LETTERS TO THE EDITOR

Rapid responses

If you have a burning desire to respond to a paper published in Br J Sports Med, why not make use of our “rapid response” option?

Log on to our website (www.bjsportmed.com), find the paper that interests you, click on “full text” and send your response by email by clicking on “eLetters submit a response”.

Providing it isn’t libellous or obscene, it will be posted within seven days. You can retrieve it by clicking on “read eletters” on our homepage.

The editors will decide, as before, whether to also publish it in a future paper issue.

Impact of professionalism on injuries in rugby union

Editor,—We were concerned to read about the alarming increase in injury in Scottish rugby union football.1 In their article, Garraway et al report the results of a 1997–1998 survey of Scottish club players, which, when compared with the findings of a 1993–1994 survey, indicate a substantial increase in the incidence of injury. The authors attribute this increase to factors associated with the advent of professionalism in rugby union football.

Garraway et al consider a number of possible explanations for their findings and then conclude that “the factor that is most likely to have contributed to the increased burden of injury is increased competitiveness and the requirement for players to tackle opponents” and that amateur players are already following their example.1 These assertions raise further questions for us: were the participants in the surveys questioned about their motives for wearing protective equipment and/or their beliefs regarding its effects on their risk of being injured? How is the risk of injury modified for players who enter contact situations confidently compared with players who approach contact more tentatively? Are confident players more or less likely to use correct technique in contact situations?

Two recent reviews have concluded that little is known of the psychological effects (advantageous or otherwise) of wearing protective equipment in rugby.2,3 The most common reasons for wearing protective equipment given by participants in a New Zealand study were: to prevent injury (57%), because of previous injury (53%), and because of medical advice (21%).4 Australian schoolboy rugby players also cited safety as the primary reason for using headgear and reported that they played more confidently when wearing headgear.5

On the basis of their conclusions regarding the impact of padded equipment on the incidence of injury, Garraway et al recommend that the International Rugby Board “place a moratorium on the further development of protective equipment until it has been established that it is not contributing to the substantial increase in player morbidity associated with the introduction of professional rugby union.” In their abstract, they go further by recommending that the moratorium should be placed on the “use of protective equipment in competitive matches”.

There is at present little evidence to suggest that padded equipment modifies the risk of injury in rugby. We have no argument with the need to find explanations for the disturbing increase in injury reported by Garraway et al. What concerns us is that their recommendations have been made in the absence of supporting evidence, and that in making such recommendations attention is diverted from other explanations for the observed increase in injuries, such as law changes that affect the way in which rugby is played. Investigation of the effects of padded equipment on injury risk, through prospective epidemiological research, is required before recommendations about its use can be made. Placing a moratorium on the use of protective equipment may make it difficult to undertake such research!

KENNETH L QUARRIE
Injury Prevention Manager, New Zealand Rugby Union

DAVID J CHALMERS
Deputy Editor, Injury Prevention Research Unit
Department of Environmental and Social Medicine
Dunedin School of Medicine, University of Otago
PO Box 913, Dunedin, New Zealand
david.chalmers@pru.otago.ac.nz


Proportions of activities in a climbing gym

Editor,—I refer to the paper on indoor rock climbing by Wright et al.1 Firstly, thanks to the authors for adding some valuable information to the under researched area of indoor climbing injuries (particularly given the popularity of this activity world wide).

While I have no doubt that many of your participants put leading or bouldering as the activity that they spent most time doing while in the gym, I would have significant doubts that that is actually the case, particularly in lower grade climbers. I suspect that the participants in the study may well have overestimated the amount of time they spent in each activity, and that an analysis of actual time spent would reveal more time spent on a top rope than any other activity. This is a possible explanation for the otherwise unexpected findings when looking at the “preferred activity” as a predictor of overuse injury. I do agree with the idea that many “committed” climbers will spend more time bouldering and leading than the non-committed, but this should logically be a factor to some extent related to grades climbed, not independent of skill level.

