

# PostScript

## LETTER

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### Silence on clinical fundamentals

Your point about lifesaving hand washing to prevent diarrhoeal illness<sup>5</sup> is well made. I have found that the inattention you have noted to such clinical fundamentals in textbooks on sports medicine is mirrored by the absence of any notation, affirmative or otherwise, in many textbooks on pain, correlating the symptom (pain) with the physical sign (tenderness), a rudimentary clinical confirmation of the validity of pain, according to my clinical training in Ireland, that could distinguish malingering from a genuine complaint of pain, for example. Perhaps I have received a false impression but, if so, the utility of eliciting tenderness, a longstanding custom during physical examination, seems a mystery.

In November 2002, I attended a conference in Florida on prescribing addictive drugs. None of the purportedly expert presenters mentioned the issue spontaneously. When I collared one of them after his lecture and enquired specifically about the point, he claimed that chronic, non-malignant pain and tenderness are usually "dissociated"—that is, a patient can suffer chronic, non-malignant pain in the absence of tenderness of the painful part, on physical examination. This assertion seemed contrary to my own, admittedly anecdotal, experience over some 24 years. Furthermore, it would seem to (a) render chronic, non-malignant pain, and maybe all pain, unknowable and undetectable (except perhaps to the alleged sufferer, although nobody else can tell), (b) place the assessment of pain in the realm of "pathological science",<sup>6</sup> and (c) invalidate the very idea of regulation of narcotic drugs to ensure that the practitioner prescribe one only when it "corresponds to the ailment".<sup>5</sup>

The silence on the subject in the medical literature seemed anomalous. A Boolean Pubmed search on the keywords "pain" and "tenderness" revealed no relevant articles. I examined all 114 textbooks on pain in the

medical library of the University of Southern California (USC) and found two<sup>2,3</sup> that addressed the issue.

Physical therapists contradicted the foregoing opinion:

Tenderness always occurs in chronic pain syndromes.(p 86)<sup>2</sup>

The only textbook I found that physicians had authored and that discussed the subject agreed:

If any doubt regarding the existence of pathologic basis for the pain patient's complaint is present, the findings can be confirmed or discounted by repeated palpation, approaching the region from a different direction each time. If this is done while the patient is distracted evocation of pain in the same region is some indication of a pathologic process.(p 272)<sup>3</sup>

Bonica thus suggests distracting the patient and approaching the painful area by stealth, presumably to prevent the patient from dissembling, but offers no references or other evidence based assessment of the efficacy of stealth and no expert opinion about any other best practices for considering tenderness. It would seem appropriate for authoritative references, which presumably promulgate best practice doctrine, consistently to hold tenderness to distinguish malingering from sincere complaint of pain, or to be dissociated from pain, or to be otherwise equivocal and therefore to hold elicitation of tenderness to be a sacred cow that has no place in scientific medicine.

Some allege that British clinicians accord more value to physical diagnosis than do Americans, who reputedly rely too much on laboratory tests. The sample bias from predominance, at USC, of American books on pain could explain my finding of widespread silence on the correlation of tenderness with pain. However, the only textbook I found at USC from the United Kingdom<sup>6</sup> was likewise silent on the topic.

**E N Grosch**

10888 Hammock Drive, Largo, FL 33774, USA;  
drgrosch@fastmail.fm

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### An amateur badminton player with juvenile dermatomyositis: courage and questions

Exercise is one of the prime ingredients of successful management of various muscle disorders. Without doubt, sport is an enjoyable way of exercising, and young patients in particular are very keen. However, for some patients, care and vigilance with regard to their disease and/or concurrent medical treatments is a prerequisite when exercise is prescribed. In this letter, we describe an amateur badminton player with juvenile dermatomyositis (JDM) and briefly consider the pros and cons of exercise therapy for such patients.

