Making of a Team Physician

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By: Terry Stanton (/search.aspx?id=32&srchtext=Terry+Stanton)

Being successful as a team doctor in big league sports
So you want to be a team physician?

If so, you might want to take stock of observations recently shared by three surgeons with high profile experience in that role at a "The Way I See It" session held during the 2016 AAOS Annual Meeting.

James R. Andrews, MD, Brian J. Cole, MD, MBA, and **Anthony Miniaci, MD, FRCSC,** and moderator **Frederick M. Azar, MD,** pulled back the glittery curtain that can obscure much of the everyday grit and grind faced by team doctors, who, they explained, must navigate a thicket of competing interests in providing care to the athlete.

Referring to the challenges and demands of serving as a team physician that he has encountered in providing care for Chicago Bulls and Chicago White Sox players, Dr. Cole asked rhetorically, "Why would you even do this?"

"People who are team physicians often are very busy people with very busy practices," he explained. "Balancing it all is a challenge. To the core issue of why would you do this, it's the same reason you and I are in this room and at this meeting: We enjoy helping people, especially those motivated to return to the activities they enjoy."

He explained that those who aspire to provide care to teams and elite athletes should be mindful of the purpose they are serving. "First, your motivation absolutely cannot be driven by finances," he said. "You need to understand the commitment. One of the things we have to know how to do on a regular basis is grade athletes and evaluate risk. You have to be prepared to help an athlete get a second opinion. It is all about relationships with other professionals. There is no question that fame is not part of the equation. Being star-struck is not an option."

Although being a team physician can raise one's public profile, Dr. Cole told the audience, "You need to know that the impact on your reputation is not always positive."

Brian J. Cole, MD, MBA, presents during a "The Way I See It" session on serving as a team physician at the 2016 AAOS Annual Meeting.

Team first

Dr. Cole pointed out that a team physician must always remember that he or she is part of a larger medical team. Quoting author and humorist Mark Twain, he said, "Really great people make you feel that you, too, can become really great."

"That's an important statement because you have to enable a large team of collaborators," explained Dr. Cole. "The job description is highly varied. There is truly no 'I' in team." At his practice, Midwest Orthopedics at Rush University Medical Center, he explained, "the entire Division of Sports Medicine helps to facilitate care. There is no possible way one person can cover every single game and also meet the needs and expectations of the organization. It's a 12-months-a-year, 24/7 job for almost any sport."

To illustrate team members' roles, he used a hub-and-spoke diagram—with the athlete at the hub and team members on the spokes—called SCOR, which emphasizes the importance of knowing when to Support, Collaborate, Oversee, and Refer.

Dr. Andrews, who has served as team physician and consultant for a number of organizations and sports at the college and professional level, also emphasized the team approach, noting that a variety of personnel are involved, including the dentist and nutritionist. But the athletic trainer is "the glue that holds it all together. And don't forget the emergency medical technicians."

He explained that he learned the hallmarks of a good sports medicine physician from Jack C. Hughston, MD, a pioneer in the field who listed them as availability, compassion, gentleness, honesty, communication, and "true love of being helpful to those who show good sportsmanship."

Dr. Cole named his "Six Cs of Being a Team Doc," as compassion, communication, competence, charting, coverage and contract.

"Compassion means letting the athlete know you care, and being available 24/7," Dr. Cole explained. "Communication encompasses a do-it-yesterday mentality," he continued, "with clear instruction about the treatment plan and information about the risks of a condition and sports participation. Competence means staying

current, while charting means documenting all encounters no matter when they occur, and coverage involves clarifying malpractice insurance and asset protection. Finally, contract means spelling out such details as services provided, insurance coverage, volunteer or paid status, and final say about return to play."

Dr. Cole also named some of the intangibles that go with the team physician role—for instance, sometimes yielding to another perspective to provide the best care. "You need to not only encourage second opinions but help arrange them," he said. "In any given week, I will be texting Dr. Andrews or other colleagues about a case. The agents expect it, the athletes expect it, and you learn a ton from these second opinions. If I feel someone can do a better job, I have no problem referring. You're coordinating care, not always providing, and you must be confident enough to accept that you're not always going to be the treating physician. I find it an honor to be asked by other organizations about my opinion related to the care of their athletes. These guys are patients first, athletes second. There is a life after sports."

