The Sideline Report
News in the World of Sports Medicine

AMSSM NEWS

AMSSM Conducts 2020 Virtual Meeting with All Lectures and Meetings Available for Playback

Following the cancellation of the 2020 Annual Meeting, AMSSM’s leadership conducted a virtual, non-CME version of the conference over the original dates of the Annual Meeting from April 25-29.

The Virtual Meeting drew almost 6,000 registrations across all courses, meetings and lectures and included the following highlights:

- **Saturday Presidential Talks** – Chad Carlson, MD, FAMSSM delivered his outgoing presidential address and Tracy Ray, MD, FAMSSM gave his incoming presidential address.
- **Case and Research Presentations** – The new AMSSM Collaborate online community served as the platform for posting the 703 Case presentations and 218 Research presentations that were submitted for the 2020 Annual Meeting.
- **Virtual Fellowship Fair** – This popular program for Residents and Fellowship programs took place on a virtual format through the AMSSM Collaborate online community.
- **Tuesday Keynote Talks** – Leaders in the sports medicine community gave lectures centered around the topic of COVID-19, including AMSSM Members on the Front Lines, Mental Health in the Time of COVID-19 and the Importance of Leadership During Crisis.

Playback and more information for all sessions is available to AMSSM members at amssm.org.

AMSSM Unveils AMSSM Collaborate Online Community

Launched in conjunction with the Virtual Meeting, the AMSSM Collaborate online community provides a forum for year-long connection, giving members the chance to have conversations, share resources and make connections with peers.

This online community served a vital role during the Virtual Meeting by hosting the hundreds of case and research abstracts that were accepted for the 2020 Annual Meeting. Sports medicine fellowship programs also used this community to share information and have conversations during the Virtual Fellowship Fair.

Ultimately, AMSSM Collaborate was created to meet a need we’ve heard from members wanting to better connect with peers and to

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AMSSM NEWS

2020 ANNUAL MEETING MESSAGE
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host important conversations within AMSSM to accomplish the following:
• Help members get their clinical questions answered and a venue to seek referrals.
• Serve as a single location for committees to share opportunities to get involved, organize and complete their work and share/archive important documents.
• Serve as a venue for special interest groups and team physicians to come together, ask questions, share expertise/resources and reach solutions for issues facing sports medicine physicians and the teams they care for.

This platform is ideal for conducting committee or subcommittee work because you can share documents with the rest of the group and store them for future reference. The entire Collaborate community is searchable, so resources and conversations are easy to find.

We have listed some common questions and FAQs below to help get you started. Feel free to browse the FAQ page for more information. You can also contact AMSSM at 913-327-1415 or by emailing Communications Manager Andy Meyer with any questions or to discuss strategies in your groups.

As sports medicine physicians continue to react to the worldwide pandemic, AMSSM is tracking government response efforts that affect how you practice medicine.

The temporary expansion of telehealth services will be a key tool to help you during the pandemic and, if some of these adjustments are made permanent, may change and enhance the way you deliver health care in the future.

Furthermore, we know that many AMSSM members in private practice are experiencing a sharp decrease in patient volume and referrals.

AMSSM has created a COVID-19 Resources page to help you navigate the changing telemedicine regulations for physicians and the government assistance available to small business owners during the pandemic response. Click here to view the COVID-19 Resources page.

AMSSM COVID-19 Resources Page

CLICK HERE TO VIEW THE REPORT ONLINE.

2019-2020 ANNUAL REPORT
American Medical Society for Sports Medicine
American Medical Society for Sports Medicine Foundation
Dr. Cindy Chang is a past-president of AMSSM. Currently, she is the director of the University of California San Francisco (UCSF) Primary Care Sports Medicine Fellowship Program. She has over twenty-five years of experience providing care for athletes at every level, including serving as the Chief Medical Officer for Team U.S.A. at the 2008 Beijing Paralympics and 2012 London Olympics. I recently had the privilege to speak with her about her clinical practice in San Francisco and perspectives on the COVID-19 pandemic.

What are your current responsibilities?
Normally, I have sports medicine clinics serving both pediatrics and adults at four different locations. At UCSF Health, we have now separated all of our physicians into being physically present at just one location to avoid cross-infection. That way, if one of us gets the COVID virus, it prevents more people from having to go into a two-week quarantine. I am now only physically seeing acute and essential musculoskeletal and medical conditions for sports medicine patients out of one facility in Berkeley. I have helped in the urgent care at the UC-Berkeley campus health center, and I do virtual health visits for my other clinics throughout the week. We have been asked to prepare to deploy to other parts of our hospital system as needed. It’s been really sobering to hear accounts of how our colleagues are dealing with the COVID crisis across the country. Reading some of their posts has helped us mentally and physically prepare. All of us as AMSSM members are primary care trained, and we need to think about putting those hats on to assist in this crisis.

Before this happened, for what teams and organizations did you provide care?
I was the head team physician at University of California Berkeley until 2008 and now continue to serve as a volunteer team physician; I also take care of a local high school. I have had no contact with our student-athletes as their seasons have been terminated, although I was still treating some of our former Cal athletes and other USA team members training locally. Now, since shelter-in-place in the Bay Area has been extended to May 3, all campus buildings are locked to even key cards until people have approval for essential access to that site. All outdoor campus facilities including the track, tennis courts, pools, and fields are closed. The athletes were using those facilities or doing their own home exercise programs. The PAC-12 recently instructed coaches to have no video-supervised workouts, but there can be instruction similar to an offseason workout. For those still on campus, they can utilize the training facilities and sports medicine services for injuries, although with this new lock-down, I don’t know if even that will be possible. If anyone is off campus, he or she still has the opportunity to work out. I am seeking some clarification on a few points of instruction from the PAC-12. For example, they say if an athlete needs a Thera-band or a foam roller, these should be provided. That’s interesting to me. Does the school have to ship it to them if they are home or off campus? With some direction from the NCAA, every conference is trying to figure out what they can and can’t do. My concern is that no one is supervising the individual athlete doing a virtual workout with teammates on a virtual site, and that athlete may push his or her body too hard without any formal supervision. These are interesting times!

Have you seen athletes who have pushed themselves too hard in their exercise programs?
I see more of the opposite, the athletes that haven’t done as much since their seasons are over. That was not the case with our Olympians. We have quite a few training in the Bay Area. U.S. Men’s Rowing is still here. U.S.A. Swimming was here training, but when the International Olympic Committee (IOC) announced that the Olympic and Paralympic Games would be postponed until 2021, the training tapered way off. They have colleagues across the world who could not train at all because everything was closed. It wasn’t going to be an equal playing field if the Games would have gone on.

How does the pandemic change the Olympics and Paralympics next year?
Some things have to change, like all the qualifying events. There are a lot of moving pieces around the Games. We need to consider whether to hold world championships later this summer. All the governing bodies have to come together to make this work for everyone. People are talking about moving training centers from urban areas to rural areas to lessen the impact of a possible virus resurgence in the fall. It’s hard to plan for the future when there is so much that is unknown.

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CMO CORNER INTERVIEW
CINDY CHANG, MD, FAMSSM

Have you guided your athletes or organizations through a comparable crisis?

One example—although it pales in comparison—might be when MRSA was spreading through our student-athlete population at Cal. It especially affected our crew, rugby, and football teams. That was a similar situation in terms of minimizing disease spread and educating teams about hand cleansing, cleaning equipment after use, making sure clothing is washed appropriately, etc. We also had to educate about recognizing early signs, seeking care, and ensuring non-contact activities until infection resolved. There were many unknowns. Coaches wanted to put a special spray on the football field to reduce the risk of spread, without any clear evidence it was going to help. This was well before social media existed that could potentially mislead people about the condition, but can you imagine the hysteria that would have spread about the “flesh-eating” bacteria that was infecting college athletes?

Have you had to address any misinformation regarding prevention or treatment of COVID-19 with your current athletes?

Some feel invincible (“I am healthy”) and others are incredibly anxious as they voraciously read unverified Twitter posts. We have been talking with athletes about the use of non-steroidal because there was information floating around that they could make you more susceptible to the virus or worsen your symptoms if you have COVID. Now we have learned there is no clear evidence linking non-steroidal use to increasing those risks. I have advised my athletes if you have a condition for which you need to take an anti-inflammatory, and you have no significant symptoms of upper or lower respiratory infection, then it’s okay. The primary concern is that in more severe cases of COVID infection, with every system being stressed, the last thing you want to do is take a non-steroidal that further stresses renal metabolism or gastrointestinal function. That is how I explain it. Certainly if they are taking it for a headache and it works better for them than, say, acetaminophen, they can continue to do that. If they feel they need to take it for a musculoskeletal condition, then I address the condition itself.

I counsel my athletes to protect themselves in other ways. Getting enough rest is key. While staying at home or sheltering-in-place, students are saying they have never gotten so much sleep! I think that is fabulous! People do not have to get up for early morning workouts. They are able to get a really healthy eight to nine hours of sleep, so that’s been great. If you get enough rest, it will help with your immunity.

We also have good evidence that exercise boosts immunity. Because of the home restrictions, some athletes have decided to be slugs. This is probably more in my high school athletes who don’t know what to expect for the future, and they haven’t done anything! I tell them, “Listen, this shelter-in-place doesn’t mean you can’t go out and take a walk as long as you social distance 6-10 feet.” They should start to walk and get on their bikes. Also, you don’t want to go from zero to sixty once restrictions are lifted and athletic seasons suddenly start. We will see overuse and acute injuries because of the relative disuse.

Are there any resources you have used to get exercise tips to your patients who are sheltering in place?

The higher-level athletes have already figured out how to exercise during this time because they get advice from their strength and conditioning coach or team coaches. If anything, we are giving advice to the national governing bodies and letting them know what we recommend. For my youth and high school athletes, I have to give them a little more instruction. It’s been nice to use telemedicine because I can refer patients to our UCSF website for exercises put together by our physical therapists. I always write down for my patient the diagnosis and the anatomy involved, and then I tell them to look online and find some of these exercises I have shown them personally during their telehealth visits. People have produced many helpful YouTube videos for this purpose. For AMSSM members, we can send our patients to our Sports Medicine Today website if they want more information about their injuries and recovery. That’s a really great resource that all of us as AMSSM members should be familiar with.

Have you seen any mental health issues that have arisen in your athletes during this time?

Absolutely. Prior to the IOC making the decision to postpone the Games, it was really hard on many athletes and coaches who were still training and preparing for the Olympics and Paralympics. I think it has been hardest for those athletes who don’t know if they are ready to commit to another year of training. They have put their second lives and careers on hold. There are reports of athletes who have been accepted to medical school; should they defer another year in order to train for the Tokyo Games? Many are asking themselves, “Do I have it mentally in me to train for another year?” The same decisions are affecting our college seniors and coaches as the NCAA ruled that those who had spring seasons cancelled due to COVID will be granted an extra year of eligibility.

How do you feel that the current situation has affected you personally?

I had a trip to Columbus, Ohio, planned in March. My father had passed away in October, and I really wanted to go home. In mid-February, before we understood how this virus would impact the United States, my 90 year-old mother and siblings
called and said, “We don’t want you to come.” I was like, “What? I’m a physician! I clean my hands all the time!” But they were so afraid because the Bay Area had cases already and the cruise ship passengers were quarantined here, and there had been no cases in Columbus, Ohio. They didn’t want me to bring anything to them. That was the first emotional, personal wrench.

This pandemic has also affected my immediate family. My daughter was playing soccer in the Premier League in France. When the league postponed the season until summer, she had to put her things in order to leave, and in case she had to return. By the time she was ready, they had cut off bus and train service where she was in Brittany. She had to rent a car, drive to Paris, and then reroute her flight through Germany to get home. She was on a two-week quarantine when she got here, and now she is living with us until she knows what is happening with her season. That was a little bit frantic for her!