A 15 year old boy presented with muscle pain in his right arm. The pain had first started 10 days previously, and occurred particularly during badminton training. It usually emerged in his right biceps and sometimes extended to the right elbow or shoulder. On detailed questioning, we discovered that he had concentrated on his "back-hand" during the preceding 10 days of training. He had had JDM for five years but was currently in remission. He was using prednisolone (7.5 mg/day), cyclosporine (100 mg/day), alendronate (10 mg/day), calcitonin, and vitamin D. Previously, he had also used various combinations of high dose steroids, methotrexate, and immunoglobulins. He had been an amateur badminton player for five years. His medical history was otherwise unremarkable.

The physical examination found tenderness on the medial side of the right biceps muscle. Elbow and shoulder motion were free and painless. The neurological examination was unremarkable except for a mild proximal weakness bilaterally. Ultrasonographic imaging was inconclusive. He was diagnosed as having a right biceps strain, caused by forceful backhand movements, and a conservative protocol was recommended including rest and intermittent cold application.

Patients with dermatomyositis may have many muscular complaints including proximal and symmetrical weakness, reduced endurance, and pain. Therefore it can have a major impact on physical function, limiting leisure and daily activities.<sup>1,2</sup> The predominant symptom of fatigue is presumed to be secondary to muscle or cardiopulmonary involvement, and deconditioning due to reduced activity and effects of medication. The perpetuating cycle of muscle atrophy, decreased body weight, corticosteroid myopathy, skeletal muscle microvessel disease, and abnormal energy metabolism usually culminates in a sedentary lifestyle with decreased aerobic capacity.<sup>3,4</sup> As children are known to do more walking and running than adults, muscle anaerobiosis may contribute

to the limitations in endurance activities in patients with JDM.

Controlled physical exercises in patients with inflammatory myopathy have been reported to be safe. These may include stationary cycling, step aerobics, walking, and strength exercises for weak muscles, along with prompt warming, cool down, and stretching exercises.<sup>5-6</sup> Besides considerably improving muscle strength,<sup>6,7</sup> these regimens have been found to increase aerobic capacity and daily physical functions of patients with JDM, without any adverse effects on the disease activity, when compared with sedentary controls.<sup>5-8</sup> However, as eccentric contractions are more closely associated with muscle damage and greater efflux of muscle enzymes into the circulation, training that consists of mainly concentric-type exercises is recommended for these patients.<sup>6</sup>

In this adolescent patient with JDM, we emphasise the positive effect of sport even though it used to be feared that exercise could aggravate muscle inflammation. Although highlighting the role of timely exercise regimens in rehabilitation programmes, we draw attention to the necessity for medical supervision. Doctors should be alert to any complications from underlying musculoskeletal pathologies such as myopathy and decreased bone mineral density in these patients.

**L Özçakar, R Topaloglu**

Hacettepe University Medical School, Physical Medicine and Rehabilitation, Ankara 06100, Turkey

Correspondence to: Dr Özçakar, Hacettepe University Medical School, Physical Medicine and Rehabilitation, Ankara 06100, Turkey; lozcar@yahoo.com

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## Sports trainers have accurate but incomplete recall of injury details

The importance of preventing head/neck injuries in Australian football is well recognised but accurate data are required. In large

scale epidemiological studies, the collection of reliable data at many different locations at once is difficult. Different strategies have been used to collect injury data, including self report surveys, injury recall reports from the treatment/first aid providers, and on site primary data collectors (PDCs). We wanted to assess the accuracy of a two week injury recall by treatment/first aid providers, compared with injuries reported on site at the football field on the same day.

We monitored head/neck/dental injury in community Australian football during the 2001 playing season. At each game and training session, PDCs (usually the team sports trainers) from nine clubs recorded the body region, nature, and treatment of injury on a standardised data collection form. A phone call was also made to the PDC within two weeks of the injury to confirm the injury details. Twenty nine head/neck/dental injury cases were recorded. The on site injury records were matched with the telephone information to calculate the level of agreement (% agreement).

In all cases, there was only missing or very non-specific information for the data collected by phone (35% of body region details, 35% nature of injury, and 14% of treatment details were incomplete). For cases with full data at both data collection points, there was 95% agreement for both the body region and nature of injury and 96% for the treatment received.