The team physician must keep his or her medical knowledge up to date, including staying abreast of treatment approaches that may still be undergoing evaluation. "We have an obligation to know the most contemporary treatments available," Dr. Cole said. "I am willing to embark on some of these unproven pathways if they are safe solutions with a high probability of success."

Credibility check
Dr. Cole also discussed the importance of the concept of "agency," which he said refers not only to the art of managing and showing respect for all stakeholders, but to the establishment of "roles and accountability."

"Our credibility depends on what lens you are viewed through and the timing of the decision in terms of where the athlete is in his career," he explained. "All the people around the athlete—agent, team owner, general manager, trainer, family, fans—play a role. Everyone has an opinion and theirs may have nothing to do with the medical aspect of what we are dealing with. We still have to be a doctor engaging our core principles despite very different forces that come from every one of these sources."

One of the great challenges a team physician faces, especially at the professional level, is earning and cementing the trust of an athlete. "Loyalty is earned in this field and can be very temperamental," Dr. Cole said.

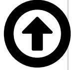
He explained that in the National Football League, "it was reported recently that a significant percentage of players "distrusted" their team physician. Some may seek treatment elsewhere, potentially [for] a particular treatment that is not available in the United States. This is not unique to any particular sport. Team physicians need to remain open-minded to facilitating safe alternatives with minimal anticipated downside."

He pointed out that criticism of other providers isn't helpful. "You have to be objective and understand that these athletes may be seeking alternatives. Be supportive. It's OK if it is not going to hurt them. Sometimes you just have to take a deep breath when you know it may not be a truly proven tactic and just let it go."

Perhaps the most unpleasant aspect of the team physician role is confronting the issues of malpractice and liability. "In general, we are at-will consultants with insurance riders," Dr. Cole explained. "You have traditional malpractice coverage and then pay a little bit more to get a bump up in single and total claims coverage. The ideal scenario would be if one could be an employee of the organization, because in general if there is an event that could otherwise pierce that corporate veil, you are relatively protected because the employer generally assumes liability if you are an employee. It has been challenged, but that is roughly how it stands."

Another part of the team physician's job that can bring headaches is dealing with the media. "This is a challenging area," Dr. Cole said, "My general approach is that I don't talk to them. The only time I will is when an organization asks me to address the press, and then it is rehearsed with talking points. You never want to be caught off-guard. Just like your private patients, the same HIPAA and ethical concerns abound, and I always respect the player and the organization first"

Dr. Andrews explained his similar approach. "After surgery, the press might call me and want to know how the surgery went on a high-level athlete, and I'll tell them that I can't deliver that information," he explains. "I'll call the team doctor or trainer. As soon as I do that, I text the team doctor or trainer to relay exactly who called me and what I told them, because that night they might be on ESPN saying what I supposedly told them. You have to cover your bases. I don't ever talk directly to the press about a player's condition but direct all inquiries back to the team's sports information director."



Leagues of their own

Dr. Andrews discussed some of the challenges specific to sports at the amateur or professional level as well as differences among the major sports. In college, he explained, one issue that looms large is preparticipation clearance.

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"Who decides medical eligibility—the team physician or an outside doctor?" Dr. Andrews asked. "It's pretty well-accepted in the sports medicine world that the head team physician has the final word on disqualification for participation, though he or she can use consultants."

Some preparticipation issues might not be so self-evident, he said. "Should walk-on athletes be able to participate with some medical problem that could be compounded? I believe we should not allow walk-on athletes to take much risk, especially with preexisting problems. It's not worth it to them. Get them in biology, get them in medical school. Don't send them out to hold dummies in practice and get hurt more."

The team physician also has the last word on "who decides to return to play in the heat of battle or week to week," but trying scenarios can arise. "There can be conflicting goals," Dr. Andrews said. "Let's say the star running back is hurt, with a meniscus bucket handle tear. It's playoff time. What do you do? Do you take out the meniscus or do you repair it? The decision may be complicated by what is best for the long haul and career versus what gets the player back quickest."

The coach's opinion sometimes serves neither the team nor the player. "You are not doing the team any good by putting a player out there who is hurt," Dr. Andrews said. "Coaches don't realize that their second-team player is better than their hurt player."