DAVID HUMPHRIES
Sports Medicine, St Helens Hospital
186 Macquarie St, Hobart
Tasmania, Australia
david.chalmers@asem.com.au

Authors’ reply

Thanks to David Humphries for his comments on our paper. We agree that our respondents may have overestimated the time they spent leading and bouldering in comparison with top roping, although, if this is the case, we should ask why, Bravado, perhaps wishing to appear bolder than they actually are, or memory error, seem the most likely explanations. Memory error, resulting in this case in classification bias, is a potent source of error in epidemiological studies, a bias to which our study is no less susceptible than others reliant on memory based replies.

If the misclassification is in all one direction—that is, some people stated that their most common activity was leading and bouldering when it was in fact top roping, and no one made the opposite error—the true odds ratio for leading and bouldering in comparison with top roping would be lower than that which we found. We have not performed a sensitivity analysis to estimate the degree of classification error that would reduce the coefficient of this variable to non-significance.

We have one further comment to make in relation to Humphries’ remarks about “committed” climbers. We have acknowledged that we cannot regard our sample as a true cross sectional representation of the indoor climbing population. In particular, it seems unlikely that “team building” clients from the commercial sector would attend such an event, and possibly not school groups, or at least not in the proportions that they are believed to represent of a rapidly expanding market. In this sense, we suspect that almost all our respondents would be “committed” climbers, but the word has a different sense here from the way Humphries has used it.

DEBORAH WRIGHT
JAMES ROYLE
TIM MARSHALL

www.bjsportmed.com
Sports doctors’ resuscitation skills

EDITOR,—I cannot resist the temptation to join the debate on sports doctors’ resuscitation skills.1 The study by Thompson et al2 suggested that there is a perceived need among sports specialists for first aid skills. However, I received no response to my letter concerning this which indirectly posed the question, “should doctors who attend aquatic sports be able to deal with a suspected cervical spine fracture and recover the casualty?” Obviously, that is the task of a lifeguard in the same way that first aid at non-aquatic events is the task for a first aider, but perhaps doctors should be competent first aiders and/or lifeguards. This was never in the medical school curriculum and perhaps that should change. At least, first aid training is part of sports medicine courses, but I would like to suggest that lifeguarding should also be included. I would also suggest that all doctors at aquatic events should hold the NPLQ, NBLQ, or at least bronze medallion and bronze cross of the RLSS or overseas equivalent.

Should the organisers of any sports medicine course want advice on this, they should contact the RLSS at River House, High St, Broom, Akester, Warwickshire B50 4HN, UK. I would be happy to help out but would make two stipulations: everyone on the course should feel obliged to join the RLSS and they should sponsor me for my next fund raising event for the RNLI.

PAUL SCHUR
Wiggo Cottage, 135 Main Road, Wybunbury, Nantwich, Cheshire CW5 7LR, UK usualperch@doctors.org.uk


“We have tried to strike a balance between being too academic on the one hand and competing with the pocket guides on high altitude emergencies on the other” proclaim Michael Ward, James Milledge, and John West, three internationally respected authors. Their third edition is an attractively covered book, its surprising weight giving suitable comprehensive, direct, accessible, and practical detail, and there is useful information on how clinical conditions such as hypoxia, COPD, and HHD are affected by high altitude.

So have the authors succeeded in their aim? On balance this is more of interest to the research scientist or high altitude specialist rather than readers like myself. There are cheaper (much) books that cover the clinical aspects at least as well, but none so logically laid out, beautifully presented, or as thoroughly researched (I counted 1557 references!). One for the serious high altitude buff who won’t even see the price tag.

Analysis
Presentation 17/20
Comprehensiveness 17/20
Readability 15/20
Relevance 10/20
Evidence basis 18/20
Total 77/100

KIERAN FALLON
Head, Department of Sports Medicine, Australian Institute of Sport, PO Box 176, Belconnen, ACT 2616, Australia kieran.fallon@aissport.gor.au


I was excited when I saw this book as the five authors are all well known to me as prominent in their respective fields. Nicola Maffulli of Stoke on Trent via Aberdeen and Hong Kong is an orthopaedic surgeon with a special interest in children’s injuries, Kai Ming Chan from Hong Kong is a widely published orthopaedic surgeon, Rose MacDonald has been prominent in sports physiotherapy in the United Kingdom for many years, Bob Malina from Michigan State University is one of the foremost experts in children’s growth, and Tony Parker has been a leading FIMS official for many years.