The high level of incomplete data at follow up is probably due to the PDC's poor recall, as there was some time lapse between injury and audit. PDCs were volunteers without a medical background, but they did have a good recall of the treatment that was provided on site. Often the original data form was the only injury record, so asking PDCs to recall information for the audit may have been difficult if they could not remember the original injury details.

This study shows that to collect complete and accurate information from sports trainers, data should be collected on site and not rely on their accurate recall. From the perspective of injury prevention and sports safety, the clubs acknowledged that they did not keep good medical records for each of their players, which was something that they wanted to develop for future football seasons.

**R A Braham**

Monash University, Clayton, Australia

**C F Finch**

University of NSW, Sydney, Australia

**P McCrory**

British Journal of Sports Medicine, Melbourne, Australia

Correspondence to: Professor Finch, University of NSW, NSW Injury Risk Management Research Centre, Sydney, NSW 2052, Australia; c.finch@unsw.edu.au

## BOOK REVIEWS

### Physical activity for patients: an exercise prescription

Edited by A Young, M Harries. London: Royal College of Physicians, 2001, £15.00, pp 159. softcover. ISBN 1860161286

This informative book addresses an important contemporary issue. It focuses on the prescription of exercise, a concept stimulated by the 1996 announcement by the US Surgeon General, of the benefits of regular physical activity to the community at large. A geriatrician and a respiratory physician are joint clinical editors of this publication with its genesis in a conference held at the Royal College of Physicians in 2000. It attracted a group of clinicians, researchers, and health-care providers to address the positive influence of exercise on a range of common clinical conditions.

The first few chapters provide evidence based arguments for the benefits of physical activity in osteoarthritis, chronic heart failure, obesity management, diabetes, the preservation of health in old age, and in injury rehabilitation. Following this section is a group of papers that offer sound guidelines for the delivery of exercise to specific groups including children, the disabled, the chronically fatigued, and the vulnerable aged population.

If asked to choose the two most valuable contributions in this book, I would unhesitatingly highlight the sections on prescribing exercise for preadolescents and establishing a basis for the training of exercise practitioners. Several authors make particularly relevant comments on the implementation of programmes of physical activity through a consistent standard of training, combined with frequent monitoring of exercise prescribers. Accredited providers demand a consistent standard of undergraduate education in sound clinical principals taught by recognised tertiary institutions. The weekend certification of the "fitness instructor" must be discouraged and replaced by a professional course under the aegis of a national educational accreditation system. Graduates from acknowledged tertiary courses in health sciences would seem most appropriately qualified to work in this area. A robust professional agency of oversight must set standards of competency, ethical behaviour, and clinical practice. The continuing maintenance of professional standards and collaboration with other healthcare professional groups are additional requisites. For exercise prescription to have impact there must be a process of delivery that meets the needs of practitioners and ensures safety and efficacy for patients. This is neither the sole preserve of the physiotherapy profession nor the singular domain of the physical educator.

This book provides a welcome addition to the library of those clinicians with an interest in exercise prescription. It offers informed statements on the clinical benefits of an active lifestyle and describes treatment protocols highlighting the benefit of combining physical therapy with medical and pharmacological agents. Examples include the contemporary management of asthma, diabetes, and certain forms of cancer that routinely include exercise prescription. Many psychological disorders are also often managed in a similarly active milieu.

This book underscores the need for well trained, accredited health professionals. I recommend this publication by the College of Physicians and congratulate the editors for reminding us how important exercise is to our increasingly more sedentary mechanised society.

**Analysis**

Presentation	16/20
Comprehensiveness	15/20
Readability	15/20
Relevance	18/20
Evidence basis	18/20
Total	82/100

**D Gerrard****Counselling athletes: applying Reversal Theory**

J H Kerr. London: Taylor and Francis Group, 2001, £16.99, pp 159, softcover. ISBN 419261206

I really liked this book. Its clear, readable style, use of quotations, case studies, and interweaving of applied and academic content held my interest throughout. Reversal Theory (RT) is sometimes placed on the fringes of sport psychology, offering little practical application because of its structural phenomenology. Kerr's book firmly quashes such criticism, illustrating RT's structural phenomenology as central to its application as an interpretive framework for an eclectic range of consultancy approaches.

