelley Street Callender, MD; Vice Chair Membership Committee); **Special Interest Groups** (Selina Shah, MD); **Mentoring** (David Wang, MD); **Scholarships** (Nathaniel Jones, MD); and **Membership Section of the Website** (to be formed at future time). All members are encouraged to join AMSSM Collaborate to join in conversations and connect with other members.

If you are interested in serving on the Membership Committee, please email us at membership@amssm.org.

Highlights from the AMSSM Annual Membership Survey

The Membership Committee wants to thank Steven Poon, MD and his sub-committee members for working diligently each year on the task of implementing our Annual Membership Survey. The sub-committee seeks input from Committee Chairs to review the survey questions from the previous year to continually evaluate/update the survey.

2020 AMSSM Annual Membership Survey Results: 1,200 responses; up from 900 from the previous year. Data reported reflects the survey responses received. The survey is posted on the AMSSM website and results are highlights below.
Diversity Special Interest Group Update

The Diversity Special Interest Group had an outstanding attendance at the Virtual AMSSM 2020 Annual Meeting.

We developed the following Interest Working Area Discussion Groups (the Jason Davenport Scholarship group is by invitation/selection only) with champions (guides or leaders) for each group.

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<th>Interest Working Area</th>
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<tr>
<td>Diversity with AMSSM/Meeting/Mentorship</td>
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<tr>
<td>Minorities in Fellowship/Representation in Programs, as Team Physicians</td>
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<tr>
<td>COVID Prevalence in Athletes of Color or Their Families</td>
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<td>Implicit Bias, An Observational Evaluation</td>
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<td>Service AMSSM members to Underrepresented Minority Athlete Communities</td>
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<td>Triad Risk and Outcomes in Athletes of Color</td>
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<td>Diversity Web/Communications/e-Blast/Newsletter</td>
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<td>Jason Davenport Memorial Scholarship</td>
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If you are interested in joining any of these Interest Working Area Discussion Groups through AMSSM Collaborative, please contact Shelley Street Callender, MD; Nailah Coleman, MD or Joan Brown and we will get you added.
Announcing New $10K Underrepresented Minority Research Grant Opportunity

The AMSSM Foundation is excited to announce a new research grant opportunity for underrepresented minority research members. The AMSSM Minority Research Grant aims to provide research opportunities specifically for historically underrepresented minorities in biomedical research to advance representation across diverse backgrounds and promote health equity in sports medicine research.

The AMSSM Foundation and AMSSM Research Committee seek to award one grant worth $10,000 for a grant cycle length of one year. To be eligible for this award, the principal investigator should identify with one of the following racial and ethnic groups who have been shown to be underrepresented in biomedical research: Blacks or African Americans, Hispanics or Latinos, American Indians or Alaska Natives, Native Hawaiians and other Pacific Islanders (NIH statement on Diversity). The principal investigator of the grant must be an AMSSM member at time of submission. Current AMSSM fellow and resident members are eligible to apply. Resident members may apply as the principal investigator but must have at least one full AMSSM member listed as a co-investigator at the time of application. Co-investigators do not need to meet the underrepresented minority criteria.

The AMSSM Foundation and the AMSSM Research Committee welcome research grant proposals that investigate issues within the broad discipline of sports medicine, including clinical practice, injury prevention and rehabilitation, quality improvement, basic science, epidemiology and education. Grant proposals can address questions related to underrepresentation and disparities in sports medicine; however, this is not a requirement for a successful proposal.

Each award winner will be paired with an AMSSM research mentor to aid the investigator in their development as a sports medicine clinician-researcher. Award winners can self-identify a mentor at the time of submission (including a letter of support from that mentor in the grant application), otherwise the research committee co-chairs will work with the award winner to identify an appropriate mentor.

Please see the RFP for complete details about the proposal, review process and more. Any questions can be directed to AMSSM Research Director Stephanie Kliethermes, PhD.
Submit Nominations for the 2021 AMSSM Founders’ Award

Nominations are being accepted for AMSSM’s top honor - the 2021 AMSSM Founders Award. Please consider nominating an individual, group or organization that exemplifies the best aspects of sports medicine. If chosen, they will receive a $500 cash award and a plaque during the 2021 AMSSM Annual Meeting (Hybrid) in San Diego, CA.

The deadline to nominate candidates for the Founders’ Award is Jan. 8, 2021.

Past Founders Award Recipients:

2019 - Chad Carlson, MD, FAMSSM
2018 - Aurelia Nattiv, MD
2017 - Fran O’Connor, MD, MPH, FAMSSM
2016 - William Dexter, MD, FAMSSM
2015 - Bob Kinningham, MD, FAMSSM
2014 - Margot Putukian, MD, FAMSSM
2013 - Warren Howe, MD
2012 - Craig Young, MD, FAMSSM
2011 - Chris Madden, MD, FAMSSM
2010 - Stephen Paul, MD, FAMSSM

2008 - Connie Lebrun, MD, FAMSSM
2007 - Jim Moriarity, MD, FAMSSM
2006 - Randall Dick; Vito Periello Jr., MD
2005 - Elizabeth Arendt, MD
2004 - John A. Bergfeld, MD
2003 - Cindy Chang, MD, FAMSSM
2002 - James Whiteside, MD
2001 - Karl B. Fields, MD, FAMSSM
2000 - David Hough, MD

This represents a great opportunity to publicly recognize a special physician or group that has been influential in the sports medicine community. Click here to view and submit the nomination form.

