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Editorials

Warm up

Looking out on a cold grey February day, few daydreams have more appeal than sunshine, the deep blue sky, and the freedom and exhilaration of the ski slope. Mountain peaks and pure green forests, the colour and the glamour, and the rush of wind through your hair. Only a spoilsport would introduce rules and regulations, guidelines, and safety recommendations to such a natural healthy environment. That is, until someone is killed. Adrienne Rees-Jones takes us through the arguments and encourages us all to wear helmets (p3). Reading this piece we would all agree that the real test comes on the piste.

Another test of rules and regulations is rugby. In this issue we publish a paper from each hemisphere, each one highlighting the challenge to make rugby one of the most exciting, entertaining, and competitive team games, safer without spoiling the spectacle. Garraway and his colleagues (p37) look at the tackle, and, in particular, at the personal and player related factors of rugby injuries. One of the great strengths of this study is the methodology. Presenting a list of injuries in one team, one season, or one region tells us little about the overall pattern or rate of injury, but this is a prospective case-control study and it highlights the dangers of high speed tackles outside the players' line of vision. Injury to the cervical spine has devastating implications, and Secin *et al* (p33) reviewed 18 cases of disabling cervi-

cal spine injury in 20 years of rugby in Argentina. Quadriplegia was the main clinical manifestation in all cases and, except for two cases of complete recovery, all players had different degrees of neurological sequelae. And the mean age of those who suffered such devastating injury: 22 years old.

Many sports do not have rules and regulations. Anyone can run but some could be accused of overdoing it. Running a 1600 kilometre ultramarathon seems somewhat extreme and Kieran Fallon (p27) monitored the haematological changes associated with this event. Not everyone wishes to run quite so far, and a standard marathon seems quite tame in comparison. Satterthwaite *et al* (p22) identified several risk factors for injuries and health problems sustained in the Auckland marathon. They concluded that those who had recently been unwell or taking medication should consider carefully the risks and benefits of competing. This seems to be reasonable advice for normal balanced subjects, but runners may not all quite fit this description. Indeed, Currie's group (p19) point out that the illness attitudes and beliefs of athletes differ from those of a well matched control population. Runners, and these were elite middle and distance runners, were more likely to somatise their concerns and deny the importance of life stresses. Hypochondriacs?

Vision or heresy

History shows us only major milestones, monuments, heroes, and villains. Contemporary records often tell a different story, and the defining moments of history were often clouded in uncertainty. Only visionaries could see the future. These are uncertain times in sports medicine. We know that education, training, specialist recognition, and accreditation are all evolving, but it is difficult to see how exactly they will fit together. All the building blocks may be in preparation, but there are no architectural drawings.

The discipline of sport and exercise medicine is at a crossroads of many competing interests. Tension and insecurity exist as each stakeholder struggles to assert ownership. Tensions include medical professional interests, a frustration on behalf of sporting bodies, and the fear among professionals allied to medicine that they will become disenfranchised. The medical Royal Colleges have rightful interest in the regulation of the medical profession and the achievement of specialist registration. They see

standards and accreditation as the key. This means assessment, examination, structured training, and continuing medical development. National sporting organisations focus on the athlete and believe that sports medicine is just another ancillary service whose role is to support elite sport. Medals are their target. They seek an athlete centred service and may attribute little importance to the medical Royal Colleges and, what they perceive as, the archaic traditions of a rather rigid profession.

Our colleagues in the professions allied to medicine (PAMs) see sports medicine as a multidisciplinary specialty where physiotherapists, podiatrists, chiropractors, and others all have a role. They consider themselves to be equals and, indeed, many of us working closely with them have benefited from their knowledge, expertise, and clinical examination skills. The medical profession clearly does not have the monopoly.

There are other organisations in the United Kingdom who feel that they too have an important role in medical

education and the setting of standards. The National Sports Medicine Institute, jointly with the BASM, organises a medical education programme, and the British Olympic Association also see a role in educating and accrediting their medical officers. There are many competing interests, overlapping responsibility, and no clear limits or boundaries.

Each of these competing interests has a valid claim to influence standards in medical education and accreditation. To create a structure that meets the needs of all these competing interests will not be easy. If mainstream medicine claims complete ownership, this will only cause conflict. The first step must be to recognise the legitimate claims of all stakeholders and to appreciate why it is important for all to be involved. The discipline of sport and exercise medicine may not fit the model of a traditional medical Royal College. However, the role of the medical Royal Colleges is also changing as public opinion demands that the medical profession become more accountable, not only in professional self regulation but also in public accountability. The Bristol cases have brought this to our attention most recently.

Training, assessment, and academic standards are recognised features of a medical specialty. There is now a patchwork of academic courses, degrees, and distance learning programmes provided by universities across the United Kingdom, although little coordination of standards or entry criteria. The Academic Forum, as it brings together the directors of these courses, should give us some cause for optimism. Currently, several competing diploma examinations exist, but the establishment of the UK diploma should lead to a common examination with common standards. BASM and NSMI jointly provide an educational programme of basic and intermediate courses. And, in response to the needs of those at post-diploma/MSc level, an advanced component will be included in the BASM annual conference. We have some accredited sports medicine specialists on the specialist register, but no formal structured training programmes are yet in place.

Tension also exists between those who feel that higher specialist training should be directed towards generic sports medicine specialists and those who feel that other specialists with an interest in sports medicine, such as cardiologists, orthopaedists, or rheumatologists, should have equal standing. There may be only a small number of doctors who wish to become career sports medicine specialists in the immediate future, but there are many others for whom sports medicine is a special interest, both in hospital practice and in primary care. The challenge will be to create a structure that can meet the needs of all. Specialist registration, accreditation, and higher specialist training are all closely interwoven, but creating a narrow specialist grouping runs the risk of excluding many of those with an interest in the discipline. Medical careers are changing too. In future, doctors are not likely to have a single career from qualification to retirement, but will have a portfolio career of various interests built around certain core skills. Sports medicine may be one of these.

Specialist registration may not offer benefits to all and could ultimately be divisive. We may have to look towards a more inclusive college structure: a matrix rather than a hierarchy—a body that can integrate all three groups, the sports medicine specialists, the specialist with an interest, and the primary care physicians with an interest. The traditional narrow base of a medical Royal College is not, in its current form, of sufficient breadth to embrace all the heterogeneous constituents of the discipline of sports medicine. We should also consider how we can include the professions allied to medicine. In this challenge we are not alone because the Faculty of Public Health Medicine has had the same problem in trying to include their non-medical colleagues. Ideally, ours would be an inclusive organisation, one that represents the changing nature of medical practice, that embraces all those with an interest in sport and exercise medicine, and one that is answerable to the greater public, to the athletes, and to the profession. A radical vision perhaps. History also records that most radical visionaries were burned at the stake!

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Australian Institute of Sport pool facilities, "Swimmer" by John Robinson. Reproduced with permission.