Kerr's use of quotations and case studies from elite sports participants is the book's main strength. Using these, he places an RT filter against sporting experience and describes and interprets what occurs. Another of the book's strengths is its clear, logical progression. This may seem obvious, but I felt that Kerr skilfully led us through increasingly complex RT concepts and applications without recourse to involved academic discussion that would detract from the book's applied focus.

The discussion points after each chapter offer opportunities to check one's understanding and provide excellent stimuli for teaching based discussions. Possible responses would have been useful throughout the book, particularly later on, where issues became increasingly complex. I would also have welcomed greater detail on the consultant's perspective in chapter 8, such as dealing with one's metamotivational states and interactions with clients' metamotivational experiences.

This book is interesting, engaging, and may inspire practitioners to integrate RT into existing practices. I would certainly purchase this book and recommend it to postgraduate students and trainee consultants in sport psychology, existing practitioners, and some athletes.

Professional qualifications: BASES Accredited for Scientific Support (Psychology), BPS Chartered Psychologist.

Target audience of the book: postgraduate students, practitioners, trainee practitioners and maybe some athletes.

Author details: John Kerr is the world's leading expert on the application of RT in sport and exercise settings. He has pioneered the investigation and application of this theory in this context and published extensively on the topic. Although clearly at the upper echelons of academe, he still has time to help others in their research and application of RT.

**Analysis**

Presentation	18/20
Comprehensiveness	16/20
Readability	20/20
Relevance	20/20
Evidence basis	20/20
Total	94/100

**J Thatcher****Orthopaedic sports medicine, 2nd edn.**

Jesse C DeLee, David Drez Jr. WB Saunders, 2003, £220, pp 2624 (2 volumes), hardcover. ISBN 0721628362

Coming nine years after the first edition, the second edition of DeLee and Drez's *Orthopaedic sports medicine* is an impressive tome to complement any bookshelf. Containing over 2600 pages, this text is at best a valuable resource for the sports medicine clinician. At worst, it is potentially a health hazard, as mishandling of either of the 4 kg volumes could deliver a significant midfoot injury to the inattentive reader!

The authors have made a noble attempt to deal with non-surgical issues such as nutrition for sports, sports pharmacology, sports psychology, the female athlete, and environmental stress. That this remains essentially an orthopaedic surgical text, however, is best illustrated by the fact that anterior cruciate ligament injury is covered over 70 pages whereas osteitis pubis is covered in less than one page.

The early chapters covering basic orthopaedic sciences are particularly well written and provide information that is both detailed and current. The orthopaedic chapters deal with different regions of the body in a piecemeal fashion. Each chapter contains sections on anatomy, biomechanics, and radiology relevant to that body region. These sections are excellent. The radiological discussions are well supported by medical imaging photographs. The brevity of the rehabilitation sections is the only disappointment with the orthopaedic chapters.

No publication of this scale can be all things to all readers. The non-orthopaedic chapters provide an informative introduction for surgeons wishing to familiarise themselves with non-surgical issues. These chapters, however, tend to be brief, lacking in detail and current references. They do not provide the depth of knowledge required for specialist sports medicine training or practice. For instance, the section on stretching is largely a recycled version of a previously published chapter (acknowledged by the authors). The section is poorly referenced and out of date (including the authors cross-reference to their own previously published work), the most recent reference dated 1988. There are glib assertions that stretching prevents injuries and provides skill enhancement, without any attempt to support such assertions with scientific evidence. There is no discussion of recent papers challenging the benefits of static stretching in asymptomatic individuals.

Overall this is an ambitious but very readable resource text. It should be included in the recommended list of texts for any postgraduate sports medicine training course. The strength is in the orthopaedic sciences. The weakness is in the non-orthopaedic chapters which tend to lack detail and current knowledge.

