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EDITORIAL

Editorial

Orthopaedics, Advocacy, Action

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Your first response to those three words is …?

After last year's bruising presidential race and developments in Washington suggesting professional uncertainty ahead, the title of this editorial might imply an incoming pitch for an orthopaedic political action committee. Many believe our specialty needs advocates where the big decisions get made.

We may. But others need our action and our advocacy even more.

In this issue, we interview the authors of two Editor's Spotlight/Take 5 articles [DOIs: 10.1007/s11999-013-2839-4 and 10.1007/s11999-013-2836-7] that remind us that as surgeons we interact with—and have a responsibility to protect—many vulnerable people.

This month we learn from Dr Della Rocca and colleagues [4] that orthopaedic surgeons continue to endorse a number of mistaken beliefs about the victims of intimate partner violence (IPV), and that only approximately one in 25 of us screens patients for IPV regularly. Although orthopaedic clinicians are positioned perfectly to discover and intervene, as a group, we do not do it. We have seen studies [2, 3] and heard calls from our Academy [1] for some time now. The message has been consistent over a period of years. Why are we not getting it?

Also in this issue of CORR®, we read about another group of patients that needs our advocacy. On the surface, these patients—elite adolescent male basketball players—appear anything but vulnerable. Many of these kids are taller than most of us. Tougher, too, at least tougher than this Editor-in-Chief. But Siebenrock and colleagues found that tough on the outside is not enough. Children who train year-round for high-level basketball develop cam-type deformities [7], which may put them at risk for premature hip arthritis. Although this needs to be confirmed, no doubt you remember that it was orthopaedic research that convinced baseball leagues to institute pitch counts and other restrictions [6]…but not before many boys were injured. Similarly, young female athletes probably tear more anterior cruciate ligaments than they should given what we know about neuromuscular training and injury prevention [5].

You probably do not treat these children in the office, but you almost certainly have observed the increases in frequency, intensity, and duration of training that have become normative in youth sports. As clinician-scientists, we need to ask how much is too much, and to determine whether these vulnerable patients are being harmed by sport. If they are, as humanitarians, we need to be vocal "first responders" and advocate for different training regimens. And as physicians, we all need to enter our offices with eyes open to the near certainty that victims of IPV are seeing us. We need to start seeing them.

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