Professional sports are colored by contracts and agents. "The overactive role by agents and representatives in players' healthcare decisions can be complicated," Dr. Andrews said. "In some cases, it can be disruptive and lead to inferior healthcare."

In the NFL, specific challenges include players who underreport the severity of their injuries. "This is not unusual, especially for the lower-level athlete trying to make the team," Dr. Andrews said. "There must be a trusting relationship with the athletic trainer, and an honest preparticipation history is essential."

On the other hand, sometimes players overstate their injuries, which can be hard to counter because the physical examination is based on subjective complaints. "The problem often arises in preseason, when the player wants to avoid minicamp, 'optional team activities,' and preseason workouts and games, for which the players are barely paid. This is why you see so many high-level NFL players pull their hamstring in preseason. There's no great solution, and the team physician is in a really tough spot," Dr. Andrews said.

In Major League Baseball, with its extensive system of minor leagues, issues related to status on the 40-man roster may come up. A player sent to the minors may claim an injury occurring while he was in the majors, which would keep him at the major league pay scale. Conversely, young players may hide injuries in hopes of trying to make the major league team or stay on it. The question of when a chronic injury occurred may be compounded by frequent trading of players and free agency. Many such injuries result from overuse. "Therefore," Dr. Andrews asked, "which team is responsible for injury treatment and/or compensation?"

In the National Basketball Association, where ironclad collective bargaining agreements and high-dollar guaranteed contracts prevail, the challenge may be that a player has no incentive to get back to play quickly.

In dealing with these various issues, Dr. Andrews said, "the team physician gets caught in the middle, and the art is in keeping both the player and the team happy. It can involve playing both ends from the middle."

He also addressed the ethical issues in serving as a team physician, including those relating to money and compensation. "To be successful in sports medicine, you must also be successful in medical economics," Dr. Andrews said. "But never let economics interfere with doing what's best in medical care for the patient and the athlete."

For his part, that generally means eschewing pay for his team physician duties. "If you consider yourself a team physician, and consider it all a 'we' situation, and you share the limelight with the people who work with you, you will be very successful," he said.

He noted that medical advertising involving sports team can raise "difficult ethical questions."

"There is no doubt that team physicians have marketing advantages," Dr. Andrews said. "These advantages should not be fueled by aggressive self-promotion. There is no question that with this notoriety comes some ethical price. Physicians should not pay for the right to be the team physician, and they should never allow themselves to be considered in the back pocket of management."

Finding the balance
Dr. Cole concluded by sharing his perspective of striking the right work-life balance in fulfilling the duties of the team physician in addition to those of a busy orthopaedic surgeon. His advice is as follows:

- It's all about balance—how you balance family, work and sport. Identify non-negotiable personal time. Fill the time with what you like doing.
- Always be a student.
- Be ethical. We took an oath to do no harm and we never benefit from disparaging our colleagues or our patients.
- Set priorities.
- Learn to say "no." Ask yourself, 'Will this take me away from family and friends? Will it enhance my career? Will the obligation take me out of balance?'
- Make a difference. You are privileged. Are you making a difference in the world?
- Quality over quantity. We can spend a relatively short time with a patient, but if the quality is good, the patient will feel as though you were there for an hour.

"If you become a team doc, give your patients something to believe in," he advised. "We are doctors first. Don't cross boundaries. It's important to build relationships with these patients, but if you cross that boundary, you lose that efficacy and trust."

In addition, he encouraged all team physicians to exceed athletes' expectations.

"Find out what they want and give more of it. Find out what they don't want and give less of it," he said. "Ask yourself, 'Would you go to a doctor like you?'"

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"Where We are in 2016"
Anthony Miniaci, MD, FRCSC, of the Cleveland Clinic, was the third speaker. He included in his "The Way I See It" presentation the following summary of "Where We Are in 2016:"

- Team physicians are the best and brightest sports medicine orthopaedic surgeons we have.
- It is a time- and labor-intensive endeavor that requires experience and passion.
- Times have changed, with an evolution from a sport to a business first.
- Many issues other than those that are medical are important, including financial concerns, contracts, liability,

and workers compensation.

- We are losing the public/player perception battle despite our dedication to the highest moral and ethical principles.
- Our dedication/passion (doing things for free) has allowed our services and expertise to be devalued.
- Our conflicts of interest are real—even if we don't think they affect our decisions.

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