FAST BREAK

Publication for team medical personnel

The role of the team doctor

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ISSUE 22

WELCOME to FAST BREAK!

Welcome to Fast Break, the official quarterly news bulletin of the FIBA Medical Commission. Our goal is to introduce our FIBA sports medicine and sports science community to newsworthy research topics and develop a community of practice among physicians and clinicians involved with basketball at every level of play across the globe.

We hope this publication will foster friendly communication and discussions within the world of basketball. We welcome and encourage your questions, comments, suggestions, and contributions to this publication.

MESSAGE FROM THE EDITOR

A few months ago, I came across Elizabeth Gallup's 30-year-old book entitled 'Law and the Team Physician'. While this is an American publication and the legal issues may not be germane across the globe, many of the topics that are addressed are still vital for the team physician, such as defining the team physician's role, team physician training/skill and preparedness, injury risk assessment and return to play decisions, as well as the team physician's role in risk management.

Team physicians have a unique role with a duty of care to the individual athlete as well as the team. Rules and regulations of the game may impact medical decisions and care.

In 2026, the FIBA Medical Commission's educational programming will focus on core concepts for the team physician and preparedness for FIBA events. Key topics will be presented as a webinar with other topics addressed in the Fast Break.

In this edition, we focus on ethical considerations for the team physician, and the team physician's preparedness for FIBA events medical coverage.

1. E. M. Gallup. Law and the Team Physician. Human Kinetics, Champaign, IL. 1995.

Marni Wesner, MD, MA, CCFP(SEM), FCFP, Dip Sport Med
Editor, Fast Break
Email: medical@FIBA.basketball

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GUEST EDITORIAL

BEING AN ETHICAL BASKETBALL TEAM DOCTOR

Dr Peter Burt, FIBA Medical Commission
New Zealand

Being a team doctor in basketball is a strange mix of privilege and pressure. You work in an environment focused on performance, surrounded mostly by non-medical colleagues who—through no fault of their own—often have little understanding of the ethical and professional standards that guide medical practice. Add to that the reality that you're frequently isolated from medical peers, and the role can feel uniquely exposed.

Travel only amplifies this. On the road, you live in the same spaces as players and coaches—hotels, buses, planes, locker rooms. You're always "on," always available, and always navigating requests that arrive at inconvenient times and in emotionally charged moments. Courtside assessments in the final minutes of a tight game rarely allow for privacy, calm, or the ideal consent process. Meanwhile, coaches may push for quick fixes, novel therapies, or decisions that edge toward the boundaries of acceptable medical practice.

Yet the doctor's core obligation never changes. As the Hippocratic Oath reminds us, the job is to do no harm. **The athlete's health—not the scoreboard, not the commercial interests, not the expectations of the entourage—must remain the priority**. That means practicing evidence based medicine, communicating honestly, respecting autonomy, and treating every athlete with fairness and dignity.

The basketball environment adds its own ethical complexities. Privacy is hard to guarantee. Consent can be rushed. Confidentiality becomes a balancing act between the player's rights and the team's legitimate need to plan.

Even social settings matter; how a doctor behaves at dinner or being involved in a night out can shape trust and future clinical relationships. This means behaving as a professional is 24/7, and this includes team dinners, on long flights, or when the post-game drinks start flowing. This is because trust isn't built in the clinic—it's built everywhere else.

The biggest challenge? The built in conflict of interest. The team wants wins. The doctor wants wellness. Most days those goals overlap. Some days they collide. That's why the best team doctors set boundaries from day one, communicate clearly, and they refuse to let the environment warp clinical judgment.

The FIBA Medical Manual gives structure and guidance, but ultimately the responsibility rests with the doctor. The real work happens in the grey zones—the sideline moments, the late night knocks on the hotel door, the conversations where you have to be both clinician and compass. The best team doctors are the ones who can stay grounded, ethical, and reflective, even when the environment around them is anything but.

Being a team doctor is about being a steady and trusted voice. It's about protecting athletes not just from injuries, but from the pressures that can push them toward bad decisions. It's about remembering that your job isn't to win games—it's to safeguard the people who play them. And in a sport built on speed, intensity, and emotion, that might just be the toughest job in the arena.

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SELECTED PUBLICATIONS OF INTEREST

Team Physician Consensus Statement: Return to Sport/Return to Play and the Team Physician: A Team Physician Consensus Statement-2023 Update

Herring SA, Putakian M, Kibler WB, Lecere L, Boyajian-O'Neill L, Day MA, Franks RR, Indelicato P, Matuszak J, Miller TL, O'Connor F, Poddar S, Svobofa SJ, Zaremski JL. Med Sci Sports Exerc, 2024. May 1; 56(5):767-775.

Return to play (RTP) is the process of returning an athlete to participate in his/her/their sport. Return to sport (RTS) is applicable to all sports and athletes. For the purposes of this consensus statement, RTS will be used to include both the process and the decision, focused on non-game-day RTS. It is important for the team physician to recognize RTS represents a continuum: return to participation, RTS, and return to performance (1). This progression can be applied for any sport, athlete, or injury/illness. The RTS decision is ongoing, is context dependent, and may change over time. The team physician has the central role in not only protecting the athlete's health, but also protecting the athlete from coercion to participate. The final RTS decision should be led by the team physician (2,3) as part of a shared decision-making process (SDM) (4–6). This model remains the best practice in making the RTS decision (4–6). The process is dynamic, and decision points may change over time based on evolving information and risk.

