LETTERS TO THE EDITOR

Sports medicine training in the United States

EDITOR,—The article “Sports medicine training in the United States” was recently brought to our attention. We applaud the journal’s interest in improving the public’s understanding of this complex area, but we are concerned about a number of serious misstatements on orthopaedic sports medicine training.

Firstly, the author states that orthopaedic sports medicine fellowship programmes are not accredited and do not have curriculum requirements or standards for supervision. It is a point of public record by the Accreditation Council for Graduate Medical Education (ACGME)—the US entity responsible for accrediting fellowships in all specialty endeavours—that there are 53 accredited orthopaedic sports medicine programmes. This compares with 64 accredited primary care sports medicine programmes in emergency medicine, internal medicine, paediatrics and family practice, combined.

All accredited programmes are required to meet the programme requirements as established by the ACGME residency review committee, which includes educational and personnel standards. Moreover, the AOSSM fellowship committee—a committee of the whole for fellowship programmes—has adopted a curriculum to ensure that fellowship education is appropriately thorough and consistent.

Secondly, the author incorrectly characterizes orthopaedic sports medicine training as generally teaching the surgical approach to sports medicine and not stressing the numerous other areas of athletic care. Although surgery is an important facet of orthopaedic sports medicine, it is a significant oversimplification to suggest that it is the only facet of the specialty. In fact, the aforementioned graduate medical education curriculum delineates what trainees should know with reference to science (anatomy, biomechanics, and biology of healing), evaluation (history, physical exams, and imaging), and management (operative and non-operative) for virtually every region of the musculoskeletal system. Equally important, the curriculum goes beyond the musculoskeletal system to cover other sports medicine topics, including medical (such as cardiac, dermatology, pulmonology, and infection), nutrition, drug testing, environmental exposure, exercise physiology, athletic populations, paediatric and adolescent issues, preventive sports medicine, trauma, protective equipment, team physician management issues and more.

Thirdly, the author suggests that the training and practice of the orthopaedic sports medicine specialist is less involved in the team setting. Late in 1999, the society surveyed its membership to better ascertain their involvement in orthopaedic sports medicine. Some 91% indicated that they served as a team physician, 8% on the field coverage only, 6% office based consulting only, and 77% both on the field and office based consulting. The types of teams these orthopaedists served is also instructive: 74% served high school teams, 62% served university teams, 46% served community teams, 35% served professional teams, and 18% served Olympic or international teams. In total, sports medicine comprised 57% of their professional activities, divided between clinical care (42%), team service (7%), teaching/consulting (5%), and research (3%).

Finally, we think that the most significant hallmark of sports medicine in the United States is that it incorporates the expertise of many specialists in the care of athletes. Every area of specialization—primary care and non-primary care—has inherent strengths and limitations which we believe are important to recognize in providing athletes with optimal care. For this reason, AOSSM, the American Academy of Family Physicians, the American Medical Society for Sports Medicine, the American College of Sports Medicine, the American Osteopathic Academy of Sports Medicine, and the American Academy of Orthopaedic Sports Medicine developed a consensus document for the physician that focuses on qualifications and responsibilities and not just specialty degree. Implicit and explicit in this statement is the recognition that sports medicine is not the domain of any one specialty.

We hope that this brief elaboration provides a more complete appreciation of sports medicine training in the United States.

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Fitness leader effectiveness

EDITOR,—While conducting research for my Masters degree in Counselling and Guidance, I was particularly interested in the approach adopted by fitness leaders/ instructors when dealing with people wishing to start exercising.

My experience, and consequent understanding, of the typical approach used in fitness facilities is that the fitness leader advocates an “expert” role which can be confusing to beginners and underestimates the ambivalence felt by anyone considering a change of behaviour, such as taking more exercise. I strongly believe that the skills developed by these fitness helpers should be guided by a counselling nature. Listening develops greater empathy, and empathy helps individuals to understand their ambivalence. This, in turn, can lead to a resolution of the ambivalence that seems to hold many in a state of indecision when they consider taking up exercise.

I hope that this contributes to the debate.

PAUL E SCHUR


AUTHOR’S REPLY

I would like to make a couple of comments. Firstly, I would like to emphasise the point that I was making in my original letter. When discussing an ill defined procedure, as exemplified by “stretching”, it is important to be precise about what is being done to what, when, and for how long for comparisons to be made or for valid debate to proceed.

