References
1. Alderman PM. Complications in a series of 1224 vasectomies. J Fam Pract 1991; 33:579–584.
2. Schmidt SS. Surgery and male infertility. In: Cockett ATK, Urry RL. Male infertility. Workup, treatment and research. New York: Grune & Stratton, 1977:271–307.
3. Schmidt SS. Vasectomy [Editorial]. JAMA 1988; 259:3176.
4. Schmidt SS. The Sturgeon Vas Cautery: the first 600 cases. Urology 1988; 31:223–4.
5. Schmidt SS, Hinman F Sr. The effect of vasectomy upon the incidence of epididymitis after prostatectomy: an analysis of 810 operations. J Urol 1950; 63:872–81.
6. Schmidt SS, Morris RR. Spermatic granuloma: THE complication of vasectomy. Fertil Steril 1973; 24:941–7.
7. Schmidt SS, Amelar R, Dubin L. Letters: Congenital absence of the ductus deferens. JAMA 1970; 213:2080.
8. Massey FJ, Bernstein GS, O'Fallon WM, et al. Vasectomy and health. JAMA 1984; 252:1023–9.

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Sports Medicine: *The Times, They Are a-Changin'*

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Consider the following "picture-perfect" scene:

> It is a brisk, clear fall night in a small midwestern town. Two high school football teams battle each other for "bragging rights" in an annual rivalry that is more than a half-century old. The team physician (also the practicing family physician in town) stands stoically on the sideline until a player goes down with an obviously painful injury. The physician runs to the aid of the injured athlete, determines a diagnosis, coordinates safe removal of the player from the field, and provides appropriate care. The player does not return to the game, but he does return to play again later in the season, after rehabilitation.

What is wrong with this image? Absolutely nothing. It has been repeated time and time again throughout our country in every small town in America. The competent medical care provided by team physicians is exemplary. But as Dylan said, "the times they are a-changin'." It is no longer sufficient to simply stand on a Friday night sideline providing episodic care to the injured athletes in competition. The "model" team physician now is expected to deliver ongoing care consistent with that espoused for all family practice/primary care patients: comprehensive, continuing, competent, and accessible. Let's pick up the story again, the next afternoon.

> The team physician, this time as speaker, quietly and patiently breaks down complicated medical jargon while speaking to a group of parents and volunteer coaches. He explains to them about the physiological and psychological stresses for adolescents participating in competitive athletics.

In this scenario, the physician is practicing both community-oriented primary care and preventive anticipatory medicine.

> The following Monday, intermixed among many others are a number of patients referred to the physician by colleagues because of his or her special area of interest.

This physician is not only a community resource, but also a resource for other physicians. What is most interesting about this physician is that he or she may be only 1 year into practice, 2 years out of family practice residency, and 1 year past completion of a primary care sports medicine fellowship.

The article by Nattiv and Puffer (*Nattiv A, Puffer JC. Lifestyles and health risks of collegiate athletes. J Fam Pract 1991; 33:585–590*) represents a sports medicine fellow and her mentor applying family medicine principles and philosophy to an athletic population. The paper concludes that athletes have a significantly higher rate of

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"risky" lifestyle behavior patterns compared with nonathletes. Methodologically speaking, this paper is limited by its sampling methods. It does represent, however, an infusion of family practice principles into a "sports medicine" population, and therefore it has served its purpose well. It is representative of the research now being done by fellows in the growing network of primary care sports medicine training programs across the country. Using skills developed in family practice, coupled with an interest in sports medicine, these fellowships facilitate study of important questions about behavior, lifestyle changes, and preventive techniques as they relate to athletes.

Discovering that college-age athletes exhibit more risk-taking behavior than a nonathletic population raises a number of additional questions: "What about other athlete populations such as high school athletes?" "Is it possible to accurately and prospectively define endpoints of risk-taking behavior (eg, trauma, injury, or even death)?" "Why do athletes take more risks?" "Is such behavior inherent to participation in sports?" "Is the psychological makeup of athletes different from that of nonathletes?" and "How can this information be of benefit in caring for the general population?" Nattiv and Puffer have taken a very important first step.

There has been considerable debate about which medical discipline can best care for the athlete-patient. I maintain that sports medicine is simply *medicine in motion*. It cannot be confined to medical specialties defined by organ systems or age groups. Because of the comprehensiveness of their training, family physicians should be the specialists who provide primary care to athletes.

Family medicine can be considered a rather large protective umbrella under which a vast array of knowledge resides. The core content of family medicine becomes clearer with the help of such focused interest areas as sports medicine. It is as if family medicine is being defined from within. There is focus in sports medicine.

Family physician involvement in sports medicine offers three very important advantages to the discipline: (1) sports medicine integrates family medicine principles with other disciplines and health professions (eg, cardiology, orthopedics, physical medicine, and rehabilitation); dialogue with these other specialties allows us to further promote the principles of our discipline; (2) involvement in sports medicine stimulates the interest of medical students in choosing family medicine as their specialty; and (3) sports medicine assures family physicians an instant patient population and a practice that has a community orientation.

Should we, as a discipline, be involved in sports medicine and its delivery? Ask any of the 50% of the United States population who regularly exercise. Ask the medical student trying to decide which specialty is best to choose. Ask the third-year family practice resident contemplating setting up practice in a community. You do not need to know the difference between a basketball and a football to deliver quality sports medicine. All you must do is respond to your patients' interests.

Our discipline has seized the moment. We are transforming sports medicine from a narrow focus on joints or muscles to a comprehensive view of the athlete, his or her family, and the community. The times . . . they need to change.

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