Their stated aim is “to address in one volume the specific problems of different categories in individuals in sport”. The four groups considered were the young, the old, the female athlete, and the disabled athlete—all important subgroups with specific problems of their own. These four groups usually get a chapter each in general sports medicine books, so one would hope that these areas would be considered in significantly more detail in this publication.

The children’s section covers all the important issues such as growth and matura-
tion, strength and endurance training, nutrition, and competitive stress. The sections on injuries have some inaccuracies—for example, in the section on navicular stress fractures, describing the pain as “well localised to the apex of the foot” and prescribing rest only in the treatment, and the use of a rigid Boston brace in all cases of spondylolysis—but they are generally well covered.

The female section also covers all the major issues but is quite repetitive, with three different chapters all covering menstrual irregularities. The section on aging and mas-
ter athletes (surely that should be masters

BOOK REVIEWS


This is the best book on the marathon that I have ever read. It is composed of a series of chapters based on lectures delivered at a British Heart Foundation symposium on marathon medicine held in London in 2000. The content includes a wide range of disciplines: history, sociology, psychology, medicine, physiology, and more.

It is noted in the introduction that the reader will be treated to the views of a verita-
tble galaxy of experts. This is no false claim.
Melbourne, Australia
Associate Professor of Sports Medicine, Centre for Sports Medicine. the title is a bit put off. successful cricketer. As a result, some readers. questions by Indian bookmakers, but it probably would not talk about how to be a successful cricketer. As a result, some readers will be a bit put off by both its layout and content. However, for those who already practice high quality medicine, this text offers an opportunity to refine their practice further.

To a large extent, clinical risk management grew out of the need to address issues arising from litigation against individual doctors and health services—an influence that still strongly underpins this volume. A somewhat broader view, that there are inherent risks in all medical practice and we must learn how to deal with them appropriately, also strongly influences this book and represents the future of clinical risk management. This will not only reduce adverse events for patients, but will also have the pleasant side effect of reducing litigation.

The most interesting aspects of this book are those that apply the principles and issues of risk management to individual clinical disciplines. The reviews in areas such as oncology, psychiatry, and emergency medicine are well thought out and well referenced, providing useful information to enable clinicians to further reduce adverse events in their specialty and the consequences of those adverse events.

While not quite having reached Bible status, this book provides an extremely comprehensive introduction to the area of clinical risk management for the novice, and also would be highly useful as a reference for individuals seeking to know more about clinical risk management. While probably not quite making it to bedside reading, it is a book where each chapter or area can be read in its own right. It is certainly a book that every clinical risk manager should have access to, and I would recommend that clinicians read their specific chapter. In future editions, this area of the book I am sure is destined for expansion.

Analysis
Presentation 15/20
Comprehensiveness 17/20
Readability 18/20
Relevance 14/20
Evidence basis 15/20
Total 79/100

PETER SLOAN
Director of Clinical Services, Box Hill Hospital, Nelson Road, Box Hill, Victoria 3128, Australia
sloan.peter@bhsh.org.au

Clinical risk management: a strange subject which will perplex many readers. If this was a book about cricket, it would have chapters on no balls, wides, missed stumpings, and accuracy by Indian bookmakers, but it probably would not talk about how to be a successful cricketer. As a result, some readers will be a bit put off by both its layout and content. However, for those who already practice high quality medicine, this text offers an opportunity to refine their practice further.

To a large extent, clinical risk management grew out of the need to address issues arising from litigation against individual doctors and health services—an influence that still strongly underpins this volume. A somewhat broader view, that there are inherent risks in all medical practice and we must learn how to deal with them appropriately, also strongly influences this book and represents the future of clinical risk management. This will not only reduce adverse events for patients, but will also have the pleasant side effect of reducing litigation.

The most interesting aspects of this book are those that apply the principles and issues of risk management to individual clinical disciplines. The reviews in areas such as oncology, psychiatry, and emergency medicine are well thought out and well referenced, providing useful information to enable clinicians to further reduce adverse events in their specialty and the consequences of those adverse events.

While not quite having reached Bible status, this book provides an extremely comprehensive introduction to the area of clinical risk management for the novice, and also would be highly useful as a reference for individuals seeking to know more about clinical risk management. While probably not quite making it to bedside reading, it is a book where each chapter or area can be read in its own right. It is certainly a book that every clinical risk manager should have access to, and I would recommend that clinicians read their specific chapter. In future editions, this area of the book I am sure is destined for expansion.