Judgement and Decision Making in Clinical and Return-to-Sports Decision Making: A Narrative Review. [Review]

Yung KK, Ardern CL, Serpiello FR, Robertson S. Sports Medicine. 54(8):2005-2017, 2024 08.

Making return-to-sport decisions can be complex and multi-faceted, as it requires an evaluation of an individual's physical, psychological, and social well-being. Specifically, the timing of progression, regression, or return to sport can be difficult to determine due to the multitude of information that needs to be considered by clinicians. With the advent of new sports technology, the increasing volume of data poses a challenge to clinicians in effectively processing and utilising it to enhance the quality of their decisions. To gain a deeper understanding of the mechanisms underlying human decision making and associated biases, this narrative review provides a brief overview of different decision-making models that are relevant to sports rehabilitation settings. Accordingly, decisions can be made intuitively, analytically, and/or with heuristics. This narrative review demonstrates how the decision-making models can be applied in the context of return-to-sport decisions and shed light on strategies that may help clinicians improve decision quality.

Surveying the Moral Landscape: How Ethical Frameworks Influence the Structure of Return-to-Sport Decision Making.

Vannatta CN. Journal of Orthopaedic & Sports Physical Therapy. 54(4):230-233, 2024 04.

Similar to all areas of health care, sports medicine has ethical considerations when making decisions-return to sport being one. Despite a general consensus on criteria to determine when an athlete is ready to return to sport, there are various scenarios that clinicians encounter that may not fall into a clear "yes" or "no" decision. These scenarios leave the clinician asking what is the "right" decision in a given circumstance? A line of questioning that invokes a moral dimension in supporting athletes when they are returning to sport. To address the moral aspect of a clinical decision, ethical frameworks and theories can guide decisions and resolve ethical dilemmas. The aim of this Viewpoint is to briefly describe 4 ethical frameworks and explore how they might apply in a clinical scenario to guide different ethical analyses and influence the final decision.

Profiles of psychosocial factors: Can they be used to predict injury risk?.

Clement D, Tranaeus U, Johnson U, Stenling A, Ivarsson A. Scandinavian Journal of Medicine & Science in Sports. 32(4):782-788, 2022 Apr.

The creation of risk profiles using the model of stress and athletic injury (J Appl Sport Psychol. 1998;10(1):5) represents a proposed shift from the reductionism paradigm to the complex sport approach in an attempt to formulate prevention strategies to combat the increasing number of injuries being reported in sporting populations. As a result, the primary purpose of this study was to: (a) identify different risk profiles based on psychosocial factors associated with the Williams and Andersen's model of stress and athletic injury model; and (b) examine potential differences in the frequency of injuries across these risk profiles. A prospective research design was utilized with a sample of 117 competitive soccer players (81 males and 36 females) from Sweden and the United States of America. Data was collected at two time points over the course of three months. At time 1 (beginning of the season) - a demographic information sheet, the Life Event Survey for Collegiate Athletes (LESCA), Sport Competitive Anxiety Test (SCAT), and Brief Cope were administered. At time two (T2), three months after the initial data collection, participants' traumatic injuries were recorded. Latent profile analysis (LPA) showed that 3 profiles solution showed best fit to data. Players in profile 1 and 2 reported fewer injuries compared to players in

profile 3. However, whereas individuals in profile 1 had a lower predictive risk of sustaining an injury when compared to those in profile 3, both profiles had similar anxiety levels and use of coping strategies with differing stress levels. These findings suggest that the interaction between different proposed risk factors might influence injury risk.

Perceived Competence, Achievement Goals, and Return-To-Sport Outcomes: A Mediation Analysis.

D'Astous E, Podlog L, Burns R, Newton M, Fawver B. International Journal of Environmental Research & Public Health. 17(9), 2020 04 25.

The purpose of this study was to explore the potential mediating effect of achievement goals on perceived competence and return-to-sport outcomes among college athletes sustaining a sport injury. Altogether, 75 male and female college athletes from the United States who returned to sport after having missed competition for an average of 3 weeks due to injury, completed valid and reliable inventories measuring perceived competence, achievement goals, and return-to-sport outcomes. Results indicated that task-approach goals significantly mediated the relationship between perceived competence and a renewed sport perspective. These data suggest the importance of promoting competence beliefs and a task-oriented focus among athletes returning to sport following athletic injury. From a practical standpoint, clinicians can foster competence perceptions by integrating progressive physical tests assessing functionality and sport-specific skills/abilities. Furthermore, these data suggest that coaches, physical therapists, and significant others may do well to use language that orients injured athletes towards attaining success as opposed to avoiding failure, to emphasize effort, task completion, and correct form, and to avoid comments that compare athletes to others or to their preinjury standards of performance. From a theoretical standpoint, our mediation findings extend previous achievement goal research into the sport injury domain, further highlighting the importance of task-approach goals.

