[Editorial]

Team Physician Quagmire

The role of the orthopaedic team physician in National Collegiate Athletic Association (NCAA) football is certainly challenging. Faced with a variety of trauma to the shoulder, elbow, hip, knee, foot, and ankle produced by a violent and sometimes brutal sport, the skills of a surgeon will certainly be tested. Sometimes the most difficult clinical questions evolve around the benefit of surgical intervention, as some injuries may be best treated nonoperatively. The experienced physician often knows which injuries should be left up to the healing power of Mother Nature.

Football athletes are some of the largest, fastest, and strongest in sports but pose many dilemmas for the treating physician because of their physical prowess. Because of their exercise history and habits, most tolerate and even enjoy the most rigorous training and rehabilitation programs. However, the bar for their physical performance is set so high that "almost" or "near peak" may not be good enough to return them to their preinjury status. Consequently, the challenge of providing orthopaedic care to these fine athletes can be daunting. The need for a complete and accurate diagnosis when injuries occur is constant. From the injured player lying on the turf to the sidelines, locker room, and thereafter, getting the diagnosis correct as quickly as possible is of highest concern. Fortunately, today, there are many more tools available than 25 years ago, including outstanding musculoskeletal magnetic resonance imaging and ultrasound.

Once the diagnosis is known, delivering the most efficacious treatment is the expectation, all while being critiqued by the players, coaches, parents, media, and public. There are many "experts" advising the athlete who are willing to second guess every diagnosis and recommendation, necessitating justification for each clinical decision.

Because of these challenges and more, the job of the team physician is not easy. While these positions do provide a degree of notoriety and prestige, the responsibilities and expectations are formidable. Despite high demands, these jobs are highly desirable for the orthopaedic surgeon. Consequently, athletic departments often enjoy the luxury of having their pick of physicians to serve in this capacity. Most physicians (65%) who serve in these roles do not receive a monetary stipend, dedicating their time and talent to the athletes and schools that they support.[1] However, in the multibillion dollar business of college sports, it is worth questioning that arrangement. Does it make sense that these highly skilled medical professionals are not reimbursed for their services to these exceptional athletes? Furthermore, while the lack of reimbursement for team physicians is difficult to understand at times, the opposite arrangement is much more troublesome, one in which team physicians pay to provide their services.[1] According to a very interesting research survey in this issue of *Sports Health*, 15% of team physicians in 2016 paid either directly or indirectly to provide team coverage.[1] These revelations generate several more questions, which, unfortunately were beyond the scope of this work. Were these team physician positions shopped around and awarded to the highest bidder? How did the qualifications and experience of candidate team physicians compare with others in the community? Are athletes at those schools receiving the best medical care available? Or, are there compromises being made because of this monetary arrangement? Even more interesting would be knowing whether the athletes receiving medical services at these institutions are aware that their physicians are paying for these opportunities to provide care. Clearly, there is potential for conflicts of interest and a desperate need for transparency. I wonder whether the entire athletic department administration at these institutions, including the coaching staffs, are aware of these arrangements. Are the medical communities associated with these Division I programs, whether they be academic or private practice groups, supportive of these policies? In light of the horrifying, long-standing debacle recently uncovered in college sports medicine at Michigan State University, there is a compelling mandate to evaluate how team physicians are selected and monitored. The student-athletes, their families, the universities at which they are located, and the public deserve to know what the requirements are for these positions. Do these positions simply go to the highest bidder at some institutions? Furthermore, the need for transparency should not end with the selection process for these positions but should continue with the regular monitoring of physician practices by individuals capable of evaluating expert medical care: qualified medical professionals capable of unbiased review. College athletes deserve nothing less, especially in football where the nature of the sport puts athletes at risk each training session, practice, or game day. This is not to say that other sports, especially for women, are not at high medical risk for other reasons. Most of these young athletes will not fully understand the medical risk that they eagerly accept until later in life—sad,

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but true. It is up to athletic departments, university administrations, their physicians, and governing boards to protect these athletes as best they can with the most appropriate, unbiased, unconflicted medical care available.

The NCAA, with the help of many contributors, has produced the Interassociation Consensus on the Independent Medical Care for College Student-Athletes Best Practices.[3] The American College of Sports Medicine has also produced a team physician consensus statement,[2] with participation from the American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine. These guidelines can assist administrators in devising health care systems for college athletes.

I congratulate this group of authors, captained by senior author Dr Eric McCarty, on an excellent addition to the sports medicine literature. Their review, which examines clinical treatment trends in Division I college football between 2008 and 2016, is well worth reading. As they correctly state in their limitations section that the study is based solely on expert opinion and not clinical outcomes, this statement pertains to the clinical trends reported. Nevertheless, it does hopefully represent the combined expertise of some of the most qualified team physicians in college sports. Seeing the clinical treatment trends converge both in a positive and negative direction on various topics hints that consensus is being developed among these experts—hopefully for the benefit of the student-athlete. More important, I congratulate this team of authors on exposing some practices in college athletics at a minority of institutions that deserve scrutiny and transparent disclosure to all involved. Hopefully a review of these programs in which physicians pay directly or indirectly to provide care would show a very healthy environment for athletes where the best available medical care is being delivered. In that scenario, if there is transparent disclosure to all stakeholders in college football, even if the selection process is questionable, the athletes may be receiving what they deserve. If, however, the opposite is true, meaning that optimal care of these athlete isn't the determining factor in decision-making, changes are needed.

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REFERENCES

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