Our son, who is a senior at UCLA, most likely won’t have a graduation. Out of his courses, only one is going to be virtual, and only once a week! The rest have just given him on-line assignments to do, which is not great. He could easily be here with us, but understandably he would rather shelter-in-place with his college roommates. His sister is letting him borrow her car in the event something happens and he needs to leave Los Angeles and come back to us.

We are lucky we are healthy. I am fortunate that I work for a healthcare system and still being paid. I am also fortunate we have savings and resources. I am very sad for the communities around us, the stores and restaurants that have been shuttered and the workers that have been laid off. This is where our government system and all of us, if able, really have to support those in need. I’m buying gift certificates to places that may not exist in a couple months. Personally, I’m fortunate. I have had no one really close to me who has been seriously stricken with the disease. Certainly, I have had colleagues who have had it, but they are recovering.

I’m prepared. I want to help. My heart goes out to our ER physicians and nurses and MAs and those who are really on the front lines. I realize my training is not theirs, but I do believe I can help in some capacity.

“Sports medicine physicians...are best positioned to provide care and direct the medical team surrounding our athletes.”

Interview with Jon Finnoff, DO, FAMSSM, Chief Medical Officer of the USOPC by Jacob Miller, MD — April 3

Recently, Dr. Jonathan Finnoff graciously agreed to an interview in which he describes his new appointment as Chief Medical Officer of United States Olympics and Paralympics, as well as the impact of the COVID-19 pandemic on our nation’s athletes.

You attended the University of Colorado in Boulder; is taking a job in Colorado Springs a homecoming of sorts for you?

This was an exciting opportunity, partly because of the job but partly because Colorado is definitely my home. Almost my entire family lives here. Unfortunately, we are all under the shelter-in-place mandate, so we have not been able to visit each other as much as we would like. As soon as that is lifted and we have passed through this crisis, I am really looking forward to being with my family.

The U.S. Olympic Committee announced on January 14th, 2020, that they were hiring you for this position. Will you take us through the process that brought you from the Mayo Clinic to Colorado Springs?

This occurred over a prolonged period and took a lot of thought. The job was originally posted around the beginning of June 2019. I received an email, like probably every other sports medicine physician in the country, advertising this job and thought, “Wow, that’s a really cool job for somebody else.” I was very happy at the Mayo Clinic. I enjoyed so many different aspects. My family was settled in the Twin Cities area, and my wife and daughter really liked Minneapolis. There was very little reason for me to leave my situation there. However, as the U.S. Olympic Planning Committee (USOPC) was identifying potential candidates for the job, my name kept coming up. They contacted me and said, “You really should talk to us about this position. This might be an exciting opportunity for you.” Towards the end...
of August, I decided I would at least have a conversation with them, and over time those conversations became more serious. This opportunity is very unique, and it did involve coming back to Colorado, which is home for me. By the end of November, I had to make a final decision. The Olympics were planned for this summer in Tokyo, and they needed their new Chief Medical Officer in place to guide preparations. I also wanted to either refocus myself at Mayo or make the transition so they weren’t in limbo. I decided that accepting the position at the USOPC was the best opportunity.

What has the transition been like?
What are your responsibilities?
The transition has been challenging to say the least. I began March 2, and that was right when COVID-19 was ramping up around the world. It was not yet officially declared a pandemic, but it was having significant impacts around the world. It was affecting planning for the Games and starting to bring into question whether they would actually happen. My original plans for job orientation all got scrapped because of the global emergency. Literally, until yesterday, I hadn’t even toured the building where my office is! I was so busy with everything else that there was not time to get my head above water and explore the rest of the USOPC. I anticipated meeting many people including medical staff at the Olympic Training Centers in Lake Placid and Chula Vista, major national governing bodies (NGB) medical leadership, and going to the IOC Injury and Illness Prevention Meeting in Monaco. All these things changed, and I have been incredibly focused on coordinating the USOPC’s response to the COVID-19 global pandemic, determining what our training center policies should be, advising the NGBs on events and cancellations, and working with groups that had vested interests in how we handle this situation.

Recently, I have had time to expand my scope, and I’m beginning to think about the COVID-19 crisis in a different context. Rather than dealing with the immediate issues of infection control, prevention, and treatment among our athlete population here at the training center, now we are starting to think about re-entry. How are our athletes going to know when it is safe to resume training? When can NGBs start thinking about planning competitions? When is international travel going to be okay? It has been a shift in focus to think about how to re-enter normal life, if we have normal life after this.

When the announcement was made about your new position, was COVID-19 on your radar?
No, because it was fairly isolated to China with some small cases outside of it, so it was really quite minor. That being said, the USOPC was already engaged with the CDC. The CDC advisors postulated if the virus got out of China, it would likely result in a significant worldwide issue. But it was just barely on my radar.

Were you involved in any of the talks about modifying or postponing the Games last month?
I was not. The decision really came from the IOC, the World Health Organization (WHO), Tokyo Olympic Games Planning Committee, and the Tokyo and Japanese governments. Those groups were taking all the information, and specifically the advice of the WHO, and weighing how to proceed. As you can imagine, Tokyo had invested billions of dollars into this. There were many logistical considerations. The question was: “If we cancel the Games, can we actually hold them at a different time?” The entire Athletes Village has been sold to private individuals, so after the Olympics and Paralympics, people will move into their homes! How do you tell people who have made legal agreements they can’t move into their homes? And if they do move in, how do you tell them to move out for the Olympic and Paralympic Games later, which will probably last about 3 months? All the competition venues had already been leased for new events.

As I work with the planning committee, I have gained more perspective into what goes into planning the Olympics and Paralympics. Understanding the risks associated with bringing fans, athletes, and support staff from around the world, holding an event, and then allowing them to disperse to their individual countries, is there a safe way of hosting the Olympic and Paralympic Games with a global pandemic? The answer to that is, despite every mitigation process you could put in place, there is no way to eliminate the risk associated with it. In my mind, despite the significant financial impacts to so many people, despite the mental stress to the athletes who have prepared and don’t know if they can do it for another year, I think the right decision was made from the standpoints of public health and global responsibility. I was supportive of the decision.

The timing of re-entry is going to be difficult since every country has a different trajectory of infection and recovery.
When you consider planning events and training, you have to consider from where the fans, media and competitors are coming. Is there active community transmission in that area, or will they travel through areas with active community transmission? Will competitors use the same equipment? Will there be close and sustained contact? Will there be bodily fluids easily transmitted between individuals? Is it a team sport versus individual? Even in track and field, if you are doing high jump and everyone is repetitively landing in the same pit, that is much different from a 10,000 meter race where they are close but not contacting the same area. Boxing, wrestling, rugby—all these sports have different risks.

There are so many implications continued on page 7.
in the delay of the Olympics and Paralympics. A little over 50% of qualifications had occurred. That means nearly 50% had not been determined. If you have already qualified, your qualification will not be revoked, but the IOC will have to figure out what criteria they will use for next year. People who are currently on doping bans who wouldn’t have been able to participate in the Olympics this year may have expiring bans allowing them to get back into competition next year.

International federations and national governing bodies are not only experiencing significant financial strain, but some are going under. USA Rugby declared bankruptcy earlier this week. USA Cycling furloughed a significant portion of their workforce, and many of the other national governing bodies and federations are facing those same financial challenges. If you lose the people who organize the events, how is there going to be a qualification system? How will the athletes be supported if that all falls apart? All the businesses supporting these organizations are going through their own financial crises and may not be able to continue their financial support. Are some of these national bodies going to qualify for the small business loans associated with the stimulus package? Will the athletes be considered independent contractors and get paid because they have significant loss of race winnings? The ramifications are just extensive, and it’s still being figured out.

You were tasked by the USOPC with creating a new focus on athlete wellness and mental health. Will you talk about how this influenced your hiring conversations?

That was a significant part of the conversations. The USOPC has gone through some considerable changes in recent years. The leadership believes strongly that mental health is an imperative aspect of the services we provide to our athletes. It’s not just about sports psychology with an emphasis on performance; it’s about mental health and all the clinical diseases associated with it. The Olympic and Paralympic athlete population has mental health issues just like anybody else, and they are thrown into incredibly stressful situations. Many of them, because of their drive and motivation, have the attitude that they will train through injuries to get to the next level. They often suppress their mental health needs similarly until a crisis arises. Throughout my interview process, it was emphasized this was going to be a major initiative they wanted me to take on.

Unfortunately, right off the bat, I was addressing infectious disease and global pandemics, but with the Games delayed, it has allowed me to take a step back and start thinking more about the mental health aspect of my position. With that being said, the USOPC had already established an external and internal working group, a sports psychology group within the USOPC, and the medical group—four different entities. The external working group has broad representation from many parties: athletes, NGB, and health care professionals. It is a diverse committee that can bring their expertise and perspective to the USOPC about how things have been done previously by other organizations, what resources are available, and what our athlete population needs. The internal working group has representation from every aspect of our entire organization: human resources, legal, security, facilities, marketing, medical, and high performance teams. Each of them has a different perspective on what is important from a mental health aspect because each deals with staff and athlete mental health in their own way. I have been meeting with all of these different groups and our leadership within the organization, all the way up to CEO Sarah Hirshland, director of athlete services Bahati Van Pelt, and director of sports performance Rick Adams, not only gaining their perspective but ensuring they understand how important this is.

After all this, I started to formulate a plan for how we were going to address the acute needs of the Games postponement and a global crisis that involves both infectious disease and finances for our athletes. We have some things in place. There are some gaps, and we are going to address them right now. We are also starting to think about our long-term plan. What infrastructure do we need to not only meet our athletes’ healthcare needs but become world leaders from a national Olympic and Paralympic Committee standpoint? I want the USOPC to be the gold standard that other committees model in their mental health care. I think we are collecting the right information, engaging the right professionals, and have a great path forward that’s going to create a phenomenal program for our athletes.

How is the postponement of the Games affecting our athletes’ mental health?

It’s significant. There is a lot of uncertainty about the future. For some people, this was their chance, and they are not sure if they will qualify for next year. If they have qualified, they are not sure if they will be able to maintain that fitness. I read a nice article about Simone Biles [U.S.A. Gymnastics Team] reporting that when she heard the Olympics were delayed, she broke down crying because she was thinking about the demands on her body to maintain fitness for another year. That mental strain is huge for all of the athletes, and they are definitely expressing that.

Then there is the financial stress. For many of them, the cancellation of an entire season is like all of us being laid off and not getting a single paycheck for a year. I don’t have a year’s worth of savings readily available, and I’m sure the athletes continued on page 8
Part of that will be supplementing the clinical services already provided by our sports psychology staff, the national medical network health providers, and ComPsych. The other part will be analyzing our current mental health emergency action plan, online education resources, and telemedicine resources and determining if we have best services available. I will then compile all that information and come up with a long-term strategy employing mental health officers and making sure we have a unified mental health medical record.

This is a financial crisis for the world. All indicators point toward possibly a recession but likely a depression, and despite the yet unknown financial impact to the USOPC, they are taking mental health seriously enough that they want to invest in our athletes’ care and are considering this essential. I have been incredibly impressed by their verbal and financial support.