Predicting Musculoskeletal Injury in National Collegiate Athletic Association Division II Athletes From Asymmetries and Individual-Test Versus Composite Functional Movement Screen Scores.

Mokha M, Sprague PA, Gatens DR. Journal of Athletic Training. 51(4):276-82, 2016 Apr.

Functional Movement Screen (FMS) scores of <=14 have been used to predict injury in athletic populations. Movement asymmetries and poor-quality movement patterns in other functional tests have been shown to predict musculoskeletal injury (MSI). Therefore, movement asymmetry or poor-quality movement patterns on the FMS may have more utility in predicting MSI than the composite score. OBJECTIVE: To determine if an asymmetry or score of 1 on an individual FMS test would predict MSI in collegiate athletes. DESIGN: Cohort study. SETTING: National Collegiate Athletic Association Division II university athletic program. PATIENTS OR OTHER PARTICIPANTS: A total of 84 Division II rowers, volleyball players, and soccer players (men: n = 20, age = 20.4 +/- 1.3 years, height = 1.77 +/- 0.04 m, mass = 73.5 +/- 4.8 kg; women: n = 64, age = 19.1 +/- 1.2 years, height = 1.69 +/- 0.09 m, mass = 64.8 +/- 9.4 kg). MAIN OUTCOME MEASURE(S): The FMS was administered during preseason preparticipation examinations. Injury-incidence data were tracked for an academic year by each team's certified athletic trainer via computer software. An MSI was defined as physical damage to the body secondary to athletic activity or an event for which the athlete sought medical care, and resulted in modified training or required protective splitting or taping. Composite FMS scores were categorized as low (<=14) or high (>14). Pearson chi(2) analyses were used to determine if MSI could be predicted by the composite FMS score or an asymmetry or score of 1 on an individual FMS test (P < .05). RESULTS: Athletes with FMS scores of <=14 were not more likely to sustain an injury than those

with higher scores (relative risk = 0.68, 95% confidence interval = 0.39, 1.19; P = .15). However, athletes with an asymmetry or individual score of 1 were 2.73 times more likely to sustain an injury than those without (relative risk = 2.73, 95% confidence interval = 1.36, 5.4; P = .001). CONCLUSIONS: Asymmetry or a low FMS individual test score was a better predictor of MSI than the composite FMS score.

Symmetry does not Indicate Recovery: Single-leg Hop Before and After a Lower Extremity Injury.

Simon JE, Yom J, Grooms DR. International Journal of Sports Medicine. 42(4):344-349, 2021 Apr.

Current recommendations for return-to-play decision-making involve comparison of the injured limb to the uninjured limb. However, the use of the uninjured limb as a comparison for hop testing lacks empirical evidence. Thus, the purpose of this study was to determine the effects of lower extremity injury on limb symmetry and performance on the single-leg hop for distance. Two-hundred thirty-six adolescent athletes completed the single-leg hop for distance before the beginning of the season (pre-injury). Forty-four adolescent athletes sustained a lower extremity injury (22 ankle and 12 knee) and missed at least three days of sports participation. All individuals had completed the single-leg hop for distance before the beginning of the season (pre-injury) and at discharge (post-injury). Injured limb single-leg hop for distance significantly decreased at return-to-play from pre-injury with a mean decrease of 48.9 centimeters; the uninjured limb also significantly decreased, with a mean decrease of 33.8 centimeters. Limb symmetry did not significantly change pre- to post-injury with a mean difference of 1.5%. Following a lower extremity injury, single-leg hop for distance performance degrades not only for the injured limb but also the uninjured limb. However, limb symmetry did not change following a lower extremity injury.

The Adolescent Athlete and the Team Physician: A Consensus Statement. 2025 Update.

Putukian M, Leclere LE, Herring SA, Benjamin HJ, Bennett CH, Boyajian-O'Neill L, Callender SS, Day M, Finnoff JT, Franks R, Jayanthi N, Magnes SA, Matuszak J, Roach R, Statuta SM. Medicine & Science in Sports & Exercise. 58(2):371-402, 2026 Feb 01.

Team physicians may be called upon to treat adolescent athletes, defined in this document as those in the range of 12-18 yr of age. Many are involved in school-based, intramural, or specialized sports participation and/or training, potentially resulting in injury and/or illness. Specialized treatments may be necessary due to growth and development of the adolescent. Additionally, psychological factors in this age group may play an important role in sports participation, emotional well-being, and injury rehabilitation. While many children younger than 12 yr of age are active in sports participation, their medical and musculoskeletal concerns are not included in the scope of this consensus statement. The healthcare team must stay educated and knowledgeable regarding potential challenges to individuals participating safely in sport. All healthcare professionals should provide quality care, free from discrimination and specific to the needs of every unique individual. Ensuring access to care, fostering welcoming sporting environments, and recognizing the distinct challenges faced by underrepresented populations will reduce healthcare disparities and improve safe participation across all sports.

Athletic identity-fear avoidance relationships of high musculoskeletal injury risk adolescent athletes during return to sport rehabilitation: a pilot study.

Nyland J, Ferman B, Elliott R, Lewis J, Richards J, Krupp R. European journal of orthopaedic surgery & traumatologie. 35(1):324, 2025 Jul 25.