Secondly, I agree that further studies need to be done, but care must be taken with exact definitions. I have heard it suggested that, in the context of slalom kayaking, both over-stretching and under-stretching may be contributory factors in shoulder injury. In a complex biomechanical system, both statements may be equally true, depending on what one is considering in the kinetic chain.

I hope that this contributes to the debate.

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should include a respect for autonomy, adop-
tion of a non-judgmental attitude, genu-
ness, and empathy, all of which are key and
core counselling qualities.

Fitness instructors may also do well to ask
themselves why they got into the industry.
Many say that they love to help others get fit,
but here’s the paradox: those who appreciate
their expert advice are generally more ready
to exercise in the first place and need little
help in doing so. Those who are less ready
seem to be in most need of help with the
change of behaviour and this requires a com-
pletely different approach which matches the
mind set of this group.

To really “help” and really make an impact
on the greater number of those who do not
exercise, fitness leaders need to re-address
their whole understanding of the issue of
exercise “counselling”. I recommend they
read Motivational Interviewing,1 Health Behav-
ior Change,2 or Changing Eating and Exercise
Behaviour.3

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[1] Miller WR, Rollnick S. Motivational interview-
[2] Rollnick S, Mason P; Butler C. Health behavior
change: a guide for practitioners. UK: Churchill
Livingstone, 1999.

BOOK REVIEW


This, the second edition, has been thoroughly updated and revamped (see the section on Achilles tendons!). It is a superb book for the clinician working with athletes, outlining the treatment of injuries in a straightforward and clear way. It is such a change to read a book written by physicians rather than surgeons, with consequently a much more functional approach! This book should be read by all sports physicians and physiotherapists in training and should be by the desk of anyone likely to treat athletes’ injuries, GPs and spe-
cialists alike.

The first part “Fundamental principles” is
excellent for someone starting out in sports
medicine, but reminds us all of the basics. It
lists more sites of stress fractures than most of
us will see in a clinical lifetime, with hints on
management. The “Regional problems” (part B) is more comprehensive than in any other book I have read with important “prac-
tice pearls” in some chapters (why not all?).
There are often, as for ankle pain, lists divided into common causes, less common
causes, and “not to miss” problems, making it
very easy to build one’s own differential diag-

nosis. The layout could not be easier to
follow, with a hugely detailed contents list at
the start and good index, and the book is well
referenced with advice for further reading.

There are also sections on “Sports perfor-
ance”, “Special groups” (the section on the
disabled is brief but good), “Medical prob-
lems in sport”, and “Practical aspects of
sports medicine”—the doping screening, etc.
So nothing is left out. If there is a fault it is
that the clinical section is too small a part of
the whole.

This book will sell like hot cakes, and be on
every course reading list.

Analysis
Presentation 18/20
Comprehensiveness 16/20
Readability 17/20
Relevance 20/20
Evidence basis 15/20
Total 86/100

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VIDEO REVIEW

First aid in motor sport (video). Motorsport Safety Fund, PO Box 239, West
Malling, Kent ME19 4BL, UK. (£10.00 including post and packing.)

This video is designed to cover first aid prac-
tices in motor sport. The authors claim that it
is aimed at giving everyone involved in all
disciplines of motor sport a basic understand-
ing of first aid. Having watched the video
through twice, I remain unclear as to whether
this aim is actually achieved.

Clearly in a 13 minute video, one cannot
hope to cover first aid in any detail. Therefore
people who watch the video need to be famil-
lar with first aid beforehand. Why would you
then watch such a video? Perhaps as a quick
update of the issues before a sporting event. I
would think for most first aiders this
information is almost too basic and would
suspect that they may gain little from the
exercise.

One problem is that the video concentrates
primarily on the basics of first aid—that is,
the “ABC” approach as well as other issues of
hypothermia, burns, and so forth which are
covered in a very superficial way. As such, the
appropriate market for the video may be par-
ticipants, marshals, or others not directly
involved in medical care, to give them at least
a passing familiarity with this area. Unfortu-
nately to cover helmet removal and so forth,
taking the role of a non-trained person too
far. Perhaps the video may serve as an intro-
duction to a first aid update or refresher
course, but then many of the segments would
require detailed discussion and explanation.
Having said all that, it is a well produced
product which, to me, does not have a simple
market in motor sport safety.