Analysis
Presentation 15/20
Comprehensiveness 17/20
Readability 18/20
Relevance 14/20
Evidence basis 15/20
Total 79/100

PETER BRUNNER
Associate Professor of Sports Medicine, Centre for Sports Medicine Research and Education, University of Melbourne, Australia
p.brunner@unimelb.edu.au

Sports Injuries Management of the Shoulder
8 December 2001, School of Physiotherapy, Manchester, UK
NSMI in partnership with ACPSM
Further details: Isabel Lancona, NSMI;
Tel: +44 (0)20 7251 0583 ext. 219; email: isabel.lancona@nsmi.org.uk

Competency Course in Musculoskeletal Ultrasound
7–8 January 2002, Oxford, UK
Further details: Alison Davies, Department of Radiology, Nuffield Orthopaedic Centre, Oxford OX3 7LD, UK;
Tel: +44 (0)1865 227765; Fax +44 (0)1865 227347; email: alison.davies@nocz.angllox.nhs.uk

II International Congress on Physical Education, Sports Medicine & Exercise Science
14–17 January 2002, Donapaula, Goa, India
Further details: Dr Jasraj Singh, Organising Secretary, LNPE Gwalior, India 21, Lakshmibai National Institute of Physical Education Shakti Nagar, Gwalior 474002 M.P

47002 INDIA; Tel: +91 75150932/340588;
Fax: +91 75150932/340588; email: jasraj@sancharnet.in
Website: www.alumni-lnipe-gwalior.com

The Sixth International Paralympic Committee Scientific Congress
4–6 March 2002, Salt Lake City
Further details: Michele E. Brown, P.O. Box 45002, Salt Lake City, Utah 84145–002, USA; email: michele.brown@saltlake2002.com

12–15 May 2002, Montreal Convention Center, Montreal, Canada
The purpose of the conference is to bring together the stakeholders to facilitate exchange between sectors and disciplines; promote the sharing of knowledge and intervention models and encourage partnerships between the public and private sectors.

The conference will include plenary sessions on all topics of concern to all professions (for example, the influence of the media on the safety of populations: the role of policies and laws) and state of the art presentations focusing on their respective fields. Simultaneous translation of these sessions and the opening and closing ceremonies will be available in French and Spanish. Additionally, as the focus is to facilitate exchange, parallel sessions (oral presentations, round tables, and debates) and poster sessions will be organised around six major themes: Road Safety, Occupational Safety, Sport, Leisure, Home, Institutional and Product Safety, Suicide Prevention, Violence Prevention and Post-trauma care and Rehabilitation.
Further details: Carol Pincus-Langevin; Tel: +1 514 848 1133; Fax: +1 514 288 6469; email: trauma@coplanor.qc.ca
Web site: www.trauma2002.com

World Conference on Women and Sport
16–19 May 2002, Montreal, Quebec
Further details: Deena Scozet (secretariat), IWG Secretariat, 15 Eddy Street, 8th Floor Hull, QC K1A 0M5, Canada; Tel: +1 604 999 0989; Fax: +1 514 956 8019; email: dscoretz@infoserve.net
Website: www.iwg-gti.org

49th ACSM Annual Meeting
20 May 2002 to 1 June 2002, St. Louis, Missouri
Further details: Fax: +1 (317) 634–7817

Physical Therapy 2002
5–8 June 2002, Cincinnati, Ohio, USA
Further details: 2002 Annual Conference Program Committee, C/O Professional Development, APTA, 1111 North Fairfax St. Alexandria, VA 22314–1488 USA

12th Commonwealth International Sports Conference
19–23 July 2002, Manchester, UK
Further details: Conference Secretariat, HIT Conferences, Cavern Court, 8 Mathew Street, Liverpool L1 6RE, UK; Tel: +44 (0)151 227 4423; Fax: +44 (0)151 236 4829; email: sport@hit.org.uk
Website: www.hit.org.uk/sport/home.htm

Fourth World Scientific Congress of Golf
23–26 July 2002, St Andrews, UK

452 Letters, Book reviews, Calendar, Notes

www.bjsportmed.com
Further details: World Scientific Congress of Golf Trust, The Scores, St Andrews KY16 9AT UK; Tel: +44 (0)1334 475560; Fax: +44 (0)1334 474322; email: golfscience@st-andrews.ac.uk
Website: www.golfscience.org.