Adolescent athletes who sustain a musculoskeletal sports injury are at high re-injury risk. Fear avoidance (FA) during return to sport (RTS) rehabilitation may be concerning either when "too high" (excessive fear) or "too low" (excessive confidence). Research suggests that adolescent athletes with an athletic identity (AI) <= 25th percentile ("low" AI") are 1.5 x more likely to sustain an initial injury, while those scoring >25th percentile ("higher" AI) are 2.3 x more likely to sustain subsequent injury. This study evaluated adolescent athlete AI and FA relationships during RTS rehabilitation. MATERIALS AND METHODS: From 159 consecutive patients, 60 (32 females, 28 males) adolescent athletes (mean = 16.9 +/- 3 years of age) completed the 7-item Athletic Identity Measurement Scale, the 10-item Athletic Fear Avoidance Questionnaire (AFAQ), and the AFAQ with two additional movement-related fear and pain questions (AFAQ +). Comparisons were made between low AI (<= 25th percentile) and higher AI (> 25th percentile) groups and between low FA (<= 50th percentile) and higher FA (> 50th percentile) groups. RESULTS: Athletes with "low" AI had greater FA than those with "higher" AI (AFAQ + scores of 30.2 +/- 10 vs. 24.8 +/- 7, p = 0.02; AFAQ scores of 24.4 +/- 8 vs. 20.2 +/- 6, p = 0.03). Athletes scoring > 50th percentile on the AFAQ (high FA) had lower AI social identity (18.2 +/- 3 vs. 19.5 +/- 3, p = 0.04) and exclusivity (8 +/- 4 vs. 9.8 +/- 4, p = 0.03) subscale scores compared to athletes scoring <= 50th percentile. Athletes scoring > 50th percentile on the AFAQ + (higher FA) also had lower AI social identity (18 +/- 3 vs. 19.5 +/- 3, p = 0.02) and exclusivity (7.6 +/- 4 vs. 10.1 +/- 4, p = 0.005) subscale scores than athletes scoring <= 50th percentile. CONCLUSION: Adolescent athletes with "low" AI had higher FA, while those with "higher" AI had lower FA. Athletes with higher FA also had lower AI social identity and exclusivity subscale scores. Identification of an effective AI and FA balance may help better determine safe RTS timing, however further research is needed.

FROM THE HISTORY BOOK

FIBA Medical Commission 2023-2027
Photo credis: FIBA

Front row from left: Dr. Jose Raul Canlas (PHI), Dr. Chin Sim Teoh (SIN), Dr. Peter Harcort (AUS)(chair), Dr. Marni Wesner (CAN), Dr. Andrew Pipe (CAN), Dr. Diego Grippo (ARG)
Back row from left: Dr. Ilker Yucesir (TUR), Dr. Ibrahim Dounia (LBN), Dr. Omega Edwards (TAN), Dr. Souheil Sayegh (SUI)(deputy chair), Dr. Rosario Urena Duran (ESP), Dr. John DiFiori (USA), Dr. Dragon Radovanovic (SRB), Dr. Peter Burt (NZL)
Missing: Dr. Anik Shawdon (AUS)

EDIFICATION FROM THE MEDICAL COMMISSION

In this segment of the Fast Break we feature an editorial from a member of the FIBA Medical Commission on topics relevant to basketball. In this edition, Dr. Marni Wesner discusses the team physician's preparedness for event travel and what's in her medical field bag.

What's In My Medical Bag?
Dr. Marni Wesner, FIBA Medical Commission

Over the 30 years of my sport medicine career, I have had the privilege of working with three different Canadian national teams. I have travelled with these teams to countless international events across the globe, including many world championships and three Olympic games. I've been a part of Team Canada at five FISU games, the PanAmerican Games and the Commonwealth Games. My considerations before team travel are pretty routine, and are outlined below. What is in my medical bag for each event differs slightly depending on what team I'm working with (i.e. contact/collision high-risk sport or not), where we are travelling, as well as the number and age of athletes and staff on the team.

Benjamin Franklin gave sage advice in 1793 when he noted, "an ounce of prevention is worth a pound of cure." The suggestions and considerations I present herein are meant only to be a

guide for the basketball team physician to assist in your preparations to be effective and efficient in providing medical services to your team and in your role at FIBA events.

Make thorough pre-event preparations for travel with the team:

