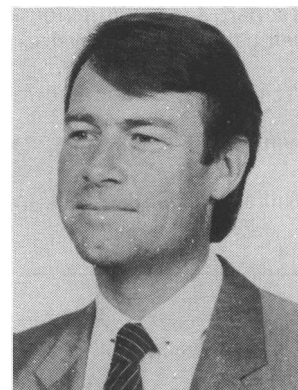


THE NOTTINGHAM SPORTS INJURY CLINIC

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The Nottingham Sports Injury Clinic stemmed from the enthusiasm and determination of the clinicians involved (one an orthopaedic physician and the other an orthopaedic surgeon) to offer a service to the sports injured of the Nottingham area. Nottingham has a high incidence of sports clubs and centres per unit of population and hence has a large number of athletes in need of attention. Though the professional sportsmen in the County have been catered for satisfactorily for some time, there has been an associated strong desire to be able to offer the amateur athlete a suitable service as none has existed at NHS level previously. The provision of Orthopaedic Surgical care in the County is excellent but because clinics are already swamped by patients needing orthopaedic opinions there has been no place for soft tissue clinics. Since the orthopaedic workload in the area is so high and the Trent Region funding already stretched to the limit it seemed inappropriate to attempt to divert currently available resources in a new direction; indeed the DHSS has gone on record as stating that the development of sports injury clinics is welcomed though local initiative is required and no new NHS money would be forthcoming. A concept therefore of an "NHS style" clinic was born using NHS premises and facilities though funded from outside the NHS. A number of requirements for a properly designed functioning clinic were identified and have been met.

The siting of the clinic is a most important consideration. The need for ancillary services such as radiology and pathology as well as (obviously!) physiotherapy makes the choice of an outpatient area in a viable district hospital imperative. Quite by chance provision was available in the outpatient department at the General Hospital in Nottingham — the old fracture clinic at the General Hospital was available for use at the times required. Both the physiotherapy and radiology departments were immediately adjacent. It was determined that the clinic should be held during normal working hours and not over a lunchtime or during an evening.

The timing of the clinic sessions was not so much to deny sportsmen a chance to work a normal day or to have consultations outside their normal working hours, as to ensure that the doctors and therapists concerned regarded the clinic to be of high priority and not a service that could be crammed in when they had the time. Monday and Thursday mornings were clear of other disciplines which allowed the clinic to operate at ideal times.

Enthusiastic and competent medical staff are considered to be essential in the running of a sports clinic and in this respect the dual interests of both a physician and surgeon were available. Both had been able to develop an interest in sports medicine over many years and were able to offer their services at clinic times. Attendance at the clinics by medical staff was not compromised by other interests (although clinics have very occasionally been cancelled in advance because of holiday commitments). The agreement of the area orthopaedic surgeons and surgical faculty was obtained regarding the establishment of the clinic and in this respect it was felt important to be able to achieve a close working arrangement with the orthopaedic department for those situations that demanded fairly urgent surgery.

Having established that there were no NHS monies available, it was therefore necessary to achieve sponsorship through private funding and this was forthcoming through the good offices of the Sports Council, the Nottingham City and County Councils and commerce (principally pharmaceutical and medical equipment firms). A determination of the appropriate amount of finance required was made following consultations with the District Finance Officer and a costing that proved to be reasonably accurate was made of the services that were essential to the smooth running of the clinic. Services that were identified were the provision of a clerical officer, a secretary, nursing attachment and a physiotherapist as well as the medical requirement. In

practical terms such voluntary funding was promised for an initial period of three years and quarterly accounts were to be submitted by the District Finance Officer for the provision of services and salaries of personnel who retained AHA employee status.

A part-time clerical officer was available who was able to cope solely with the clinic's requirements and a part-time secretary was also available for eighteen hours a week from the pool of orthopaedic secretaries. After a year the secretary's hours increased to thirty hours per week. The physiotherapist (who was anticipating extending her career in sports medicine) commenced duties initially in a part-time capacity by spending half of her time with patients from the Sports Injury Clinic and half of her time with other aspects of the District Physiotherapy Service. As the clinic soon worked up to capacity, however, her services became full-time within a few months. She is able to utilise the facilities of the Physiotherapy Department in the General Hospital and although a large gymnasium is not available, the facilities are otherwise adequate. Although the NHS does not provide funds for the clinic it does provide such facilities and the values of the floor space of the Outpatient clinic and Physiotherapy Department are not unsubstantial on a rental basis.

It was considered necessary at the outset to have patients referred from the Accident and Emergency Department at the University Hospital only, i.e. to run what is known as a "closed clinic". This is regrettable in some ways as GP referral should be available in the running of a sophisticated service; however the County of Nottinghamshire is so large that "over-demand" could be a problem unless the A and E service acts as a "sieving" system. Referral of acute injuries is therefore made following a patient's initial attendance at the A and E Department. It remains to be seen whether as time goes by a more open referral system can be achieved, though the experience of other sports injury clinics which have developed waiting lists has to be borne in mind. The Nottingham Sports Injury Clinic is already busy using the described reference system and achieves the initial target of seeing patients within three days of

their injury. Many injuries occur at the weekend and reference to the Monday morning clinic can normally be made. It is hoped that in the future, liaison can be established with the available sports and gymnasium services at the University of Nottingham so that more complete rehabilitation of certain injuries can be made.

The clinic opened in mid-November 1980 and in the first twelve months 605 new patients were seen of which 493 were men and 112 women. During the second twelve months to November 1982 new patients numbered 659 (551 male and 108 female) and 'old' patients 1527 (1209 male and 318 female). Injuries were catalogued according to sport, regional anatomy, type of injury, X-ray findings and age and sex of patient. From early 1983 computerised record maintenance is planned.

Throughout the year the proportion of acute injuries to stress (overuse) injuries approximates 50:50. During the winter months there is a higher incidence of acute traumatic injuries, often in sports of direct contact, in patients attending the clinic. As a result of 'marathon fever' there is a steady stream of patients with stress injuries in the lower limbs throughout the year.

Once a week two or three 4th year medical students attend the clinic as part of their orthopaedic commitment. Junior doctors from the A and E Department also attend regularly – there continues to be a need to teach soft tissue injury medicine both to preclinical students and post-graduate groups of doctors. It will obviously take some time to get rid of the diagnostic NBI ("no bone injury") label.

A particular interest has been established in the clinic with regard to the cast brace system for management of substantial ligament injuries around the ankle and knee. So far the results are most encouraging and a controlled trial of the use of cast brace mobilisation of lateral ligament ruptures of the ankle as compared to surgery or POP immobilisation is being initiated. The place of the Cybex isokinetic dynamometer in management of sports injuries in Nottingham has also been assessed.