Sports Medicine Course
3–10 August 2002, Vancouver, Canada
Further details: Cathy Means; Tel: +1 608 263 6637; Fax: +1 608 262 8421; email: cjmeans@facstaff.wisc.edu

XVI IEA World Congress of Epidemiology
18–22 August 2002, Montreal, Canada
Further details: Conference Secretariat, Events International Meeting Planners, 759 Square Victoria, Suite 300, Montreal, Quebec, H2Y 2J7, Canada; Tel: +1 514 286 0855; Fax: +1 514 286 0666; email: info@eventsintl.com
Website: www.iea2002.com

Sports Medicine of Australia 2002 Australian Conference
12–16 October 2002, Carlton Crest Hotel, Melbourne, Australia
Further details: Prue Robertson, Project Officer, Sports Medicine Australia, PO Box 237, Dickson ACT 2602; Tel: +02 6230 4650; Fax: +02 6230 5908; email: prue.robertson@sportnet.com.au

The 5th Asian Federation of Sports Medicine Congress
24–27 October 2002, Seoul, South Korea
Further details: AFSMC 2002 Seoul Secretariat, Hanjim Travel Service Co Ltd, (c/o Young CHANG) Marine Center New Bldg 5th Fl, #51, Sogong-dong, Chung-gu, Seoul 100–770, South Korea; Tel: +822 726 5555; Fax: +822 778 2514; email: ychang@kaltour.com
Website: http://www.afsmc2002.or.kr

Second World Congress of Science and Medicine in Cricket
4–7 February 2003, University of Port Elizabeth, South Africa
Further details: Dr Richard Stretch, University of Port Elizabeth, PO Box 1600, Port Elizabeth 6000, South Africa; Tel: +27 41 5042584; Fax: +27 41 5832605; email: sparas@upe.ac.za

Vth World Congress on Science & Football
April 2003, Lisbon, Portugal
Further details: Dr J Cabri; email: Jcabri@fmh.ulis.pt
Website: http://www.fmh.ulis.pt/wesf

The LTA Sports Science and Sports Medicine Conference

NOTES AND NEWS

www.basem.co.uk
The British Association of Sport and Exercise Medicine has launched its new website—www.basem.co.uk. The site provides information on the educational opportunities in sport and exercise medicine, and advice to those wishing to be involved in this area. BASEM members can also access the latest information of BASEM events.

www.UKSI.net
The UK Sports Institute (UKSI) is currently developing a password restricted website—www.UKSI.net—for the elite professional sporting community including athletes, coaches, and those in sport science and medicine. The site will be commissioning experts to write articles on a variety of topics. Each article will be aimed at the entire audience, promoting the integrated philosophy of the UKSI.

Bayesian statistics and evidence based medicine
Evidence based medicine is the buzzword of the day. But in fact, the standard statistics that are used in almost all studies do not answer the questions that are of interest to the clinician, even though they are misinterpreted as if they do. A new website www.physio.mcgill.ca/smcourse/bayesian is now available that compares the inferences that can be drawn from standard statistics with those that can be drawn from the Bayesian statistical approach. The authors welcome all questions and comments. This site is designed for both clinicians and epidemiologists.
Impact of professionalism on injuries in rugby union

Kenneth L Quarrie and David J Chalmers

Br J Sports Med 2001 35: 450
doi: 10.1136/bjsm.35.6.450

Updated information and services can be found at:
http://bjsm.bmj.com/content/35/6/450.1

These include:

References
This article cites 3 articles, 3 of which you can access for free at:
http://bjsm.bmj.com/content/35/6/450.1#BIBL

Email alerting service
Receive free email alerts when new articles cite this article. Sign up in the box at the top right corner of the online article.

Notes

To request permissions go to:
http://group.bmj.com/group/rights-licensing/permissions

To order reprints go to:
http://journals.bmj.com/cgi/reprintform

To subscribe to BMJ go to:
http://group.bmj.com/subscribe/