1) **Consider the location of the event**: Is it in an urban center where medical services and medications are readily available, or are you going to a remote location where you need to be more prepared and self-sufficient, and may not be able to acquire or restock consumable supplies and reliable medications? Are there any regional endemic issues where you are going that you need to be prepared for? Are travel vaccines required or recommended for the location you are travelling to? Are there different climate or altitude conditions where you are going that will impact health and welfare of the team that you need to prepare for?
2) **Consider customs and regulations** for the location of the event. This may impact what medications (and quantities) you are allowed to import and may require you to alter your go-to medications for some conditions. Also consider that criminal and antidoping laws pertinent to medications may differ from your home location, and the medications in your bag should reflect this. Having a letter or documentation from your local and host sport official that outlines the purpose of your trip and reason for your possession of medical equipment and medications can come in handy if you are challenged by customs and boarder security agents. Append to that letter a detailed listing (digital and hard copied) of the entire contents of your medical bag, including dosage and quantity of medications that will be imported; be sure to count and double check your medications and supplies upon arrival as bags can be tampered with while in transit. Be sure your medical bag can be locked for travel/transport.
3) **Consider the age and composition of your team**. Your medication supply may need to provide for pediatric and adult dosages as not all medications can be cut. Other members of the team or support staff may have chronic diseases (i.e. diabetes, heart disease) for which you may be required to provide emergency assistance and treatment, and your medication and equipment supplies needs to accommodate for this. Female athletes may experience an unexpected menstrual cycle. Sexual experiences or assault can result in unwanted pregnancy and emergency contraception (and post-exposure prophylaxis for sexually transmitted infections) may be required while travelling for sport.
4) **Know the medical history of your team**. Prior to travel, review the medical history of all the athletes and staff who will be travelling with the team. Ensure you will have necessary medications or equipment to address any known preexisting medical issues. Any ongoing or outstanding medical problems should be addressed before leaving your home country. Ensure vaccinations are up to date and consider/provide appropriate/required travel vaccinations. It is vitally important to assure travel medical insurance is current and appropriate for your destination of travel for each member of the team.
5) **When possible, prepare the team for travel** with strategies to deal with jetlag such as phase-shifting the circadian rhythm in the days before departure, and instruction of how to re-entrain the sleep/wake cycle upon reaching your destination. Devise sleep strategies for how to manage the disruption travel has on the team's sleep. Make suggestions for items to include in a 'travel kit' to increase comfort on a plane or bus (i.e. earplugs, sleep mask, saline nose spray, tissues, gum/breath mints, lip balm, hand sanitizer and lotion, a folding fan). Carry a small selection of select medications in your travel kit (i.e. analgesia, anti-nausea, antihistamine) in case a team member becomes ill in-transit. Encourage your team to stay well hydrated. Discourage the sharing of water bottles, towels/face cloths and personal products to diminish the risk of illness transmission.
6) **Ensure all athletes Therapeutic Use Exemptions (TUE) are valid**.

7) **<u>Create a list of contacts at your destination</u>** that may be helpful, i.e. local embassy or consulate, hospitals, local/host physician. Ensure you know the emergency medical number/code for your destination (i.e. 911 in North America, 999 in the UK, 112 in the EU, 000 in Australia). Create an emergency action plan (EAP) for your team, and upon arrival at your destination, review the hotel and training facilities and ensure everyone on the team is aware of the EAP at your location(s). Ensure that your medical resources at home are aware you will be traveling with the team in case you need to reach out for assistance or advice from your home-network while you are on-the-road, or arrange for further expedited assessment upon the athletes/teams return.

Pack an effective and efficient medical field bag:

In these times of significant and diminishing size and weight limits for baggage on planes, and limited cargo-holds on buses, the size, weight and portability of your medial field bag requires careful consideration. You need something that is large enough to contain and protect all your equipment and medications, is easily portable and lockable, and is durable to withstand the rigors of airline travel.

For over 20 years, my bag of choice has been this Ogio luggage case. It is an incredibly durable, 10-lb carry-on sized wheeled luggage case with sturdy wheels, rugged zippers that accommodate a travel lock, an expandable interior compartment, and a reliable handle. The bag has two outside pockets for items that are needed readily and frequently like gloves, gauze, and blood management. The inside zippered top compartment is perfect to contain - and make readily accessible - medications, while the expandable bottom compartment had enough space for necessary diagnostic equipment and consumable medical supplies. The zippers can be locked to deter looting of the bag while in transport.

****NOTE: this is not an endorsement or promotion of this product; this is presented only to demonstrate what has worked for me for many years.***

The larger outside pocket of my field bag contains nonsterile 4x4 gauze and gloves, as well as plastic bags for ice. The smaller pocket has hand sanitizer, bandaids, tape, pen/paper and a small plastic container for the incidental things athletes' hand to me to keep safe as they enter the field of play. I also keep a nail clipper in this pocket to snip the zip-ties I use to doubly-secure the zippers during travel.

In the bottom of my medical field bag is an adjustable cervical spine collar. On top of that and filling the bottom compartment are individual packing cubes that contain what is needed to provide emergency and routine medical care for the team.

1) <u>Diagnostic equipment</u>: stethoscope, oto-opthalmoscope, blood pressure cuff, glucose meter and test strips, thermometer, reflex hammer, tuning fork, O2 saturation monitor, tape measure, tongue depressors, pen light, bandage scissors, nail clippers.
2) <u>Airway management</u>: pocket mask, a selection of oral and nasal airways, peak flow meter, aerochamber. With high risk, contact/collision sports I also carried a Ambu-bag, King LTS-D laryngeal mask airway, and an emergency cricothyroidotomy kit. (NOTE: An Automated External Defibrillator (AED) is carried in the team bags.)