**In addition to athlete mental health, what other areas of emphasis does the USOPC want you to address?**

It’s really a very broad job! I serve on the USOPC’s leadership team and provide medical perspective in the organization’s decision-making process. I develop comprehensive plans for athlete physical and mental health. I provide direction and oversight from the representation of the USOPC to the IOC’s Injury and Illness Prevention Research Center. I provide the strategic direction and oversight of the national medical network, which consists of medical providers around the country with whom we work closely and to whom we send our athletes for their care. I provide medical leadership and liaison with the national and international Olympic and Paralympic Committees on medical best practices. I provide medical advice and oversight to all of the NGBs. Criteria are being created that NGBs need to meet in order to be certified by and receive funding from the USOPC; some of the criteria are medical, so I develop those policies and procedures. I oversee all of our medical team and volunteers who work with our teams at every national and international competition. I oversee the facilities and resources and develop strategic plans for the future including new equipment needs. I oversee all the research initiatives within our sports medicine center. I can keep going, but the list of things under my purview is seven pages long. It is going to keep me busy!

**Do you engage in any direct patient care at the Olympic Training Center in Colorado Springs?**

I will, but I am doing very little right now, mainly because most of the athletes have moved offsite. We certainly have athletes who are onsite, but they are not training. We are only providing essential medical services. That is in line with the local and federal mandates. We are seeing people who have acute injury, acute illness, or what is considered essential rehabilitation. If someone had an ACL injury before the lockdown, we continue providing rehabilitation services. As we start reopening our facility and more people move back, I will provide more medical care. However, the majority of my job is administrative.

**How does this pandemic impact sports medicine long-term?**

As impactful and tragic as this global pandemic has been for the world, we are going to learn a tremendous amount from it and be better prepared to protect our athletes’ health, specifically with infectious disease. It will likely result in behavioral changes within the entire population in terms of hand washing and wearing a facemask if you are ill. It really fine-tunes a lot of our infectious disease policies and procedures.

While COVID-19 has brought this acutely into focus, people get sick all the time. Outbreaks happen. Considering only the Olympics, there was Zika virus before and during Rio, **continued on page 9**
of field of fair play. The whole premise to postpone the Games was the idea injury. and resources and how that will their fitness with minimal oversight athletes have been able to maintain the coming months about how our I am curious what we will learn in managing the infectious disease physicians, we are on the frontlines community. As sports medicine throughout the sports medicine there is a lot of learning happening sport. This is a horrible situation, but develop a tool that is applicable to make appropriate return-to-play recommendations. It is also going to make us start thinking more about return-to-sport after infection and outbreaks. There has not been much guidance on that in the past. The WHO created a nice mass gathering risk assessment tool for event planners to help determine if an event is safe. They are going to develop a tool that is applicable to sport. This is a horrible situation, but there is a lot of learning happening throughout the sports medicine community. As sports medicine physicians, we are on the frontlines of managing the infectious disease policies for our athletes and ensuring they are healthy.

I am curious what we will learn in the coming months about how our athletes have been able to maintain their fitness with minimal oversight and resources and how that will impact quality of performance and injury.

A major determinant in the decision to postpone the Games was the idea of field of fair play. The whole premise of the Olympics and Paralympics is that it is a fair and even playing field for all participants. In preparation for these Games, the preparation was completely different based on the country in which you lived, the prevalence of COVID-19 in that area, and access to training facilities. It also shut down many anti-doping programs. In the United States, only essential tests were performed to protect both the testers and athletes from spreading infection. It reduced the ability to make sure that people were not cheating, and it reduced the ability to have a training regimen going into the Olympics. All of that created an uneven field of play. When we talked to athletes, they told us, “I can’t train. I can’t lift weights. I can’t wrestle. How am I supposed to be ready for the Olympics in three months if I can’t touch somebody else? In other countries, they are wrestling. That’s not fair!” What they could and could not do based upon access to training facilities was a huge stress to the athlete.

Coming out of the activity restrictions, if an athlete’s chronic training load is really low, and he or she suddenly has a large influx of acute stress upon return to activity, we are going to see a lot of injuries. We will not only see a decrement in performance but many people will get hurt because they do too much too quickly, and their bodies will not be prepared for it. Currently, our exercise physiology group is writing up a plan to address this. We do incredible acute-to-chronic load monitoring through a program called Athlete360, which is a management system that monitors an athlete’s health, wellbeing, training regimens, and so on. They are looking at each individual athlete’s chronic-to-acute training load amount and then planning a re-entry into activity. However, your high school athletes aren’t going to have that! They are essentially going to go from probably doing nothing to doing two-a-days if they are allowed.

Do you have a message you would like to send to your colleagues?

I am incredibly honored to be in this position. The only reason it is even available to me is because of the great sports medicine physicians who have come before me. Within the AMSSM, there are many great leaders in very prominent positions such as Dr. John DiFiori, Chief Medical Officer for the National Basketball Association, and Dr. Margot Petukian, Chief Medical Officer for Major League Soccer. Dr. Cindy Chang was the Chief Medical Officer for the London Olympics. Many great physicians have opened this door allowing me to be in this position, so I want to thank them. I am just so excited with this opportunity, and I would never have had it without their leadership.

I hope I will leverage my position to improve the overall awareness of the benefits of sports medicine physicians to our United States population. I also want to enable sports medicine physicians to integrate more fully into elite athletics so we can provide the optimal care for our athletes. I am a true believer that sports medicine physicians are the leaders in sports medicine, and we are best positioned to provide care and direct the medical team surrounding our athletes.
What does it mean to be a Chief Medical Officer for a professional sports team? What is your role within the organization, and what is the scope of your responsibilities?

I was named CMO and head team physician for the Utah Jazz about five years ago. One of my responsibilities was to set up a network of University of Utah physicians in each subspecialty to ensure we are offering the finest care for the athletes and their families. I’m the lead for that, but we have many resources within the University that are involved. In the NBA, the home team has an orthopedic surgeon and the primary care doctor (usually a sports medicine doctor) at every home game. With the addition of an ophthalmologist and a dentist at every game, we are able to treat most injuries or medical problems that could occur.

You also have experience working with high-level college and Olympic teams. How do those experiences differ from your work with the Utah Jazz?

Within the college setting, you frequently have to protect the athletes from themselves because they are so excited to get back and help their team. We often have to temper some of their enthusiasm and remind them that there’s another game down the line. The NBA is a long season with many games, and the professional athletes want to make sure they stay healthy throughout the season to ensure a long career. When we deem them ready to return to play, there is collaborative communication that takes place between the training staff, coaches, the general manager, and the athlete’s agent. There are definitely more layers involved with professional sports compared to college sports.

Was there any aspect of your position for which you felt unprepared when you started?

The NBA is very much a player- and agent-driven league. Often you realize that your opinion isn’t the only one considered for significant injuries. Agents frequently want to have their players see other doctors and gain opinions from people that they know and trust, so even though you’re the team doctor, there may be other opinions to take into account. Ultimately, the athlete is in charge of his own career.

In an environment where there are a lot of stakeholders and opinions, how do you maintain your role as advocate for your athletes?

It is key to treat the athlete as a patient first. It is important to have an open dialogue about his injury and diagnosis. We strive to maintain good communication with the training staff, coaches, and general managers, but the athlete always has to come first.

How do you approach challenging return-to-play decisions, and how have you been able to develop consensus among these stakeholders?

That’s a fantastic question; it’s not always that easy. I work very closely with the medical personnel employed by the team, and that may include athletic trainers, development and performance coaches, and physical therapists. As team physicians, we’re employed by the University and not directly by the team, which is an important distinction. Ultimately, our allegiance is to the health and well-being of the athlete.

With the emphasis on mental health in professional athletes recently, how have you seen organizations effectively make this a priority, and what resources do you rely on?

We’re lucky at the University of Utah because we have a great psychiatry department. We create action plans around what could potentially happen if certain situations arise with an athlete from an emergency, clinical or psychological, or performance standpoint. We have these pathways proactively established; it is just up to us to communicate and share the available resources with the athletes. I believe highlighting mental health issues among professional athletes has removed some of the stigma associated with these conditions and hopefully makes it easier for athletes to come forward and ask for help.

In addition to your clinical work, you serve as faculty for a sports medicine fellowship. Has your perspective as a CMO influenced the way you teach and mentor your trainees?

When fellows work with me in clinic and an athlete is seen, they are able to gain first-hand experience with the “behind-the-scenes” steps that are taken to treat these athletes. For instance, they see the consistent communication with agents, trainers, and management to ensure everyone is on the same page with the

continued on page 11
We are in the midst of the Coronavirus pandemic that has impacted all of us. Members of the Utah Jazz were among the first professional athletes to be diagnosed with COVID-19. Will you please share with us what that experience was like?

The Utah Jazz were on an away trip to Oklahoma City, and the game was on a Wednesday. Tuesday night at the hotel, Rudy Gobert started feeling a little feverish. In the NBA, the home team physician covers both home and away teams, so I was not with the team. The trainer checked his temperature, and he had a low-grade fever. I was then in contact with Dr. Jim Barrett, team physician for Oklahoma City, and we ordered an influenza, strep throat, and PCR upper respiratory panel. They were all negative. We then contacted the Oklahoma Health Department to find out if we should do a COVID test. The health department felt that would be a good idea. He was taken to the emergency room where the test was collected and then went back to the hotel.

The game was at 7 pm Wednesday night, and I got a text about 15 minutes before the game that his test was positive. I got on the phone with the league office and spoke with Dr. John DiFiori, Director of Sports Medicine for the NBA. He and I were literally looking at the TV, and the game was ready to tip-off with the Jazz against the Thunder. Dr. Barrett did not go to the game for fear he might infect someone, but he notified the athletic trainer, who then told the referees that Rudy Gobert had tested positive. Rudy was never at the arena; he was back at the hotel and was made aware he tested positive for COVID-19. Then the referees got the head coaches from both teams together, sent the teams to their locker rooms, and 30 minutes later the game was cancelled. I was on the phone with the league office. They had their sports science team and NBA administrators together, and an hour later, the NBA season was suspended. About 24 hours later, it seemed like essentially all sports around the world were suspended. It was a domino effect all starting with that one positive test, and from there things happened very quickly.

Because the NBA is such a high-profile and worldwide sport, I think it really opened the eyes of other sports organizations where they said, “This is probably something we need to do as well.”

From that point, the Oklahoma City athletes were cleared to leave, but I was on the phone that night with the CDC, the Utah Health Department, and the Oklahoma Health Department. The Oklahoma Health Department felt like we should test everybody who traveled with Utah so we could get those not infected on one plane and those testing positive on the other plane, and make arrangements to quarantine people. The next day, we learned Donovan Mitchell had also tested positive. The rest of the team and travel squad all tested negative.

I was on the phone most of the night. I got calls from the [Cleveland] Cavaliers, the [New York] Knicks, the [Boston] Celtics, the [Detroit] Pistons, and the [Toronto] Raptors, who all played Utah within the last ten days. They implemented a 14-day quarantine for those athletes. The league acted very quickly and responsibly. Dr. DiFiori did a phenomenal job. There was a lot of pressure, and many decisions had to be made in a very rapid manner. They made the right decision by suspending the season.

Once the players were all back in Utah, what happened then?

Once our team plane landed in Salt Lake City, I had the Utah Health Department meet them at the airport. We made arrangements for each athlete to be quarantined. It was actually pretty mellow from that point other than answering a lot of questions.

The team was quarantined for 14 days. They had thermometer checks three times a day. They had to call an athletic trainer and give their CMO a call if they had any issues.

Continued from page 10

How have you been able to balance your home and family life with the demands of the job of CMO?

Yes, some people think it’s great that I get to attend the games and all, but there are 41 home games and travel with the playoffs, so it’s a lot of time away. I have understanding kids and an understanding wife, but it can be hard sometimes because you are on call 24 hours a day. If something comes up between games or after a game, I may get a call to talk over some issues that come up, but I look at it as part of the job. I tell the fellows that if you don’t enjoy sports, you’re probably not going to enjoy doing the job. I tell the fellows that if you don’t enjoy sports, you’re probably not going to enjoy doing the job. I tell the fellows that if you don’t enjoy sports, you’re probably not going to enjoy doing the job. I tell the fellows that if you don’t enjoy sports, you’re probably not going to enjoy doing the job.