**Analysis**

Presentation	17/20
Comprehensiveness	16/20
Readability	17/20
Relevance	18/20
Evidence basis	15/20
Total	83/100

**D Hughes****Statistics in clinical practice**

David Coggon. London: BMJ Books, 2003, £14.95, pp 109, softcover. ISBN 0727916092

This is a concise and well written introduction to clinical statistics for those reviewers, students, and clinicians who wish to be able to better interpret the statistical side of research papers. It is a very light book which has the advantage of *not* intimidating those readers who are fearful of statistics. These are the readers who would derive the most benefit. It does not provide enough information for most postgraduate authors of papers who need more detail about how to choose and perform the actual statistical tests. Sections that could be expanded are those on assessing confounding and bias in papers, which is an important skill for reviewers and readers even if they don't need to write their own papers. Study examples and questions are included for most chapters, with an exception being the small section in the final chapter on bias, where a practical example of a biased study would have been particularly useful. I can recommend this book to anyone who *should* have an interest in statistics but who has previously avoided the topic out of fear. If you already have a comprehensive textbook on statistics that you have actually read, then you are unlikely to derive much benefit. That is unless you want a read to brush up on statistics on an airline flight and the other book would tip your baggage over the weight limit.

**Analysis**

Presentation	16/20
Comprehensiveness	11/20
Readability	18/20
Relevance	16/20
Evidence basis	14/20
Total	75/100

**J Orchard****CALENDAR OF EVENTS****Medicare India**

6-8 April 2004, New Delhi, India

This exhibition and conference will be held for the first time, following India's ambitious "health for all" programme launched in 2002. Further details: Rob Grant, Kinex Log, 5 New Quebec Street, London W1H 7DD, UK; tel: +44 (0)207 723 8020; fax: +44 (0)207 723 8060; email: [rob.grant@kinexlog.com](mailto:rob.grant@kinexlog.com); web-sites: [www.medicare-expo.com](http://www.medicare-expo.com) and [www.kinexlog.com](http://www.kinexlog.com)

**The 6th STMS World Congress on Medicine and Science in Tennis in conjunction with the LTA 2004 Sports Science, Sports Medicine and Performance Coaching Conference**

19-20 June 2004, London, UK

Keynote speakers include Professor Per Renstrom (SWE), Professor Peter Jokl (USA), Professor Savio Woo (USA), Dr Carol Otis (USA), Dr Mark Safran (USA), Dr Ben Kibler (USA), Prof Bruce Elliott (AUS), and Professor Ron Maughan (UK).

Further details: Dr Michael Turner, The Lawn Tennis Association, The Queen's Club,

London W14 9EG, United Kingdom; email: michael.turner@LTA.org.uk

### BASEM Conference 2004

14–17 October 2004, Belfast, UK

Main themes: Overuse Sports Injuries and Muscle Injuries. Keynote speakers include: Chris Bradshaw, Medical Director, Olympic Park Medical Centre, Melbourne and Kim Bennell, Assistant Professor, School of Physiotherapy, Melbourne University.

Further details: [fionnuala.sayers@greenpark.n-1.nhs.uk](mailto:fionnuala.sayers@greenpark.n-1.nhs.uk)

### 1<sup>st</sup> World Congress on Sports Injury Prevention

23–25 June 2005, Oslo, Norway

This congress will provide the world's leading sports medicine experts with an opportunity to present their work to an international audience made up of physicians, therapists, scientists, and coaches. The congress will present scientific information on sports injury epidemiology, risk factors, injury mechanisms and injury prevention methods with a multidisciplinary perspective. Panel discussions will conclude symposia in key areas providing recommendations to address the prevention issue in relation to particular injuries and sports.