I was disappointed that, although it is sup-
posed to be about motor sport, very few
action shots of motor accidents are shown
and most of the first aid is stock standard stuff
not necessarily related to motor racing. There
is little information specific to motor sports
for example, extraction of injured drivers

from vehicles—mainly because this area
gightly needs further training. There is a dis-
cussion of helmet removal in the vehicle;
however, I was slightly uneasy as to whether
this is an appropriate recommendation for an
introductory first aid video. Although a
doctor is shown directing the process, I am
not sure that it is relevant for basic first aid.

There are clearly situations where it is nec-
essary, but this perspective was not clear to
me from watching the video.

Towards the end of the video, a spectacular
heap hit is shown with a rally car tumbling down
a steep ravine and landing upside down in a
river. As a race medical doctor, this sent chills
down my spine as to the logistics of medical
care in such a situation. The only issue
discussed then is drowning, and the scene
jumps to an unconscious driver already out of
the vehicle on level ground. The video then
shows the first aider pushing heavily on his
back to expel any water in his mouth before
rolling him over to perform CPR. No mention
is made of the ABCs at this point or whether
the diagnosis needs to be assessed.

Simply the treatment of a drowning is the
focus of the segment. I was also surprised
about the pushing on the back as the initial
step. I obviously need my first aid skills
brushed up on this point, and, coming from a
country where drowning/near drowning is a
common occurrence on our beaches, I will
follow this unusual approach up with our
local authorities. Perhaps the video should
emphasise the point that, regardless of a
potential spinal injury in such situations,
a clear airway is the primary goal.

In my hometown, we are lucky enough to
have a F1 Grand Prix every year, and the elite
medical care available is impressive both to
observe and take part in. At smaller motor
racing events where the medical care is
limited, the need for appropriately trained
first aiders and marshals is paramount. The
Motorsport Safety Fund does a fantastic job
promoting safety issues in this sport. They
produce a range of videos, manuals, booklets,
tabards, etc of the highest standard as well as
a regular newsletter. Anybody involved in the
sport would do well to be in contact with this
organisation.

I am not sure that this video is the answer
to motor sport safety. It is too superficial for
the experienced motor sport first aider, does
not cover specific extraction or other medical
issues for rescue crews, and, to me, the mar-
ket for such a product is unclear apart from
a quick overview for participants and mar-
shals. With that caveat, there are issues
discussed that go beyond their level of exper-
tise. The video has many strengths, however.
It does reinforce the basics of first aid, is very
professionally produced, and the advice is
practical rather than didactic. As a quick
overall update of the ABCs, it is simple and
to the point.

Analysis
Presentation 15/20
Comprehensiveness 5/20
Readability 12/20
Relevance 10/20
Evidence basis 10/20
Total 52/100

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CALAENDER OF EVENTS

20th BRUCOSPORT Meeting
19–20 October, 2001; Congress Centre, Brugge, Belgium.

Australian Conference of Science and Medicine in Sport
The theme for the 2001 Australian conference is “2001 A Sports Medicine Odyssey: Challenges, Controversies and Change” and will focus on what the future holds for sports medicine, especially following the Sydney Olympic Games.
Further details: Sports Medicine Australia, PO Box 897, Belconnen ACT 2616, Australia. Tel: +61 2 6230 4650; Fax: +61 2 6230 5908; email: smnat@hma.org.au. Web site: www.sma.org.au

British Association of Sport and Exercise Medicine: 2001 Congress
25–28 October, 2001; Vale of Glamorgan, Wales, UK.
Speakers include: Kirsty Arbuthnott, Richard Busgett, Tom Crisp, Rhondri Evans, Gerry Hagerty, Paul Jackson, Ken Kelly, Ben Kilber, Tony Lewis, Paul Massey, Ron Maughan, Paul McCrory, TK Miller, Nicholas Peirce, and Michael Stroud.
Further details: Mrs Sue Roberts, BASEM Company Office, 12 Greenside Avenue, Frodsham, Cheshire WA6 7SA; Tel/Fax: +44 (0)1928 732 961; email: basesoffice@compuserve.com

New Zealand Sports Medicine Conference
1–4 November 2001; Sky City, Auckland. Keynote speakers are Ken Crichton, Craig Purdham, and Louise Bourke.
Further details: Conference Secretariat, PO Box 6396 Dunedin, New Zealand; Tel: +64 3 477 7887; Fax: +64 3 477 7862; email: smnzsnat@xtra.co.nz