What advice do you have for sports medicine physicians who are looking to become CMOs?

Stay up on the literature. Give lectures and educate people. Be involved in your community. Focus on doing the best job you can with what is in front of you, and if other opportunities come up, jump in!
Stories from the 2020 Winter Youth Olympic Games

By Jason Lee, DO

I, like many involved with AMSSM, have had the opportunity to serve as a team physician in many realms, from high school to the professional ranks and in many different capacities and avenues in the sports medicine world in between. I became involved with USA Hockey during my fellowship year at the University of Michigan. Over time, I’ve had the chance to serve as a physician with this organization for numerous events, including the 2016 Winter Youth Olympic Games, All-American Prospects Game and more. Another opportunity presented itself during the summer of 2019, when I was asked by Dr. Michael Stuart to provide medical coverage for the Team USA men’s hockey team at the 2020 Winter Youth Olympics Games in Lausanne, Switzerland, in January 2020. I jumped at the invitation.

Before embarking on this experience, I communicated with USA Hockey and the USOPC to talk about logistics and medical needs/cares that were to be provided while in Switzerland. The USOPC does a wonderful job of providing medical equipment and supplies in the Olympic Village, but time was spent adding additional supplies to my medical bag/kit before setting out for this event.

Before the start of the Games, we had a training camp in Romanshorn, Switzerland, where the Swiss National Team was training along with an exhibition game against Switzerland before heading to Lausanne to move into the Athletes’ Vortex. That’s where the top 1,800 athletes between the ages of 15-18 from approximately 80 nations competed in the Games over a two-week time frame. There was a polyclinic in the Vortex that treated athletes from different countries there, but additionally, Team USA had a medical clinic providing care to all members of the delegation. I was able to meet and provide care in conjunction with other health care providers from the USA delegation, including physicians, athletic trainers and other providers from all over the world.

Our team of players and staff primarily walked and used the train system in Lausanne to get to and from Vaudoise Arena, where the team played and practiced during the Games. The US Men’s Youth Olympic Hockey Team went 3-0-0-1 overall and lost 4-0 to Russia in the gold-medal game, earning a silver medal during the event.

I enjoyed my time in Switzerland offering medical coverage to this wonderful group of athletes with USA Hockey. Providing care to this team was special and unique all at the same time. Being able to represent your country in any capacity is an honor and a privilege, giving me memories that will last a lifetime.
Executive Summary - Osteochondritis Dissecans of the Knee

By Kayla Washuta, DO and Jonathan Santana, DO

General Information
Osteochondritis Dissecans (OCD) is a disorder of subchondral bone that can extend into the overlying cartilage. It is most commonly located in the knee, elbow, and ankle. Within the knee, the posterolateral medial condyle is most commonly affected, followed by the lateral condyle, patella, and proximal tibia.

Population
Peak incidence is between ages 12 and 19 but can be diagnosed as young as 6 years or into adulthood. Incidence of knee OCD is 6-9.5 per 100,000 population and is 3-4 times more common in males compared to females. Additionally, up to 29% are bilateral. A patient with open physis is considered to have juvenile OCD (JOCD), while closed physis represent adult OCD (AOCD).

Etiology
The exact cause is still controversial and likely multifactorial. Some hypotheses include traumatic, ischemic, hereditary/genetic and idiopathic, the most popular being the micro-trauma hypothesis which attributes OCD to repetitive impingement by the tibial spine. It is thought to be a progressive disease process with decreasing stability over time.

Signs/Symptoms
OCDs can be incidentally found on imaging of an asymptomatic knee but more often presents symptomatically. Early symptoms of poorly-localized pain with activity can progress to persistent pain, swelling, crepitus, catching, locking, and giving way. Physical exam findings of effusion, tenderness to palpation over the femoral condyles during range of flexion, or decreased ROM may be present. The Wilson Test (pain with internal rotation of the tibia during knee flexion that is relieved by external rotation of tibia during knee flexion) has been described but lacks validation of clinical diagnostic value.

Diagnosis
Radiographic imaging of the knee assists in diagnosis. Four views are recommended: AP, lateral, tunnel or notch view, sunrise. The characteristic finding is a well-circumscribed area of subchondral bone of varying density levels separated by a sclerotic and radiolucent border. Since stability is hard to discern on plain x-ray, MRI is often indicated for staging as follows:
1: A small change of signal in the subchondral bone without clear margins
2: Osteochondral lesion with clear margins, no underlying fluid between fragment and bone
3: Fluid partially visible between the fragment and underlying bone
4: Fluid completely surrounding the fragment, fragment remains in situ
5: Loose body
Arthroscopy is the gold standard for staging but controversial in younger athletes with good non-operative healing potential.

Treatment
The treatment pathway depends on several factors, the most important being stability of the lesion followed by status of the physis. Non-operative management is indicated in juvenile OCD lesions staged 1-3. This consists of non-weightbearing or immobilization for 2-6 weeks or until a patient has non-painful ambulation followed by gradual weightbearing progression over the next 6 to 12 weeks with physical therapy and rehabilitation. A patient should avoid running, jumping, cutting, or other high-impact activities until he or she is pain-free with a normal exam and radiographic evidence of healing. Healing may take up to 6-12 months. Once return-to-activity criteria are met, a patient may progressively load and stress the joint until there is return of full strength and function.

Operative management is indicated in adults for stages 2-5 and for JOCD meeting stage 4 and 5 criteria. It is also indicated after failure to improve with 3-6 months of non-operative management. Operative treatment can consist of subchondral drilling to fixation to osteochondral allografts or autografts depending on stage and findings during arthroscopy. Lesions should be followed regardless of treatment until radiographic healing is evident.

Prognosis
Prognosis depends on age, location, size, and stage of lesion at diagnosis. High index of suspicion and early diagnosis and treatment can lead to improved outcomes and joint preservation. The best prognosis is in patients with open physis who achieve complete resolution with non-operative management. Swelling, mechanical symptoms, non-weightbearing lesions, patellar lesions, stage 3-4, and those that have > 2 cm surface area involvement have a lower likelihood of healing and return to full function. Stage 3-4 lesions that do not heal completely have a high chance of chronic pain, mechanical symptoms, swelling, and arthritis. Overall, patients who allow for complete healing should be able to return to previous levels of function.

Further Research
The Research in Osteochondritis Dissecans of the Knee (ROCK) study group is a multi-center group dedicated to furthering understanding of pathophysiology, validating MRI classifications, and creating evidence-based treatment protocols. Please contact the authors for references.
Aloha All!

First, I'd like to start by saying my heart goes out to everyone and their families who have been directly affected by the novel coronavirus pandemic. As a medical student pulled from the hospitals early in March, I haven’t been affected much more than not being able to get my usual Macha Latte from Grouchy John’s Coffee, but for others this pandemic has struck much deeper. Please remember to love one another during these uncertain times and do what you can to stay positive and safe.

Year 2020 Began with Two Engaging MSIG Webinars

January 27: Sports Specialization: The Past, Present and the Future of Single Sport Training led by Neeru Jayanthi, MD and Stephanie Kliethermes, PhD; AMSSM Research Director. Online webinar was immediately followed with a LIVE Twitter Chat where Coach Alan Bishop joined Drs. Jayanthi and Kliethermes in leading an engaging discussion with webinar participants.

February 12: Be the Best Sideline Physician: Developing and Implementing an Emergency Action Plan (EAP) led by Steven Cole, MS, ATC; Christopher Hogrefe, MD; and Michael Petrizzi, MD. The three speakers shared their insight on the importance of advance planning on every aspect as you develop and implement an EAP.

If you were not able to attend these webinars, you can 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 Member

As the 2020 MSIG President, I want to invite all Student members to become active participants in the MSIG as we continue to expand. This year a goal of ours is creating 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 six other MSIG Officers. Currently the AMSSM MSIG Facebook Page has 90 Likes and 99 Followers and we’d like to drive this up as we continue to be more engaged as a community. If you are a President of your local interest group or a Faculty Champion, look forward to hearing from us soon. Each MSIG Officer will be working individually with a pod of schools to create a more collaborative environment for local chapters to exchange ideas.

Do you have an idea or topic you would like to see discussed in an upcoming webinar? Has your local sports medicine interest group found new ways to connect during the pandemic you would like to share with the MSIG community? Send an email AMSSM_MSIG@amssm.org with your update, question or suggestion – we would love to chat. Looking forward to an exciting year ahead!

Is Your Sports Medicine Interest Group Connected with the MSIG?

49 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 featured in an upcoming edition of The Sideline Report. (must be a Charter Medical School)
UPDATE FROM THE AMSSM SMRF (SPORTS MEDICINE RESIDENT COUNCIL)
A Resident Interest Group Led by AMSSM Resident Members

President’s Message
Jeffrey Fleming, DO
PGY2, Family Medicine Resident
Rowan University School of Medicine

I’m pleased to announce that the SMRC is already hard at work on projects to enhance the resources and opportunities available to AMSSM Resident members. Some of our first projects for this year include increasing our social media presence to make sports medicine educational material more accessible and working to compile updated, specialty-specific lists of sports medicine fellowships. Special thanks to all of the outgoing 2019 SMRC Officers for their exceptional work building the foundation to these projects last year.

I would also like to acknowledge this year’s SMRC Officers for their continued dedication to our group in the face of adversity. Several of our Officers are on the front lines of the battle against the COVID-19 pandemic. They have been working all day in the inpatient wards, emergency rooms and clinics, while still tirelessly making time to send emails and take phone calls in order to drive our SMRC projects forward. Their efforts are greatly appreciated.

Given the dedication and the enthusiasm that our Officers have already demonstrated, I’m confident they will be able to achieve great things through the SMRC. We are looking forward to helping improve the experience of all AMSSM Residents during this year!

UPDATE FROM THE AMSSM SMFC (SPORTS MEDICINE FELLOWS COUNCIL)
A Sports Medicine Fellows Interest Group Led by AMSSM Fellowship Members

Fellowship Member Liaisons & Class Representative Selected to AMSSM Committees for 2020-2021

The AMSSM Fellows Matters Subcommittee is pleased to announce that the following incoming fellows have been selected as the AMSSM Fellowship Class Representative to the Fellowship Committee and Fellowship Member Liaison for the 2020-2021 academic year! The Committee Co-Chairperson(s)/Vice Chairpersons are looking forward to working with their Fellowship Member Liaison and Class Representative. We would like to thank all of the incoming fellows that applied for one of these fellow leadership positions, and we also want to express our gratitude to all of the Fellowship Directors who nominated their incoming fellows for these positions. Please join us in congratulating these physicians.