3) Intravenous resuscitation: 500 ml normal saline, 2x21G IV cathlon, tourniquet, IV tubing, alcohol wipes, tape.
4) Suture kit: 2 disposable suture trays (sterile drapes, needle driver, forceps, scissor, gauze, fluid cup), selection of 3, 5, and 10 ml syringes, selection of 22, 27 and 30G needles, lidocaine with and without epinephrine, marcaine, alcohol swabs, small bottle of chlorhexidine, selection of 3-0, 4-0, and 6-0 absorbable and non-absorbable sutures, selection of steri-strips, 4 pairs of sterile gloves, disposable scalpels, small sharps disposal container.
5) Dressing kit: selection of sterile 2x2 and 4x4 gauze, rolled bandage (like kerlix and kling), occlusive dressings, selection of medical tape/adhesive dressings, selection of bandaids, rolls of Power-Flex absorbent foam dressing (this is an excellent product for basketball as it quickly controls bleeding, the cohesive bandage will stay in place on sweat-slicked skin and it can be applied in seconds), nasal packing and bayonet forceps, and a small spray bottle of hydrogen peroxide (H2O2) for cutting blood from uniforms.
6) Eye and dental kit: ophthalmic anesthetic drops, fluorescein strips, bottle of eye wash/normal saline, antibiotic eye drops/ointment, steroid eye drops, eye patch and padding, pocket eye chart, roll of tape, dental first aid kit, dental picks and probe .
7) Splinting kit: selection of finger splints, roll of SAM splint, selection of 2, 3 and 6" tensor/elastic rolled bandages, roll of medical tape, stack of nonsterile 2x2 gauze pads, triangular bandage or forearm sling.

I use the separate inside top zippered compartment for medications. Medications are the biggest expense in the medical field bag, and the product usually expires before it is ever used, so over the years I have significantly diminished the quantities of medications I travel with – unless the event is in a remote location where restocking any consumed supplies will be difficult. In general, I take enough medications to fully treat two people (i.e. urinary tract infection: I have sufficient antibiotic for a full course of treatment for two people). But frequently used medications like analgesics and anti-diarrhea medications are stocked in quantities sufficient to treat half the team for the half of the duration of travel.

I source the medications from a pharmacy fulfillment center that supplies long-term care and nursing homes as this allows me to customize the packaging into single day supplies with individualized labeling of the drug name, dosage, and expiry date (see photo). This significantly decreased the weight and volume of medications in the field bag. Alternatively, a supply of small envelopes is needed to dispense – and properly label - medications from larger bottles in the medical bag. Small plastic zip-lock bags are good for dispensing ointments and creams. I contain (and protect) all the individual packages of medications in three light-weight, hard plastic, waterproof containers that fit in the inside top zippered compartment of the bag for quick and easy access.

What is listed below are the medications I used when traveling with Basketball Canada. I adjusted the quantities of items depending on the location of the event and length of time the team would be away from home.

ANALGESICS
Acetaminophen (500 mg x100 tabs)
Ibuprofen (400 mg x100)
Naproxen/Esomeprazole (500/20mg x70)
Ketoralac PO(10 mg x100)
Ketoralac IM(30 mg/ml x5 ml)
Tramadol (30 mg x50)

GASTROINTESTINAL
Colace (x10)
Senokot (x10)
Diphenhydrinate PO(50 mg x20)
Diphenhydrinate IM(50 mg/mL x2ml)
Peptobismol (1 bottle)
Omperazole (40 mg x10)
*Loperamide (2 mg x 36 tabs)
*Hydralyte electrolyte tablets (1 tube)
Glucose tablets (1 tube)

ANTI-INFECTIVES
Metronidazole (500mg x20)
Terbeinafine (250 mg x10)
Valcyclovir (500 mg x4)
Azithromycin (250 mg x12)
Fluconazole (150 mg x2)
Ciprofloxacin (500 mg x28)
Cephalexin (500 mg x56)
Trimethoprim/Sulfamethoxaole DS (x10)
Ozeltamivir (75 mg x 10)

COUGH/COLD/FLU
Strepsils cough drops 1 box
Otrivin nose spray
NS nose spray
Tylenol cold 1 box
Robitusssin cough syrup (100 ml)

AIRWAY/ALLERGY
Epipen
Diphenhydramine (50 mg/ml x2 ml)
Diphenhydramine (50 mg x24)
Salbutamol (1 MDI)
Fluticasone (1 MDI)
Triamcinolone acetonide (1 MDI)
Certrizine hydrochloride (x24)

TOPICALS
Tetracaine (single use x3)
Flourescein strips (5)
Diclofenac eye drop (15 ml)
Florometholone eye drops (5 ml)
Terbinafine cream 30 g
Ciprofloxacin/Dexamethasone eye drops 15 ml
Mometasone furoate 30 gm
Hydrocortisone 1% 50 gm

Clotrimazole cream (15 gm)

INJECTABLES/MISCELLANEOUS
Diphenhydramine 50 mg/mL
Dexamethasone 4 mg/mL
Prednisone (5 mg x 5 tabs)
*Zopiclone (7.5 mg x50)
Ondansatrone (4 mg/ml x 2 ml)
ASA chewable (81 mg x4)
Lorazepam (1 mg SL x 10)
Nitroglycerine spray (1 bottle)

