SOME MEDICAL ASPECTS OF TEAM CARE AT HOME

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The original title of this paper was to have been "Orthopsychopodics in the Valley", as Orthopaedics must be combined with Psychology, if not even with Psychiatry, when dealing with the treatment of injured footballers, a population in which there is a large variation of intellectual ability. It has been suggested that the ideal travelling medical team would consist of a general practitioner, an orthopaedic surgeon, and a psychiatrist, but this is open to dispute, for if a player needs the services of an orthopaedic surgeon he would best be flown home. A psychiatrist would be a more valuable asset, if a well adjusted one familiar with the stresses of the competitive event could be found. This leaves the general practitioner, - the real 'Doctor', - qualified in both the science and the art of medicine, - interested in athletics, and probably a former athlete himself (or else he is not likely to volunteer for such an appointment), and his experience would enable him to undertake the treatment of the whole patient. There is a tendency for the specialist to concentrate too much upon one aspect of his patient, his X-Ray, cardiac output, or his personality defect.

The duties of the doctor attached to a club vary greatly from one club to another. In Charlton Athletic Football Club, my duties are nebulous; a member of the Board of Directors, as well as an Orthopaedic Surgeon. The club is visited two or three times a week, so that recent injuries can be discussed in detail with the trainer. During matches, players injured sufficiently to justify their being brought off the field are examined in the dressing-room, and can be treated immediately, or evacuated to hospital when appropriate. Each player can be treated as an individual, being well known to the club's regular doctor, who frequently knows the player's domestic background as well as his playing ability and his personality. Most of the straight forward strapping and bandaging is left to the trainer, who is most competent in this field, but some special procedures, such as the strapping for the support of a sprained medial ligament of the knee, is best done by the surgeon himself, who will also undertake the suture of wounds, sometimes after infiltration with local anaesthetic.

One of the more important duties of the doctor during a match is to decide whether a player should be advised to return to the game, or to advise the manager to arrange for a substitute. Here the personality of the injured player has a large bearing upon this decision; a man with a high work rate, who can command the game and lead the other players, may be allowed to take some risk in being allowed to continue, but the spectacular player who is likely to lie down on the ground after every slight knock is best kept off.

The application of psychology is of great importance in the rehabilitation of a player following injury. After a meniscectomy for example, some players need driving, some need leading, many need encouragement, and a few even need restraining. Medical advice may be needed during a game; for instance the manager of a losing side may tactfully be discouraged from being too critical, and causing a breakdown in morale by telling a team that they need their heads examining, however true that may be. Despite the inauguration of the International Association of Sports Psychology in Rome in 1965, little is being done in this country in the way of serious study. To many, it suggests witchcraft and black magic, but the future advancement of performance, both individual and team, must ultimately lie in the harnessing of some of those forces whose existence we hardly like to admit at the present time. Several examples of the performance of feats that are theoretically impossible, illustrate how the mind can overcome physical factors, - the fire-walkers of Fiji, the recorded miracles at Lourdes, and numbers of observed and authenticated hysterical and hypnotic practices whereby men are influenced by "healers" or rendered insentitive to pain by the unrecordable but very powerful force of some emotional influence or experience.

Most of us who have competed at various sports have had experience of "off-days" and "on-days", and have seen examples of one coach getting good results from a competitor that another equally good coach failed to get. The exact reason is not known. If it were, it would be possible to get a superb world-beating performance out of quite an average team. It has been suggested by J. B. Rhine, of Duke University, U.S.A., that extra-sensory perception may exist as a separate skill, and might raise the possibilities of controlling a team through these channels from the director's box!

Teams do need their own medical adviser, as so many of the problems of the competitors are not really suitable for the standard procedures of the National Health Service. Illustrative case histories can be quoted.

Case Histories

Patient No.1. is a diver, a girl aged 12 years. She injured her back by spinal hyper-extension following a dive from three metres. X-Ray of the spine in another hospital showed an area of osteochondritis in the lower thoracic and upper lumbar areas, and the patient was advised to give up diving altogether. When seen later, there was no pain in the thoraco-lumbar junction, but all pain was limited strictly to the lumbo-sacral ligament, far removed from the area showing the radiological changes. Experimentally, the tender area around the lumbo-sacral ligament was injected with prednisolone and a local anaesthetic, and she resumed diving despite the X-Ray changes. It is possible that she may be troubled later with the osteo-chondritis, but this is inevitable, and meanwhile she should be allowed to continue with her favourite sport. After the injury it was too late to tell her that her recovery from the dive, at her age, should have been by flexing and not extending the spine. Mostly, she needed sympathy, understanding, and effective treatment, - that is,

"Proper doctoring".

Patient No.2. Adult male, and an outstanding trampolinist. He suffered a rotation strain of the lumbo-sacral joint in an awkward landing from a multiple twist. His general practitioner, without specialist examination or advice, told him to give up trampolining. He was later treated by infiltration of the interlaminar facets with local anaesthetic, cortisone and an anticoagulant enzyme. He returned to trampolining, much improved but not entirely free from pain, until he fell on the frame, since when he has not had any more pain at all. Perhaps he should have seen an osteopath in the first place!

Patient No.3. A professional footballer, who had sustained a typical intervertebral disc lesion at the level of the fifth lumbar - first sacral vertebrae. He had sciatica, with weak dorsiflexors, depressed sensation, and absent ankle jerk. As there has been little reported work on disc excisions in athletes, the advice of a neurosurgeon was sought. He recommended conservative treatment, regarding the patient like any other, and ignoring his occupation. He failed to improve with rest, traction and exercises, the signs remaining unaltered. At operation, a small but completely prolapsed disc was removed, and after two weeks the patient walked out of hospital, free from pain and all other signs. Minor symptoms which cause only minor inconvenience to a sedentary worker will bar a professional athlete completely from carrying out any part of his job at all. With this well-motivated patient, the main problem is to keep him relatively inactive for six weeks to allow the posterior longitudinal ligament to heal, following the disc protrusion, and he should certainly be fit to resume full play by the beginning of next season.