Further details: Oslo Sports Trauma Research Centre and Department of Sports Medicine, University of Sport and Physical Education, Sognsveien 220, 0806 Oslo, Norway. Email: [2005congress@nih.no](mailto:2005congress@nih.no); website: [www.ostrc.no](http://www.ostrc.no)

## NOTES AND NEWS

### Intercollegiate Academic Board of Sport and Exercise Medicine

Professor Donald Macleod has completed his four year term as Chairman of the Intercollegiate Academic Board of Sport and Exercise Medicine. Professor Charles Galasko has been elected by the IABSEM Board to replace him. Professor Macleod has also been replaced as the representative of the Royal College of Surgeons of Edinburgh on IABSEM by Professor Angus Wallace.

### Winners of the annual BASEM Prizes

Dr Eileen Mackie (Clopidogrel inhibits platelet activation and exercise induced ischaemia in stable coronary artery disease) and Mrs Eleanor Curry (Role of exercise in multiple sclerosis) (joint winners).

The poster prize was won by Dr Stuart Reid (Injury patterns and injury prevention strategies in the winter sports population attending the English medical centre in Val D'Isere).

### Diploma in Sport and Exercise Medicine for Great Britain and Ireland

Details of the above examination can be found on the Royal College of Surgeons of Edinburgh Website at <http://www.rcsed.ac.uk>. Alternatively, applicants can write to: The

Royal College of Surgeons of Edinburgh, Eligibilities Section, Careers Information Services, 3 Hill Place, Edinburgh, UK; tel: +44 (0)131 668 9222 or Mrs Yvonne Gilbert, Intercollegiate Academic Board for Sport and Exercise Medicine, Royal College of Surgeons of Edinburgh, Nicolson Street, Edinburgh EH8 9DW, UK; tel: +44 (0)131 527 3409; email: [y.gilbert@rcsed.ac.uk](mailto:y.gilbert@rcsed.ac.uk)

### Intercollegiate Academic Board of Sport and Exercise Medicine Diploma Exam

The following were successful diplomates in the Intercollegiate Academic Board of Sport and Exercise Medicine Diploma Exam, the two exams held in 2001 and 2002:

- Dr Andrew I Adair
- Dr Abimola Afolabi
- Dr Sinead M Armstrong
- Dr Terence J R Babwah
- Dr Catriona E L Boyle
- Dr Susan J Brick
- Dr Lawrence J Conway
- Dr Alan J Dawson
- Mr Patrick D Dissmann
- Dr Niall WA Elliott
- Dr Christopher J Ellis
- Dr Roger K Goulds
- Dr Niall A Hogan
- Dr James R Hopkinson
- Mr Ananta K Jayanti
- Dr Michelle Jeffrey
- Mr S P Kale
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- Dr Martin D McConaghy
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- Dr Martin O Rochford
- Dr Hungerford A T Rowley
- Dr Shaun A Sexton
- Dr Jason E Smith
- Dr Aravinthan Suppiah
- Dr James A Thomas

For further information contact: Mrs Yvonne Gilbert, Administrative Secretary, Intercollegiate Academic Board of Sport and Exercise Medicine, Royal College of Surgeons of Edinburgh, Nicolson Street, Edinburgh EH8 9DW. Tel: +44 (0)131 527 3409; fax: +44 (0)131 527 3408; email: [y.gilbert@rcsed.ac.uk](mailto:y.gilbert@rcsed.ac.uk)

### [www.basem.co.uk](http://www.basem.co.uk)

The British Association of Sport and Exercise Medicine has launched its new website—[www.basem.co.uk](http://www.basem.co.uk). The site provides information about the educational opportunities in sport and exercise medicine and advice to those wishing to become involved in this area.

### Interested in Sports Medicine? Gain a higher degree from Australia's leading university

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Web site: [www.medunsw.edu.au/sportsmed](http://www.medunsw.edu.au/sportsmed)

### NCPAD NEWS

A monthly publication of the National Center on Physical Activity and Disability. NCPAD is the leading source for information about organisations, programmes, and facilities nationwide providing accessible physical activity and recreation. NCPAD also has a large and growing online library of fact sheets, monographs, and contact information on physical activity and recreation for people with disabilities.

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## Silence on clinical fundamentals

E N Grosch

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