Dr. Peter Burt (FIBA Medical Commission) has summarized my approach to team travel preparedness and the medical field bag into this helpful check list to guide your preparations for your team:

Pre-Event Travel Preparation Checklist for Team Doctor

1. Destination & Environmental Assessment

- [ ] Determine whether the event is in an urban or remote location
- [ ] Assess availability of medical services, pharmacies, and emergency care
- [ ] Identify regional endemic diseases or health risks
- [ ] Review required or recommended travel vaccinations
- [ ] Evaluate climate, weather, and altitude considerations
- [ ] Prepare supplies appropriate for environmental conditions

2. Customs, Regulations & Documentation

- [ ] Review host-country rules on importing medications and medical equipment
- [ ] Confirm which medications and quantities are permitted
- [ ] Ensure all medications comply with local criminal and anti-doping laws
- [ ] Obtain documentation from home and host sport authorities explaining:
  - [ ] Purpose of travel
  - [ ] Need for medical equipment and medications
- [ ] Prepare a detailed inventory of all medical bag contents
- [ ] Include medication names, dosages, and quantities
- [ ] Lock medical bags for transport
- [ ] Recount and verify all supplies upon arrival to detect tampering

3. Medical Field Bag:

Size & Weight
- [ ] Ensure bag meets airline size and weight restrictions
- [ ] Ensure bag is a manageable weight for your use/portering

Durability & Construction
- [ ] Choose a bag built for repeated airline and bus travel
- [ ] Sturdy wheels and handle
- [ ] Strong zippers with travel locks

Internal Layout
- [ ] Compartment for medications

[ ] Compartment for diagnostic equipment
[ ] Space for consumable supplies

External Pockets

[ ] Quick-access pockets for frequently used supplies

Security

[ ] Lock bag during transport

4. Team Composition & Special Considerations

[ ] Ensure medication supply covers all team members
[ ] Prepare for chronic disease emergencies (diabetes, cardiac conditions, etc.)
[ ] Include supplies for unexpected menstrual issues
[ ] Carry emergency contraception where legally permissible
[ ] Consider potential sexual assault response needs

5. Team Medical Histories & Ongoing Care

[ ] Review medical histories of all athletes and staff
[ ] Confirm necessary medications/equipment for known conditions
[ ] Address unresolved medical issues before departure
[ ] Ensure routine vaccinations are current
[ ] Provide or arrange required travel vaccinations
[ ] Verify each traveller has appropriate medical/travel insurance

6. Travel Health, Jet Lag & In-Transit Care

[ ] Provide jet-lag mitigation strategies (e.g., circadian phase shifting)
[ ] Educate team on sleep/wake re-entrainment upon arrival
[ ] Develop sleep strategies for travel disruptions
[ ] Recommend personal travel-comfort kits (earplugs, mask, tissues, gum, lip balm, sanitizer, lotion, saline spray, folding fan)
[ ] Carry small in-transit medication kit
[ ] Encourage hydration
[ ] Discourage sharing of water bottles, towels, or personal items

7. Anti-Doping Compliance

[ ] Confirm all Therapeutic Use Exemptions (TUEs) are valid and current
[ ] Ensure medications carried do not violate anti-doping rules

8. Emergency Planning & Local Contacts

[ ] Compile key local contacts:
    [ ] Embassy/consulate
    [ ] Hospitals and urgent care centers
    [ ] Local/host physician
[ ] Confirm local emergency number (e.g., 911, 999, 112, 000)
[ ] Create a destination-specific Emergency Action Plan (EAP)
[ ] Review hotel and training facility layouts upon arrival
[ ] Ensure all team members understand the EAP
[ ] Notify home-base medical resources of travel dates and destination
[ ] Arrange pathways for remote consultation or expedited follow-up after return.

9. **Medical Bag Diagnostic Equipment**

- Stethoscope
- Oto-ophthalmoscope
- BP cuff
- Glucose meter + strips
- Thermometer
- Reflex hammer
- Tuning fork
- O_2 saturation monitor
- Tape measure
- Tongue depressors
- Pen light
- Bandage scissors
- Nail clippers

I. **Airway Management**

- Pocket mask
- Oral airways
- Nasal airways
- Peak flow meter
- Aerochamber
- Ambu-bag (if high-risk sport)
- King LTS-D airway (if high-risk sport)
- Cricothyroidotomy kit (if high-risk sport)
- AED in team bags (verify)

- **Fluid Resuscitation Management**

- 500 mL normal saline
- 2 × 21G IV cathlons
- Tourniquet
- IV tubing
- Alcohol wipes
- Tape

II. **Suture Kit**

- 2 disposable suture trays
- Syringes: 3, 5, 10 mL
- Needles: 22G, 27G, 30G
- Lidocaine (with/without epi)
- Marcaine
- Alcohol swabs
- Chlorhexidine
- Sutures: 3-0, 4-0, 6-0 (absorbable + non-absorbable)
- Steri-strips
- 4 sterile glove pairs
- Disposable scalpels
- Small sharps container

III. **Dressing Kit**

- Sterile 2×2 and 4×4 gauze
- Rolled bandages (Kerlix/Kling)
- Occlusive dressings