Fellowship Class Representative to the Fellowship Committee:
Nicolás Hatamiya, DO
Residency: Stanford Health Care–O’Connor Hospital Family Medicine
Fellowship: UCLA Primary Care Sports Medicine

Communications Committee:
Alberto Oseguera, MD
Residency: CHRISTUS Santa Rosa Family Medicine
Fellowship: University of Washington Primary Care Sports Medicine

Education Committee:
Mallory Lewis, DO
Residency: University of Oklahoma Health Science Center Family Medicine
Fellowship: University of Alabama at Birmingham Sports Medicine

International/Inter-Organizational Relations Committee:
Kimberly Casten, MD, MPhil
Residency: University of Michigan PM&R
Fellowship: University of Washington Primary Care Sports Medicine

Membership Committee:
Stephanie Carey, MD, MPH
Residency: Penn State Hershey Family & Community Medicine
Fellowship: Penn State Hershey Primary Care Sports Medicine

Practice & Policy Committee:
Michael-Flynn Cullen, MD
Residency: National Capitol Consortium, WRNMMC, PM&R
Fellowship: UC Davis PM&R Sports Medicine

Publications Committee:
Kristian von Rickenbach, MD, MSc
Residency: New York Presbyterian Columbia/Cornell PM&R
Fellowship: Spaulding/Harvard Sports Medicine

Research Committee:
Emily Miller, MD
Residency: Stanford University PM&R
Fellowship: Stanford University Primary Care Sports Medicine

Sports Ultrasound Committee:
Christina Giacomazzi, DO
Residency: Stanford Health Care–O’Connor Hospital Family Medicine
Fellowship: University of Washington PM&R Sports Medicine

Communications Committee:
Alberto Oseguera, MD
Residency: CHRISTUS Santa Rosa Family Medicine
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Fellowship: Spaulding/Harvard Sports Medicine

Research Committee:
Emily Miller, MD
Residency: Stanford University PM&R
Fellowship: Stanford University Primary Care Sports Medicine

Sports Ultrasound Committee:
Christina Giacomazzi, DO
Residency: Stanford Health Care–O’Connor Hospital Family Medicine
Fellowship: University of Washington PM&R Sports Medicine
Note from the Editor

Colleagues, I hope this message finds you safe and well. Certainly, all of us have been affected by the COVID-19 pandemic and its repercussions. I pray that you are able to stay healthy and serve your patients as you would like. I admire so many of you for the good and selfless work you perform to ease the burdens of others. Know that your skills and compassion are appreciated and required more than ever during this challenging time.

Within this edition of The Sideline Report, I hope to provide you with updates from the AMSSM and how we are responding to this crisis as a medical society. Of note, we will learn from three distinguished members and hear their insights into caring for patients during the COVID-19 crisis. Dr. Asad Siddiqi presents an interview with Dr. David Petron, CMO of the Utah Jazz basketball team, in which he shares his experiences as the medical lead for a professional sports franchise. I had the chance to converse with AMSSM Past President Dr. Cindy Chang and hear her perspective on the pandemic’s impact on her practice, student-athletes, and the Tokyo Olympic and Paralympic Games. We also present an interview with Dr. Jonathan Finnoff as he describes his new responsibilities and challenges as CMO of the U.S. Olympic and Paralympic Committee.

As in other issues, we highlight recent developments in the field of sports medicine. I am pleased to present the efforts of two new contributors. Drs. Kayla Washuta and Jonathan Santana bring us a succinct review of evaluation and management of osteochondral defects in a new Executive Summary.

It is a great privilege to serve our membership by providing this newsletter, and I hope you find it useful and educational. Please understand how important each of you are. Your patients, families, and colleagues value your efforts at this time. Stay active, stay well, and stay safe.

Jacob Miller, MD

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.
Resource Utilization for Patients with Distal Radius Fractures in a Pediatric Emergency Department

By Jesse Charnoff, MD

Recently, Keith J. Orland and colleagues at Emory University reported a significant number of children presenting to the emergency department (ED) with distal radius fractures could have had the fractures treated as an outpatient with immobilization via cast application instead of undergoing procedural sedation and manipulation, based on evidence-driven radiographic and demographic criteria. They examined 258 consecutive children under the age of 10 years with distal radius fracture, with or without ulna involvement, treated at their pediatric ED in 2016-2017, including 142 (55%) who had closed reduction with procedural sedation. Sixty percent of patients were male; mean age was 6.7 years.

Thirty-eight procedures (27%) were rated as possibly unnecessary, based on the published criteria of less than 1 cm of shortening of the radius bone and angulation of less than 20%. Closed reduction requires sedation and time, adding risk and cost to a patient visit. Mean sedation time was 13.9 minutes. Twenty-one patients (14.8%) developed complications, with 10 having severe apnea or hypoxia events that necessitated oxygen or bag mask ventilation while sedated. Closed reduction and manipulation with procedural sedation in the ED cost $8,078, based on Common Procedural Terminology (CPT) charges, compared to $1,027 for outpatient casting. The authors extrapolated their data nationwide and found that with 280,000 distal radius fractures treated at EDs every year, eliminating unnecessary reductions could save almost $270 million annually. This study may force clinicians to reconsider their emergency management of distal radius fractures in the pediatric population.

Further reading | Original article

Neuro-Ophthalmologic Response to Repetitive Subconcussive Head Impacts

By Manoj Poudel, MD

Concussion and subconcussive head impacts have been widely discussed both in the medical fraternity and general population. Recently, Nowak et al published a randomized clinical trial in JAMA Ophthalmology about neuro-ophthalmologic response to repetitive subconcussive head impacts in adult male and female soccer players. The players were randomly divided into a heading group (36 subjects) and control group (31 subjects). The mean age was 20.6 years. The heading group executed ten headers with a soccer ball at 25 mph while the control group kicked the ball in a similar way. The King-Devick test (KDT) was primarily used to assess the players at 0, 2, and 24 hours and compared to their baseline. The mean peak accelerations and peak rotational accelerations per impact were higher in the heading group and did not have a detectable level in the kicking group. The data analysis revealed that both groups had improvement in KDT speed; however, the kicking group performed KDT faster when compared to the players in the heading group at postintervention assessment at 2 hours and 24 hours. The authors concluded that neuro-ophthalmologic function is affected by subconcussive head impacts in the short term. Further studies are required to establish these findings and to explore the long-term effects in contact sports. Additionally, future studies are required to find if these measures can be useful clinically in detecting acute subconcussive injury.


Long-Term Outcomes of Arthroscopic Debridement With or Without Drilling for Osteochondritis Dissecans of the Capitellum in Adolescent Baseball Players: A ≥10-Year Follow-up Study

By Gregory Walker, MD

A recent study published in Arthroscopy investigated long-term clinical outcomes of arthroscopic debridement for capitellar osteochondritis dissecans (OCD) in adolescent baseball players. The study evaluated outcome measures for 23 baseball players who were at least 10 years (mean 11.5 years; range, 10-13 years) removed from arthroscopic debridement, with or without drilling (microfracture), for capitellar OCD. Osteochondral defects detected on preoperative radiographs were small in 10 patients, moderate in 7, and large in 6. Twenty of twenty-three baseball players were able to successfully return to their pre-operative level of activity. Of these 20 baseball players, 15 were non-pitchers and returned to the same position; 5 pitchers were able to return to pitching. Ten of the 23 baseball players underwent concomitant drilling with arthroscopic debridement, with 9/10 of these athletes returning to their pre-operative activity level. Timmerman/Andrews score improved significantly from 160 to 195 at the most recent follow-up (p<.0001). The strength of this study was its long-term follow-up. The weaknesses were its retrospective nature and the small number of subjects. The study also did not evaluate postoperative imaging or long-term radiographs. The authors concluded that arthroscopic debridement with or without drilling allowed for return to play in adolescent baseball players for positions other than pitching.

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.
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international@amssm.org

Mederic Hall, MD
ultrasound@amssm.org

Cynthia LaBella, MD
practicepolicy@amssm.org

Jason Matuszak, MD, FAMSSM
publications@amssm.org

Ken Mautner, MD, FAMSSM
fellowship@amssm.org

Rebecca Myers, MD
education@amssm.org

Andy Peterson, MD, MSPH, FAMSSM
research@amssm.org

Anna Waterbrook, MD
education@amssm.org

Jason Zaremski, MD
fellowship@amssm.org

Outgoing Presidential Speech

By Chad Carlson, MD, FAMSSM
Presented during the AMSSM Virtual Meeting on April 25

As President of the American Medical Society for Sports Medicine, it’s my privilege and pleasure to welcome each of you to this virtual meeting. Certainly, it’s a reflection of the times we find ourselves in that a group that has flourished in the soil of collegiality and personal association finds itself convening electronically via computer screens. But what a blessing that we live in an age where the opportunity for these electronic meetings exist.

Last year in Houston I spoke about the market pressures that were poised to spark crisis in health care, including the aging of the population and resultant increases in Medicare spending, as well as the push toward consumer-driven service such as urgent care and telemedicine. I proposed that utilizing home exercise programs in the context of our medical practices was one way to reduce the need for physical therapy and reduce costs for our patients. This is especially pertinent during the pandemic, and is something we have been using to good effect here in Des Moines. I also indicated that an emphasis on public health in the form of improving exercise compliance was one of the only ways to significantly bend down the societal health care cost curve, and that we in sports medicine were in a good position to help drive this. Well, as much as the cost crisis was a baked in problem before, it is much more so as we move into the new world wrought by COVID19. We will need to consider this as we consider the role of the sports medicine physician in American society moving forward. Much has been said already about the coronavirus pandemic, and I’m sure, like myself, many of you have had your fill of all things COVID. So, in the interest of the cup being half-full, I’d like to take this opportunity to discuss everything that AMSSM is accomplishing right now on your behalf. Because as with many institutions in our society, our value will ultimately be defined, not by how the pandemic has impacted us, but by our response to it, and the degree to which we continue to move forward. And there is no question that AMSSM is moving forward. So let’s take a few moments to consider how that is occurring, and celebrate our accomplishments.

Organizationally, it was a busy and productive year. AMSSM found itself in a strong financial position in first quarter 2020, with total net assets exceeding five million dollars. This allowed our board to commit to a five year plan to fund over 1 million dollars in CRN research grants, giving the CRN a firm footing to continue their important work. Our managed investment portfolio has lost significantly less ground than market average, limiting our financial loss from market volatility. We have also been able to work with leadership from the AMSSM Foundation to commit to the development of a capital campaign to allow members the option of legacy giving to AMSSM. Legacy giving to grow our Foundation will be vital to allow us to protect our research initiatives and expand our ability to support all of our organizational goals.

One of my beliefs coming into this job was that the job of leading this organization should be defined less by what can be accomplished in the span of a year, and more by what high-impact initiatives, either already-begun or yet to be started, merit the organization’s longitudinal continued on page 19
commitment and attention. What I wanted to avoid was working in a silo. So one structural change that I made, which I think has been helpful was to bring AMSSM executive leadership into regular discussions about strategic initiatives and goal-setting. Prior to this year, the president has met with AMSSM staff every other week to discuss the business of running this organization. Starting this year, our executive committee was brought into these discussions once per month. This promotes cross-communication among members of the executive committee, and coordination of effort across long-term initiatives. It has shaped my own policy priorities to know where the interests of other members of the executive committee lie. It has helped us to coordinate longer-term projects that can accomplish more for the organization.

