Editorials

Warm up

Little women and big men attract attention in this issue. The athletic and aesthetic demands on dancers and gymnasts expose them to similar long term female health risks. The wonderful performance of an elite ballet corps, or the supreme athleticism of the prima ballerina match the beauty of any athletic achievement, but not without cost. Professional dancers with delayed menarche and amenorrhoea are at risk of osteoporosis (p 143). Gymnasts too amaze us with the grace and elegance of their performance and have similar problems. Karen Forbes (p 94), a former elite gymnast herself, reminds us of some of the problems associated with a sport that puts excessive emphasis on physical appearance but also shows us some of the solutions. Personal experience gives her particular insight.

Other papers suggest that girls may benefit more from encouraging long term enjoyment in activity and positive attitudes than a strenuous short term programme (p 139), and that we need to look to long term studies to see the effect of physical activity promotion in the pre-pubescent period (p 159).

Big men also get injured (p 135) and heavier rugby players seem to be at greater risk. In a sport where players are getting bigger all the time this should worry us. Indeed, in the coming weeks we see the biggest Lions ever to tour South Africa. JPR Williams, one of the Lion kings, reflects on some of the problems this year's pride will encounter (p 95). Altitude, however, should not be one of them (p 151).

Family doctors: players or spectators in the future?

Sports injury primary care in the United Kingdom is usually provided by general practitioners (GPs). There are few specialist sports medicine clinics and only a handful of full time specialists to provide a service nationally. If specialist training and specialty recognition were to happen overnight it would be impossible to offer a comprehensive service in the foreseeable future. The GP is likely, therefore, to remain the key professional in sports injury management. Even if we exclude sports injury, there will always be the need for advice on exercise for health, training and rehabilitation, first aid, cover for local sports events, the school ski trip, and boxing tournaments.

There are other reasons why we should positively support continued GP involvement. Family doctors have shown themselves to be versatile and responsive to many new initiatives and ideas. Faced with the challenge of new contracts, changes due to fundholding, and developing out of hours initiatives, among others, practices have responded dramatically and rapidly to meet new needs and opportunities. If realistic opportunities are offered to expand primary care expertise, training, teaching, and career development in sports medicine, then we can be certain that GPs will respond. There are already encouraging signs as GPs are the majority participants in distance learning courses, attenders at postgraduate education, and exam candidates.

General practitioners also hold the key to the success of any initiatives in secondary care. It is unlikely that there will be new money freely available within a future NHS budget to develop hospital services. The GPs' role will be pivotal in the development of any specialist clinics. Fundholding GPs will refer, but only if the sports medicine service is cheaper and more effective than an orthopaedic consultation. In reply, specialists will have to market their services vigorously to fundholders and show hospital managers that they can generate revenue. Those GPs who are not fundholders will have an uphill struggle to persuade their health authorities that a sports medicine service is justified on need. They will, however, have the support of a vocal sporting lobby and, from a public health perspective, there

is very strong epidemiological evidence that physical activity is the best buy in public health.

Family doctors will therefore have a very important part to play in future developments. But, let's not get carried away, GPs are still grappling with problems of their own, and we must recognise the shortcomings of general practice. Even those GPs who are interested in sport and exercise medicine find it difficult to maintain their enthusiasm and commitment when swamped by a normal practice workload on a busy Monday morning. There is evidence that some GPs are demoralised and are thinking more of reducing to core services rather than expanding. Health promotion did not deliver what was expected, and in exercise prescribing schemes, GPs have had only limited success and delivered little formal evaluation.

There has been a lack of leadership from academic departments of general practice. In North America there are a number of combined academic departments of sports medicine and family medicine, but few educational initiatives have come from academic departments of family medicine in the United Kingdom. This apathy masks a great opportunity. In the future, sports medicine is unlikely to thrive on service provision alone and will need the imprimatur of an academic background in research and teaching. In the current funding climate we cannot expect universities to fund entire new departments. Sports medicine will need leadership, cooperation and support of an existing university department, and general practice seems the natural foster home. But, there is a dual responsibility and academic departments of general practice will need to offer resources, funding, curriculum time, and status. At a national level, the Royal College of General Practitioners must also recognise the huge contribution that its members make to sports medicine and offer support and encouragement within the College to those members who make this commitment. In short, general practitioners will remain major players in sport and exercise medicine, but there is much work to be done in nurturing and developing skills and in providing the organisational infrastructure and academic support.

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