Concussion in Sport
2–3 November 2001; Vienna, Austria. International symposium organized by the International Ice Hockey Federation (IIHF) in cooperation with the International Olympic Committee Medical Committee, and the Federation Internationale de Football Association Medical Assessment and Research Center (F-MARC).
The conference will present scientific information on the epidemiology, on site management, treatment, grading, and prevention of concussion in sport.
Further details: Darlene Scheurich, International Ice Hockey Federation (IIHF), Parking 11, 8002 Zurich, Switzerland. Tel:+41 1 289 8614; Fax: +41 1 2898629; email: scheurich@iihf.com

5th Annual Football Association’s Coaching Association Conference
8 November 2001; Liverpool, UK. Supported by the Football Association and the World Commission of Science and Sports.
Further details: Dr Mark Williams, Research Institute for Sport and Exercise Sciences, Liverpool John Moores University, Henry Cotton Campus, 15–21 Webster Street, Liverpool, L3 2ET, UK. email: m.williams@lvm.ac.uk

II European Federation Sports Medicine Congress
14–17 November 2001; Oviedo, Spain.
Further details: Tel: +34 902 103 873; Fax: +34 902 120 880; email: info@2e3c3.com

Advanced Team Physician Course
6–9 December 2001; Palm Springs, California, USA.
Further details: AOSSM; www.sportsmed.org

Beyond the Horn: Australian Pain Society
24–27 March 2002; Sydney, Australia.
Exploring the journey of pain between the periphery and the brain, from basic clinical practice.
Further details: DC Conferences; Tel: +61 (0)2 9439 6744; e-mail: mail@dconferences.com.au

2nd World Congress Postgraduate Sports Medicine, 8th Int. Congress Science of Sport
23–28 April 2002; Colima, Mexico.
Further details: World Association of Postgraduate Studies in Sports Med; email: deport_medico@infosel.net.mx

6th World Conference on Injury Prevention and Control
12–15 May 2002; Montreal, Canada.
The conference will cover the theme of Injury, Suicide and Violence: Building Knowledge, Policies and Practices to Promote a Safer World.
Further details: www.trauma2002.com

48th ASCM Annual Meeting
XXVI IFSM World Congress
5–9 June 2002; Budapest, Hungary.
Further details: Fax: +36 1 385 2127; email: conventioncentre@pannonialhotels.hu

NOTES AND NEWS

Association news
Members were asked in a recent postal opinion poll if they wished the association to remain a multidisciplinary association. By a majority of over 2 to 1, members voted that BASEM should remain multidisciplinary. A small minority were in favour of a doctors sub group being formed within BASEM. Co-operation is taking place between the British Institute of Musculoskeletal Medicine (BIMM) and BASEM, with the possibility of establishing a joint educational venture.

Memorandum of collaboration between BASEM and BASES
1. This memorandum of collaboration aims to improve the integration of the sports science and sports medicine services provided to British sports people, and to both recreational and health related exercises, by developing a formal working relationship between BASEM and BASES.
2. BASEM and BASES share the common goals of ensuring that all the above client groups receive the world’s best practice in the provision of professional support services, and that optimum value is offered in the pricing of such provision.
3. To facilitate collaboration between the two organisations, each is invited to send a representative to all meetings of the other’s Executive Committee. From time to time, as seems necessary for the pursuit of particular objectives, the Executives will also set up joint working groups.
4. BASEM and BASES will work towards the establishment of interdigitating quality assurance schemes.
5. In pursuit of the preceding objective, BASEM and BASES will expand their participation in one another’s workshops and conferences (facilitating this participation where possible by favourable financial terms) and will collaborate in the establishment of correlated continuous professional development programmes.
6. BASEM and BASES equally recognise the importance of evidence based practice, both in developing scientific and medical interventions in sport and exercise programmes, and in evaluating the effectiveness of such programmes. Thus, they jointly value applied, performance, or well focused research as the essential means of developing innovative forms of intervention. Accordingly, they will work together in pursuit of more generous funding for such research.
7. In all interactions with third parties—individuals, other organisations, or government departments—the two organisations will act with the other’s interests in mind as well as their own, and wherever possible will do so on the basis of mutual consultation.