Research continues to be a major focus of this organization. Last year’s meeting saw a record number of original abstract submissions, representing a growing list of research interests. The 2019 Summit on Youth Sports Specialization in Houston not only produced a research agenda on the subject that highlights key priorities, but has resulted in numerous speaking invitations and invitations to participate in working groups on youth sport specialization. Based on the success of the 2019 Summit on Youth Sports Specialization, AMSSM has committed to funding a 2021 Summit on the promotion of physical activity. This summit, led by our “exercise champion” Irfan Asif, will lead to the development of physician training modules that will be open access to doctors everywhere. Participants at the Summit will also examine clinical models that are effective in driving improved patient participation in exercise. The intent of this summit is also to generate a request for proposals for multi-site research in exercise promotion. Geoff Moore is chairing a related task force looking at different economic strategies for exercise promotion in the clinical setting. AMSSM has committed to support an International Hamstring Research Summit that will lead to further research collaboration between the CRN and the NFL, opening up new opportunities for members to engage in research. In addition to this, we were able to join several other collaborative efforts that will provide research opportunities for members in the areas of physical activity promotion and biologic therapies. I’ll speak more to these in a moment. The CRN itself continues to spark development of NIH-quality research. The study on sub-symptom aerobic exercise therapy to improve recovery from sport-related concussion, with John Leddy as primary investigator, was the first recipient of CRN grant money, and is approaching completion. This past year, a $150,000 grant was awarded to Ruth Chimenti and Mederic Hall from the University of Iowa to study the “Safety of Ultrasound-Guided Tenotomy for Achilles Tendinopathy and Feasibility of a Standardized Ultrasound Imaging Protocol.” Dan Herman, MD, PhD, Katherine Rizzare MD, MPH, and Prakash Jayabalan, MD, PhD were the recipients of the $300,000 AMSSM-Avonos grant to study the treatment of MSK conditions using cooled radiofrequency ablation technology. Education is one of our core mandates. In addition to our annual meetings, AMSSM has continued to sponsor a top-notch multi-day meeting for incoming fellows, sponsor multiple regional ultrasound courses and of course help develop the Advanced Team physician course each December. AMSSM partnered with MLS and AOSSM in a State of the Art Soccer Medicine course in September. We’ve developed a growing number of online webcasts on various sports medicine topics. Finally, this year, we expanded our Global Exchange Program, developing partnerships with national sports medicine associations in Japan, Norway and South Africa that will grow our clinical, educational, research and societal collaborations. 2019 was a banner year for us in Advocacy as well. Shortly after our meeting, AMSSM undertook a national search for a full-time Director of Policy and Advocacy who could help coordinate messaging for us in the areas of patient care, research and practice economics. After an exhaustive search, we were very pleased to secure Brian Williams in this role. Brian brings decades of experience in government to AMSSM, and was the Government Relations Manager for the American Heart Association from 1999-2004, where he promoted their physical activity and nutrition policy. Brian later served as the Director of Government Relations for the American Public Health Association, where he helped obtain CDC funding for various public health initiatives. Having an effective influencer in the policy arena provides an organization like ours with strategic introductions and ongoing connections that raise our visibility with decision-makers, both in elected office and in administrative agencies where decisions are made that affect our practices on a daily basis... An effective advocacy strategy recognizes that if our voice can be more widely disseminated, our influence will rise, both with the public in general and with policymakers specifically. Expanding networks of connections result in greater opportunities for research funding, more appointments of AMSSM members onto relevant government or NGO commissions whose work can benefit our patients, and more invitations to contribute perspective when issues within our circle of expertise are being debated. Since bringing Brian onboard, AMSSM has had a regular presence on Capitol Hill, attending briefings, one-on-one meetings with relevant Congressional offices, as well as events for the President’s Council and CDC Active continued on page 20
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People, Active Nation campaign. We have never had this sort of presence before, and this presence has already led to new opportunities for us. Brian was able to use his networking capabilities to bring Congressman Rodney Davis, co-chair of the Congressional Youth Sports Caucus, Kristina Harder, Executive Director of the President’s Council on Sport and Physical Fitness, as well as U.S. Surgeon General Jerome Adams to the kickoff meeting of AMSSM’s Youth Sports Advocacy Team in January. In the states, AMSSM has revitalized our state key contact program through a training webinar and training materials, and we have tracked and weighed-in on relevant state legislation as needed. For example, in Idaho, we were able to help members block legislation that would have allowed chiropractors to clear concussed athletes. One of my own goals coming into this year was to work with the American Physical Therapy Association to promote state-based legislation that would allow joint business venture partnership between physicians and physical therapists. These business relationships would have the potential to open up many new job opportunities for our members. We have been in dialogue with APTA throughout the year. Currently, template legislation has been crafted and is being submitted to APTA for review. Our plan, should we gain agreement with APTA on acceptable language, is to begin submitting this bills in various statehouses in time for the 2020-2021 legislative season. This year, AMSSM became an inaugural member of a new organization – the Physical Activity Alliance. This group, a co-venture between the American Heart Association, AMSSM, ACSM, NATA and other organizations, is a merger of the National Physical Activity Plan Alliance, the National Physical Activity Society and the National Coalition for Promoting Physical Activity. This will focus efforts to create, support and advocate policy that promotes physical activity, and AMSSM will be a voting member of this coalition. This group has already worked with HHS to publish physical activity tips during the pandemic. Finally, AMSSM remains committed to promote community advocacy through our Advocacy awards. As a side note, newly elected Board Member Cynthia LaBella was recently named to the President’s Council’s Science Board. As incoming chair of Practice and Policy, we are definitely poised to have a major impact in public policy.

The Publications Committee was responsible for the development of several position and consensus statements, and their work is ongoing. This past year, our membership committee launched the AMSSM Fellow designation to identify sports medicine physicians who have demonstrated an ongoing commitment to the field in general and AMSSM in particular. I believe this fellow designation will result in even better member retention than we have now, as well as increase member involvement across AMSSM’s many committees.

AMSSM has attempted to provide resources to our many members who are interested in regenerative medicine. Last year at our meeting in Houston, we developed a Regenerative Medicine Symposium, led by Ken Mautner. Piggybacking on this well-received session, at the direction of past-president Chad Asplund and myself, Ken was then asked to pull together a task force that ultimately Shane Shapiro chaired. The goals of this group were to provide appropriate definitions for regenerative sports medicine, gauge member interest through a survey that was sent out this year, publish a position paper and partner with the CRN to provide research opportunities and resources to AMSSM members. 79% of physician responders to the survey thought that AMSSM should train its members in regenerative techniques, and that this should be a component embedded within fellowship training. Partly in recognition of this high level of member support, AMSSM’s board approved funding for AMSSM to become a founding organizational member of the Biologic Association – a multi-organizational association dedicated to the advancement of evidence-based research in regenerative medicine. The inaugural summit was in California in February, and AMSSM has designated official representatives to that group going forward.

I want to spend a little time discussing certification and how I believe it plays into larger discussions of our identity and future. During the course of its work in 2018, the branding and marketing task force undertook primary consumer research with patients, and one of the most important questions potential patients had was whether or not their physician is “board-certified.” Properly applied, a designation of board certification in sports medicine should elevate us among our physician peers. Tracy Ray’s Task Force has spent the better part of a year looking at ways to increase the educational rigor of our field. I believe a more comprehensive training pathway will lend itself to a broadened scope-of-practice for our members, and a greater degree of economic viability in the healthcare marketplace. Implicit in this push for broader educational training is an increasing level of separation between the skill set of a primary care physician and a sports medicine physician. Indeed, as reflected in the 2019 Membership survey, only 30% of our members have practices that are majority primary care. Over 50% of the membership have practices that are at least 75% sports medicine, with one third of members practicing sports medicine exclusively, which coincides with data reported from continued on page 21
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the ABFM last month. I believe the continuation of these trends toward subspecialization are absolutely necessary to the long-term viability of our profession, with an emphasis on respecting our primary care roots. That primary care training makes us who we are, but it does not define us. As colleagues from other specialties have joined us, we have educated each other and grown collectively. We are morphing, over time, into something more. Something different. And as the branding work we did made clear, for the purposes of defining ourselves in the marketplace, it is vital that we work to homogenize the end product created by completion of an accredited sports medicine fellowship. This is necessary for multiple reasons, including consistent representation to the public, creation of unique skill sets for the purposes of hospital credentialing and scope-of-practice, establishment of better specialty-specific utilization benchmarks and more effective payer negotiation. These points underlie the hugely important work that Tracy’s group has undertaken. But undergirding this, as we become more distinct, our involvement in the sports medicine certification process needs to change to reflect that. It is important that certification options exist that can evolve nimbly with our own desired changes in accredited training standards.

Back in November, I sent a survey to AMSSM members with family medicine backgrounds, asking them about their overall satisfaction with the current certification through ABMS, and their thoughts on a pathway for development of alternate, stand-alone certification in sports medicine. Over 750 members responded, indicating a high level of interest in the subject. Of these, 35% indicated that they were highly satisfied or satisfied with the current process, while 40% were dissatisfied or highly dissatisfied. 77% of all responders indicated support for the development of a stand-alone pathway for certification in sports medicine, with 60% voicing support for pursuit of this pathway through a non-ABMS board if necessary. Needless to say, there was extensive commentary in response to these questions, as well as mixed opinion. Some thought that we had already predetermined that we were going to seek certification with a different board. After much discussion with our board and with the executive committee, our current relationship with ABFM was affirmed in the sense that we remain committed to dialoguing with them to try to institutionalize a more involved role in the certification process than we currently have. In order to begin this discussion, our Executive Director Jim Griffith and I met with representative leaders of ABFM at their board meeting in New Orleans in late January. At that meeting, we agreed, that we would move toward a change in nomenclature away from “Certificate of Added Qualification” and toward “Board-certified.” We also agreed to bring together a representative group of AMSSM leaders and leadership from ABFM in a more formalized setting, to discuss what is feasible in terms of structural changes to the current certification process. This working group will meet sometime this summer, when the pandemic allows. I am optimistic that this will prove to be a productive process that benefits our members and lays a foundation for the adaptability in exam content we will require once more institutional changes in our training programs that flow from Tracy Ray’s work begin to occur.

This year, AMSSM solidified its commitment to the reduction of sexual abuse in sport. At our meeting in Houston last year, we invited Arkansas gymnastics coach and former Olympian Jordyn Wieber to speak to the group about her experiences as one of Larry Nassar’s many victims. Dr. Jeff Tanji spoke about the need for a “reboot” in sports medicine. At that meeting, I asked Dr. Jennifer Koontz to form a Sexual Abuse Task Force to look at codifying ways that we as a society could contribute to reducing risk in the training room and office setting. And shortly after this group was formed, the investigation from Ohio State about the abuse allegations involving former team physician Dr. Richard Strauss was released to the public. Thus, the work of the task force was both timely and relevant.

The goals of this task force were to
1. State clearly that AMSSM recognizes the problem of sexual violence in sport.
2. Identify ways in which AMSSM and its members can contribute to the reduction of sexual violence in sport
3. Create a position statement with AMSSM’s commitment to solutions, including education of sports medicine physicians on issues related to sexual violence in sport. This document is completed and is scheduled for co-publication in four separate journals in the summer of 2020.
4. Start to build multi-disciplinary and inter-organizational relationships to create collaborative solutions to reduce sexual violence in sport.

There is also an ongoing plan to develop educational materials that are open access through the website, including, among other things, establishing sport-specific safeguarding policies, independent reporting mechanisms, case management procedures and prevention interventions, bystander intervention training, recognition of grooming behavior and establishing examination and treatment policies that help avoid vulnerable situations. Some of these materials will be created based upon information obtained from surveying the membership this past year. Through this work, AMSSM has continued on page 22
been able to appoint Dr. Koontz to a working group developing online training modules through The U.S. Center for SafeSport. The work of this group may become permanent and ongoing. Thanks again to Dr. Koontz and her task force for their important work. As relates to this, you might have heard of the broken window theory. This theory states that there is a linkage between physical disorder in a community and crime. The person who coined it noted that when a broken window in a building is not fixed, there is a high likelihood that other window breakage will start to occur. Litter begets litter. Graffiti begets graffiti. And what happens as this blight starts to increase is that people who live in the community start to withdraw. As socially responsible individuals go into hiding, socially-disruptive elements start to dominate, and over time, a community drifts from physical disorder to social disorder, usually reflected in rising crime statistics.

How does this relate to people? Well, Immanuel Kant wrote that we should treat all people as ends, not means. Your involvement, again, treating others as they want to produce in the world, they seek each other out; and when they have found each other, they unite. From then on, they are no longer isolated men, but a power one sees from afar, whose actions serve as an example; a power that speaks, and to which one listens.