2021 Foundation Auction: Call for Items

In its 10th year, the AMSSM Foundation Auction continues to support and benefit AMSSM programs that promote research, education and initiatives developed by AMSSM and funded by the Foundation. For the last seven years, the AMSSM Foundation Auction has collectively raised more than $270,000 providing a substantial source of funding.

Auction items ranging from authentic sports memorabilia and event tickets to scenic vacation stays and course registrations are popular items. Members affiliated with professional and collegiate teams can also consider donating team apparel or memorabilia that will be included in the auction.

During the 2021 Annual Meeting in San Diego, CA, we’re asking members to consider what item(s) or package(s) you, your team, university and/or company might donate for the 2021 Foundation Auction.

You can view the 2021 Annual Meeting web page for a copy of the Auction Donation Form, and the Prospective Donor letter that you can pass on to your employer, team, league, etc. You can also submit your form online. Donors will receive letters acknowledging their gift for tax purposes. Winning bidders may claim a tax deduction for anything paid above fair market value.

Deadline to submit your items is March 12, 2021.

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Member in the Spotlight

Heidi Prather, DO

By Lauren M. Simon, MD, MPH

Consume a “whole food-plant based” diet is a mantra that I repeat to my patients in the “Blue Zone” in Loma Linda, California, and I was excited to hear our Member in the Spotlight, Heidi Prather, DO, giving the same advice to legions of her patients in the cattle region of Missouri. Dr. Prather has had a special focus integrating lifestyle changes to promote wellness and reduce musculoskeletal pain in her sports medicine patients. Last month, she built on that interest when she passed the American College of Lifestyle Medicine board exam. She describes that the accelerated move to telehealth services during the COVID-19 pandemic has created additional opportunities to educate her patients about nutrition, exercise and sleep to help improve function.

Dr. Prather was raised in Kansas City, Missouri, and attended Liberty High School, where she ran track and played tennis. In high school, she held the record for the two-mile run “simply because no one else wanted to run that far.” She became interested in pursuing medicine while working as a nursing assistant at a rehabilitation hospital during high school. Through that work, she developed a keen interest in the musculoskeletal system and how it affects one’s quality of life (a precursor to her Lifestyle Medicine focus). She attended Drury College in Springfield, Missouri, where she competed on the tennis team. After medical school at University of Health Sciences in Kansas City, she finished her transitional year internship at Presbyterian/St. Luke’s Family Medicine program in Denver. She completed the Physical Medicine and Rehabilitation (PM&R) Residency in Chicago at Northwestern University. Her mentor, Dr. Joel Press, encouraged her to consider the musculoskeletal, spine and sport disciplines and she subsequently pursued sports medicine.

Dr. Prather was a faculty member at Washington University School of Medicine for 22 years where she developed and grew the PM&R program in the Department of Orthopedics, started one of the first of five PM&R ACGME accredited Sports Medicine fellowships in the nation and served as Fellowship Director. She was one of the initial PM&R physicians to achieve Board certification in Sports Medicine in the United States. She developed musculoskeletal and sports medicine curricula which became core education for medical students, orthopedic and physiatry resident physicians at Washington University. Further, she helped to develop PM&R didactic ultrasound curricula for students and residents. At Washington University, she also developed an intensive lifestyle medicine program, the Washington University Living Well Center, for patients with spine and other musculoskeletal disorders to reduce pain and improve their function and quality of life. She served as a team physician for local high schools, Washington University, the NFL’s Rams and the NHL’s Blues.

Never one to shy away from new opportunities, Dr. Prather became the first female President of the North American Spine Society and the Physiatry Association for Spine, Sports and Occupational Rehabilitation in PM&R and serves as Senior Editor for the PM&R Journal. She recently retired from Washington University in Missouri and will be starting her new job at the Hospital for Special Surgery in New York in 2021.

When asked about her leadership advice to AMSSM members and learners she encourages others to “Be your authentic self in your leadership role, as this will enable you to do your best work. Don’t try to lead in a way others think you should do, rather lead in the way your talent and strengths direct you to lead.”

Dr. Prather is thankful to PM&R physicians such as AMSSM Founder Dr. Stan Herring and charter member Dr. Stuart Weinstein for promoting sports medicine and sports medicine accreditation in the PM&R specialty while paving the way for clinicians such as herself to mentor other learners in the field. She appreciates the leaders and members of AMSSM who welcomed the PM&R clinicians into the primary care sports medicine family and notes that sense of openness and inclusion in AMSSM builds energy in our sports medicine field. She has enjoyed participating in case and research presentations at AMSSM Annual Meetings with her fellows and the educational collaborations with our members.

Outside of work hours, she enjoys preparing plant-based cuisine, reading biographies and running. Other favorite activities include hiking with her husband, Dr. Jeffrey Bradley, skiing and other winter sports. This season, before there is enough snow to effectively use snow shoes, you may find Dr. Prather outside “Yakking” (using Yaks attached to her hiking boots and hand poles to get great exercise on the trails). Thank you, Dr. Prather, for being our winter Member in the Spotlight!