- Medical tape/adhesive dressings
- Bandaids
- Power-Flex absorbent foam dressing
- Nasal packing
- Bayonet forceps
- Hydrogen peroxide spray

IV. Eye & Dental Kit

- Ophthalmic anesthetic drops
- Fluorescein strips
- Eye wash/normal saline
- Antibiotic eye drops/ointment
- Steroid eye drops
- Eye patch/padding
- Pocket eye chart
- Tape
- Dental first aid kit
- Dental picks/probe

V. Splinting Kit

- Finger splints
- SAM splint
- Tensor/elastic bandages (2", 3", 6")
- Medical tape
- Non-sterile 2×2 gauze
- Triangular bandage/sling

VI. Medication Compartment

- Medications packed readily accessible compartment
- Quantities adjusted for destination (urban vs. remote)
- Consider enough medication to treat two people for most conditions
- Frequently used meds stocked for half the team for half the trip
- Single-day pharmacy-labeled packets (if available)
- Small envelopes for dispensing meds
- Small zip-lock bags for ointments/creams
- Medications stored in protective containers

Team Composition & Special Needs

- Adult + pediatric dosing available
- Chronic disease emergency supplies
- Menstrual supplies
- Emergency contraception (if legal)
- Sexual assault response supplies

SHARE YOUR PHOTOS

Please send us your funny, interesting, or remarkable basketball pictures that we can share with the medical and sport science basketball community. Email: medical@FIBA.basketball

Dr. Kolli Eswar Teja, Team Physician of the Indian Basketball Team, shared this picture of the medical team from the 75th Indian Senior National Basketball Championship which happened from 4th January to 11th January 2026 where a record number of 65 teams (31 women & 34 men) participated.

THE STUDENT'S CORNER

This space is intended for sport science and medical students, residents, and fellows to contribute to our knowledge and conversation.

Please encourage your students to contribute to the Fast Break on a topic of their choosing related to basketball injury, rehabilitation or sport science. The work published here is reviewed and approved for submission by the student's preceptor.

Unfortunately, there were no student submissions to this edition of the Fast Break.

NEWS AND NOTABLE FROM THE FIBA MEDICAL COMMISSION

In 2026 the FIBA Medical Commission's educational programming will focus on core concepts for the team physician's preparedness at FIBA events. The next webinar will address ethical and professional issues for the basketball team physician. The date will be confirmed and shared soon. The recordings of previous webinar sessions can be found here: **https://about.fiba.basketball/en/services/medical/webinars**

Resources from the FIBA Medical Commission can be found here:
https://about.fiba.basketball/en/services/medical/information-for-medical-staff

BASKETBALL CME OPPORTUNITIES

A listing of varied sport medicine and basketball meetings and conferences you may be interested in attending:

Sports Medicine Australia conference events can be found here: **https://sma.org.au/about-sma/honour-board/sma-national-conferences/**

Sports Medicine New Zealand conference events can be found here: **https://sportsmedicine.co.nz/**

The Australasian College of Sport and Exercise Physicians events can be found here: **https://www.acsep.org.au/page/events**

The Asian Federation of Sport Medicine conference events can be found here: **https://afsm2024.com/index.php**

The South African Sports Medicine Association hosts several events throughout the year:

https://www.sasma.org.za/events/

The South African Sports Medicine Association hosts several events throughout the year:

https://www.sasma.org.za/events/

The British Association of Sport and Exercise Medicine conference events can be found here: **https://basem.co.uk/learning/**

The FIMS (International Sport Medicine Federation) list of events can be found here: **https://www.fims.org/news-events/events/**

The National Basketball Strength and Conditioning Association hosts a performance conference. Check here for the latest updates regarding the date of their next conference: **https://thenbsca.com.**

The Euroleague Strength and Conditioning Coaches Association list of upcoming events can be found here: **https://escca.net/events/.**

The High-Performance Basketball Symposium dates are coming soon: **https://www.highperformancebasketball.com/index.cfm.**

A listing of all the American Medical Society for Sports Medicine conferences can be found here:

https://www.amssm.org/Conferences.php

The Society for Sport Exercise and Performance Psychology website lists a number of mental performance educational opportunities:

https://www.apadivisions.org/division-47/about/resources/conferences

Conference Locate.com allows you to search globally for conferences on an extensive array of medical topics:

https://www.clocate.com

A listing of exercise physiology conferences across the world can be found here: **https://conferenceindex.org/conferences/exercise-physiology**

And for something a little different:

https://unconventional.com.au/conferences/south-america/medical-conferences/2024/

If you prefer self-study to earn CME credits while you are on vacation, have a look at these options.

Date	Location	Event website
April 24-29, 2026	Seattle (USA)	American Medical Society for Sport Medicine annual symposium
May 26-30, 2026	Salt Lake City (USA)	American College of Sport Medicine Annual symposium
April 29-May 2, 2026	Kelowna, BC, (Canada)	Canadian Academy of Sport and Exercise Medicine annual symposium
Sept 9-11, 2026	Singapore (Singapore)	Medical Fair Asia + Medicine and Sports Conference
Jun 1-4, 2027	Indianapolis (USA)	American College of Sport Medicine Annual symposium