There is nothing, according to me, that deserves more to attract our regard than the intellectual and moral associations of America. We easily perceive the political and industrial associations of the Americans, but the others escape us. One ought however to recognize that they are as necessary as the first to the American people, and perhaps more so.

In democratic countries the science of association is the mother science; the progress of all the others depends on the progress of that one.

Here’s a little secret: “AMSSM” itself does not accomplish anything. And although our small staff is extremely talented and productive, and the financial contributions we make to this organization are important, it is ultimately the sacrificial giving of our members’ time that makes AMSSM truly unique and impactful. It is so important for you to keep that in mind. If you want the field of sports medicine to advance professionally. If you want our reach in advocacy to expand. If you want to see the continued expansion of clinical research toward the goal of NIH funding. If you want to see fellowship training and our educational meetings continue to grow and diversify, then recognize the incredible impact factor that one individual can have, and get involved, again, treating others as ends, not means. Your involvement, aggregated with the work of others, builds a culture that can move mountains. Margaret Thatcher said that the “virtue of a nation is only as great as the virtue of the individuals who compose it.” The work of this...
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organization, in some small way, helps build a culture of civic virtue. And that starts with each of us. To avoid facing the consequences of the actions of sports medicine physicians who abuse sends a message that the action is not that important and leaves a broken window that will surely beget others. Addressing it directs our members to virtuous behavior, which builds on itself. Individual virtue, multiplied, leads to institutional virtue. Never minimize the ability of the individual to spark much accomplishment, both through direct action and through legacy behavior. For the latter, I love to use the example of Jonathon Edwards, who was a minister in the 1st half of the 1700’s and one of the first Presidents of Princeton University. Edwards obviously valued education, and transmitted that value to his children. How do I know? Because years later, an analysis of Edward’s children. How do I know? Because years later, an analysis of Edward’s family tree revealed that this man and his wife Sarah had given rise to 100 pastors, 80 public office holders, 75 military officers, 65 college professors, 60 physicians, 30 judges, 3 mayors, 13 college presidents, 3 governors, 3 U.S. senators, 1 medical school dean, 1 law school dean and 1 Vice-President of the United States. People in society are like yeast in bread dough. Their influence tends to expand exponentially for good, or for bad. This organization is filled with many good people. So help us. Let AMSSM be the beneficiary of a portion of your own legacy. We are almost 30 years old now, and it is amazing to look back and see where we are in comparison to where we began. But that’s the great thing about exponential growth. Over the next thirty years, with the help of each of you, AMSSM has the potential to be truly transformative.

And now it’s time to turn the reins over to Dr. Tracy Ray. Tracy is a true friend and mentor to me. He and I hatched the idea for the chapel service that meets each year at our meeting and occurred this year virtually as well. He is smart, gracious, and has a leadership mindset, and he understands the need for educational pathways in sports medicine to continue to evolve to meet the current needs of sports medicine diplomats and the public. AMSSM is in great hands. Past President Chad Asplund is rolling off executive committee, and I appreciate the support and leadership he has provided our group for the last four years. I also want to personally thank our outgoing board members for their service. Board members Ashwin Rao, Jennifer Koontz, Marci Goolsby, and Kelsey Logan are all wonderful people who I respect and whose friendship I value. I wish each of them well and look forward to their continued successes in our organization. Thanks to AMSSM’s staff: Jim, Jody, Michele, Joan, Andy, Kristin, Stephanie, Ellen, and Brian – you are all so talented and fun to be around. I appreciate each of you. Special thanks to my wife Amanda for her grace and patient support, and to my children, Ian, Ava and Eli, who make our home perfect in so many ways. It has been a true honor and privilege to lead this organization. Thanks again, and Godspeed. ■

Incoming President’s Message
By Tracy Ray, MD, FAMSSM
Presented during the AMSSM Virtual Meeting on April 25

My hope is that you all are and will all stay safe and healthy as we each find meaningful ways to contribute to the ongoing efforts to tend to our current situation. First, I would like to thank Drs. Chad Asplund and Chad Carlson for laying the most recent foundation for my presidential year. You guys are great to work with.

Thank you to all who have mentored and helped me, particularly Jimmy Robinson during my residency at the University of Alabama, and Bob Dimeff during my fellowship at the Cleveland Clinic. Thank you to my Warthog family for all the support and friendships. To John Zisko, my fellow fellow at the Cleveland Clinic, and Dr. Jimmy Andrews, for taking a chance on me as a fellowship director early in my career, I give my thanks. But mostly, thank you to the over 50 fellows I have had the honor of training. You all are my best legacy in sports medicine.

I have already had the true pleasure of working with the BOD and I look forward to working with the latest edition of very talented Board members and our wonderful AMSSM staff led by Jim Griffith.

And thank you to the founders, as they are those who set the foundation. We need to continue to build on that foundation of hard work done with excellence, integrity and service while we continue to transform into the society that we have already become and are becoming - the world-wide leader in Sports Medicine.

I can still remember my initial AMSSM Annual Meeting in Orlando in 1996. I was near the completion of residency. I came home telling my wife how I had found a home, and it was where I wanted to have an impact. My first committee work was with Margot Putukian on the Public Relations Committee. I still recall our frustration with our struggle for AMSSM recognition in the world of sports or medicine. We so badly wanted to share with the world who we were and what we could do and what we knew. Now we are “invited to the table” with every major sports organization continued on page 24
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Including IOC, USADA, NCAA, NFHS, and all professional leagues.
Recently, I learned of an organic development of a group of AMSSM team physicians who became a vital link for NCAA leadership in its decisions surrounding COVID-19. In a call with Brian Hainline, he expressed deep gratitude to this key group of team physicians within AMSSM who are living this pandemic with their NCAA programs and then, in turn, sharing their experience and expertise with decision makers at the NCAA. At Brian’s request, we are now building structure around this group to continue needed/desired input to the NCAA as we move forward in this pandemic. I want to recognize Stephanie Chu, Cindy Chang, Kim Harmon, Chad Carlson, Matt Leiszler, Carly Day, Doug Aukerman, Sourav Poddar, Karin Van Baak, Eugene Hong, Deena Casiero, Kyle Goerl, Mark Stovak and Chad Asplund for their initiative and leadership. You all have selflessly represented AMSSM in the best way.

I am disappointed that we could not gather as a society in Atlanta, my hometown, for AMSSM 2020. It is always special to renew friendships, work on committees and learn. We would have enjoyed an outstanding program put together by Jason Zaremski and his outstanding PPC. But there are year-round opportunities to learn and serve.

To ensure discussions can continue throughout the year, we are pleased to announce that the AMSSM Collaborate online community is now open for all members to join. “AMSSM Collaborate” provides a forum for year-long connection, giving members the chance to have conversations, share resources and make connections with their peers.

In addition to forums for Team Physician Groups, Special Interest Groups and Committee discussions, the AMSSM Referral listserv will be migrated here. Members can also find a section for Complicated Cases to help get answers to your clinical questions. “AMSSM Collaborate” will also be the platform for Case and Research Presentations, the Virtual Fellowship Fair and the hub for the Fellows Online Learning resources.

For additional learning there is significant content on the website that you might want to catch up on. Position statements such as the most recent Mental Health document, US modules, EKG workshops and the latest on concussion are just to name a few options. Chad Carlson has also recently lead some discussion on creating a “clearing house” for outside CME offerings to membership to access online content that is CME eligible.

Plus, thru Jason’s continued hard work, and with our AMSSM staff, these presidential presentations kick off a virtual meeting which will allow us to share research, committee work, special interest meetings and even a workout. It is not intended to be a substitute, and we will “come together” again next April in San Diego with a new-found appreciation for the Annual Meeting. This year’s virtual meeting will give us a chance to stay somewhat connected as we carry on with the work of AMSSM.

My emphasis this year, and likely for years to come will be centered around our training - the future training of SMPs. There will obviously be other acute issue with which to deal, but this area will be one of emphasis. Dr. Kathy Dec’s work with marketing and branding pointed out our continued need for clarification regarding “what is sports medicine” and how can we as SMPs distinguish ourselves from our colleagues with similar primary specialties - to our health systems, other physicians, referral sources, as well as the public. Dr. Jenni Koontz, in her work with our Scope of Practice document has attempted to give structure to “what it is that we do” with great difficulty due to the variability of our training. We have been at this for a while, and yet we still struggle to pin down either of these issues.

I feel, and many others agree, that our identity and our scope of practice are tied back to our training, and that training has often lacked consistent structure and rigor across all fellowships across the country. Without changes to our training, we will continue to struggle in other areas.

I am honored to have been selected by the membership two years ago to be in line for the AMSSM presidency. I will be forever grateful for each vote cast for me. It is very difficult for me to fully express how meaningful and humbling it is to take on this position.

The school motto at Berry College, where I completed my undergraduate degree, is, “not to be served, but to serve” (Mark 10:45). As someone who values servant leadership, I have always been drawn to AMSSM as it is fine example of this model like few other organizations. I hope to continue keeping this motto at the forefront as I lead our organization. I would hope that each member would also keep this motto in mind as you serve this organization. Each member is uniquely equipped to serve this society in some way - review a case or research submission, be mentor to a med student or resident, jump in with your ideas on a committee, donate to the Foundation. So get involved.

This will be a fantastic year as we all continue to realize the opportunities to impact sports medicine and serve the membership of AMSSM together. Please feel free to connect with me directly with ideas or concerns. Please receive my deepest gratitude for the trust that has been given to me.

Thank you. Stay safe, and let’s have a great virtual meeting. I hope you enjoy.
NEWS FROM THE BOARD

AMSSM Officers and Board of Directors Election Results

Congratulations to the following leaders elected to serve as Officers and Directors on the AMSSM Board of Directors:

Elected as an AMSSM Officer:
2nd Vice President
Mark Stovak, MD, FAMSSM

Elected to the AMSSM Board of Directors:
Casey Batten MD, FAMSSM
Nailah Coleman, MD
Cynthia LaBella, MD
Anna Waterbrook, MD

Re-elected to the AMSSM Board of Directors:
Carly Day, MD
Ken Mautner, MD, FAMSSM

AMSSM Officers and Board of Directors Election Results

Congratulations to Casey Batten MD, FAMSSM; Nailah Coleman, MD; Cynthia LaBella, MD; and Anna Waterbrook, MD on being elected as new Directors on the AMSSM Board.

Congratulations also to Carly Day, MD and Ken Mautner, MD, FAMSSM on their re-elections to the Board.

2020 AMSSM Award Winners Announced

AMSSM is pleased to announce the following awards in conjunction with the 2020 Virtual Meeting.

Best Overall Research Award ($500)
Christopher Hauglid, DO - Male Versus Female Adolescent Performance On The Buffalo Concussion Treadmill Test Early After Sport-Related Concussion

Harry Galanty Young Investigator Award ($500)
Kristopher Paultre, MD - The Therapeutic Effects Of Turmeric On Pain And Function For Individuals With Knee Osteoarthritis: A Systematic Review

NCAA Research Award ($500)
Mark Matusak, DO - Increased Sleep is Associated with Physical and Psychological Well-Being in Division I Men's Basketball Student-Athletes

AMSSM Community Advocacy Award ($500)
Alex Diamond, DO, MPH, FAMSSM
Safe Stars is a new effort to recognize Tennessee youth sports leagues and schools with high standards of health, safety and wellness for athletes, and it is the first youth sports safety rating system in the United States. The goal of the initiative is to improve safety for all by providing free resources and opportunities for every youth sports organization and school in the state to meet the recommended criteria.

2020 Resident Scholarship Award Recipients
Meredith Ehn, DO, DPT, Jeff Fleming, DO, Charles Kenyon, DO, MS, CSCS, Tyler Schmitz, DO, Allison Schroeder, MD and Kristian von Rickenbach, MD, MSc
The six Resident Scholarship Awards will be given a $500 cash award and complimentary registration towards the 2021 Annual Meeting and recipients of both 2020 and 2021 will be presented with their plaques at the 2021 Annual Meeting.

2020 South Bend/Notre Dame Resident Scholarship Award Recipient
Jordan Geroksi, DO
This is a new scholarship for St Joseph Regional Medical Center residents who are current members of AMSSM and are interested in a career in sports medicine. The scholarship award (a $450 value) covers the cost of registration to attend our Annual Meeting and will go towards attending the 2021 Annual Meeting.

2020 Galen Society Medical Student Scholarship Award Recipient
Sonal Singh, BA
The Galen Society Scholarship supports the participation of a medical student interested in a career in sports medicine attending the AMSSM Annual Meeting. The recipient receives $500 cash award and complimentary registration towards the 2021 Annual Meeting and recipients of both 2020 and 2021 will be presented with their plaques at the 2021 Annual Meeting.

2020 Jason Davenport Memorial Scholarship Award Recipient
Giorgio Negron, MD
The Jason Davenport Memorial Scholarship Award is presented to an AMSSM member who represents an underrepresented minority group and presented a case and/or research abstract at the Annual Meeting. The recipient receives a plaque and a $500 cash award to help defray expenses towards attending the 2021 AMSSM Annual Meeting.
COVID-19 has unfortunately reshaped the world in a manner not seen since World War II. During this crisis, AMSSM members led local, regional, national, and international efforts to control this pandemic. Ten years ago, we would not have been a blip in the newsfeed, and now our members are at the forefront. This is the result of the steady, continued growth and maturity of our Society and Foundation. And our growth will continue long after the threat of SARS-CoV2 is mitigated.

Having joined the AMSSM as member #22, I have had the opportunity to be a part of this organization from its inception. As former Member and President of the Board of Directors and as a Member and President of the Foundation Board, I have witnessed the amazing growth of this society from a dream to an international leader in sports medicine. The Foundation is the lifeblood of the Society. Without a strong, well-supported Foundation, the AMSSM would not be able to create and support the wide variety of programs that are currently offered, that are proposed, or that are just a dream. I lived through the period of growing pains when we did not know for sure if we could pay our bills. It is inspiring to now see the fiscal strength of the Society as it weathered this storm and continues to grow.

The cancellation of the 2020 AMSSM 29th Annual Meeting and Foundation reception at the Georgia Aquarium in Atlanta was a disappointing side effect of the coronavirus pandemic. We sorely missed the opportunity to interact with corporate supporters and contributors. And I very much appreciate the donations our members made to the Foundation. In the past year, nearly a quarter of our active members made contributions, providing over $96,000 in total. I wish I had the opportunity to personally thank everyone who would have attended the Annual Meeting and reception, but like many events this year, I will have to do it virtually!

In spite of the economic downturn as a result of COVID-19, the foresight of the AMSSM leadership has allowed our financial status to remain secure and as strong as ever. But we must continue to support the Foundation to allow the AMSSM to remain a worldwide leader in sports medicine. With the help of our members, I expect that the AMSSM will accomplish great work in the coming year, and the 2021 Annual Meeting and reception will be another tremendous success.

The following are some of the highlights of the Foundation activities in the past year:

- **The AMSSM Foundation Policy Manual**: This is the first policy manual created and approved by the AMSSM Boards. The manual is available on the website for members to review to help them understand the roles and responsibilities of the Foundation and its Board Members and Officers.

- **2019-20 Corporate Support: $369,100**: Since the AMSSM was forced to cancel the 2020 Annual Meeting, the Foundation has earmarked some of these monies for next year’s events. As more companies recognize the national and international impact of the AMSSM and its members, we are gaining more corporate support. This provides valuable financial and educational support of AMSSM initiatives. If you have relationships with companies that should be working with AMSSM or that may be interested in becoming a Foundation corporate supporter, please forward leads to Executive Director Jim Griffith.
• **Member Giving:** $96,251 More Active AMSSM members gave to the Foundation this year than ever in the past with 23.3 percent of our membership making a donation. This is a true testament that our members believe in our mission and that the AMSSM is working for them. This speaks volumes to the quality of our society members.

• **2019 Foundation Auction:** $23,740 Thanks to those who donated and purchased items as part of the Foundation silent auction at the 2019 Annual Meeting. The auction has raised more than $250,000 since its inception.

• **2020 Current Assets:** $1,980,000 The value of the Anderson, Davenport, Galen Society, Halpern, South Bend, and General Foundation Funds rises every year.

• **Education:** $187,000 The Foundation support of the Annual Meeting, Fellows Research and Leadership Conference, Traveling Fellowship, fellows starter kits, and sports ultrasound training increases annually.

• **New Traveling Fellowships:** With assistance from corporate sponsors, the Foundation is committed to supporting these new programs. In addition to the original Traveling Fellowship, the Global Exchange and Ambassador Traveling Fellowships will further expand the global reach of the AMSSM.

• **Research:** $225,000 The Foundation contributed to the AMSSM Collaborative Research Network (CRN) efforts which includes programs such as the Request for Proposal (RFP) Award, Bridge to R34 Grant, annual Research Summit, Young Investigator Grants, AMSSM/ACSM Clinical Research Grant Award, AMSSM Research Grant Awards, and Youth Sport Specialization Grants. The Foundation has also committed to providing ongoing financial support for the CRN RFP and Bridge Grants through 2025.

• **Humanitarian:** $16,000 Support for the Annual Meeting service projects and the ongoing Global and Local Humanitarian Outreach Grants increases yearly.

These grants support sports medicine projects in our local and international communities.

• **Long Term Giving Programs** to perpetually fund the Foundation and CRN have been delayed due to the COVID-19 pandemic but will be addressed in the next year.

• **Corporate Members:** I want to thank Marje Albohm, MS, ATC and Brian Hainline, MD for their continued support of the AMSSM Foundation. Their input is invaluable as we continue to grow and move forward.

• **New Board Members:** Congratulations to Verle Valentine, MD and Darryl Barnes, MD, for their election to the Foundation Board. Verle will serve a 4-year term as a former AMSSM Board Member, and Darryl will serve a 2-year term as at-large Board Member. I know that both of these members will provide outstanding input to the Board, and I want to personally thank them for volunteering their time and wisdom.

• **Re-elected:** Sourav Poddar, MD will serve an additional 4-year term and I am confident will continue to provide valuable guidance to the Foundation.

• **Special Thanks:** to William Meehan, MD, who completed his term as at-large Board Member, and Rob Johnson, MD, who completed his term as Board Member and Officer with 11 years of dedication to the Foundation Board.

• **New Officers:** for 2020-2021 are
  - Kim Harmon, MD, FAMSSM, President
  - Susan Joy, MD, Vice President
  - John DiFiori, MD, FAMSSM, Secretary Treasurer
  - Robert J. Dimeff, MD, FAMSSM, Immediate Past President

• **The 2021 AMSSM Annual Meeting** promises to be another outstanding educational experience, and I hope to see you in San Diego from April 13-18, 2021.

Please stay safe and healthy as we develop better treatment, effective vaccines, and herd immunity and SARS-CoV-2 mutates to a less virulent virus.
Member in the Spotlight

Marissa Vasquez, MD, MBA

By Lauren M. Simon, MD, MPH

On International Women’s Day, I was privileged to interview an amazing AMSSM Member in the Spotlight: Dr. Marissa Vasquez, who is leading the way for women in sports medicine caring for professional athletes.

In March 2020, after nearly seven years serving both as Sports Medicine Fellowship Director and Physician in Charge for the Division of Sports Medicine at Kaiser Permanente in Los Angeles, Dr. Vasquez became the first female, Senior Lead Team Physician for Major League Baseball’s (MLB) Los Angeles Dodgers. She also serves as one of the first female physicians in this role for all of Major League Baseball. With her years of experience taking care of family medicine and sports medicine patients, her expertise in culturally responsive care and her experience serving as bilingual (English and Spanish) media representative for Southern California Kaiser Permanente, she brings a breadth of skills to care for the athletes and staff in the LA Dodgers organization.

Her scholastic background in biochemistry and experience in large health systems and operations management at Kaiser Permanente are particularly useful as she navigates care during the COVID-19 pandemic, which has coincided in the United States with the start of her new position with the LA Dodgers.

Dr. Vasquez earned a Bachelor of Science degree in Biochemistry and Chemistry at University of California, Riverside, with a minor concentration in Spanish Literature. She received her medical degree from Temple University in Philadelphia, where she found she could combine her love of anatomy and procedures by pursuing a career in sports medicine. She completed a Family Medicine Residency at White Memorial Medical Center in Los Angeles followed by her Primary Care Sports Medicine fellowship at Kaiser Permanente, Los Angeles (KP-LAMC). In 2018, she completed an executive Master of Business Administration degree and Certificate of Marketing at Anderson School of Management, University of California, Los Angeles (UCLA).

After Sports Medicine fellowship under the leadership of AMSSM members Dr. Daniel Vigil and Dr. Joseph Luftman, Marissa joined the Kaiser Permanente Los Angeles Medical Center Family Medicine Residency faculty in 2007, where she developed a surgical walk-in/ sports medicine/MSK clinic and served as Clinical Instructor for the USC and UCLA Medical Student Musculoskeletal (MSK) course. She spilt her time between Family Medicine and Sports Medicine for several years until she became Associate Program Director and later Program Director for the KP-LAMC Sports Medicine fellowship and transitioned to full sports medicine practice along with AMSSM member, Dr. Michael K. Fong.

In her medical practice and teaching roles she enjoyed having “the ability to care for athletes comprehensively and address the entire spectrum of medical and MSK” concerns.

She served as Associate Head Team Physician for Occidental College for 13 years prior to her role with the LA Dodgers. In 2015, she was a great site lead and medical captain for the Special Olympics World Games at UCLA, where she efficiently organized hundreds of physicians (including me), caring for more than 6,500 of athletes, from around the world (177 countries), who have intellectual disabilities and special needs.

Currently, in her position with the LA Dodgers and UCLA Health, Dr. Vasquez serves as an Associate Clinical Professor of Family Medicine-Division of Sports Medicine at UCLA.

Marissa is well familiar with health care and sports teams in Southern California. She grew up in the small town of Brawley in the Imperial Valley, an agricultural region of California near the Mexico and United States border. During high school, she competed locally in club swim team. She remains an avid swimmer and has

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competed in several Olympic distance triathlons. She, her husband Walter, and daughter enjoy swimming and participating in races and fun runs such as the “Color Run” pictured here.

She is a former professional musician (who plays 5 instruments); Den leader for Scouts and a humanitarian. Dr. Vasquez helped start a nonprofit organization “Elevate Med”, which supports medical students with mentoring and scholarships and seeks to promote diversity in medicine.

Dr. Vasquez joined AMSSM in 2006. She has served on the AMSSM Fellowship Committee; the inaugural In-Training Exam (ITE) Subcommittee, ITE question writer, Case editor, and Maintenance of Certification (MOC) Part IV contributor. She has guided numerous sports medicine fellows to become involved with AMSSM.

When I asked Dr. Vasquez, on International Women’s Day, what advice she has for our AMSSM members and future members, she said, “I seek to empower women in sports medicine and all fields of medicine to break glass ceilings.” She shared one of her favorite quotations from Ralph Waldo Emerson, “Do not go where the path may lead. Go instead where there is no path and leave a trail.”

Thank you Dr. Vasquez for being our AMSSM Member in the Spotlight, and “Go Dodgers!”

Color Run at Dodger Stadium - Marissa Vasquez, MD, husband Walter Machuca and their daughter.

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