Warm up

The end of the beginning

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The recent BASEM meeting in Edinburgh highlighted the growing gulf in the future direction of sports medicine that exists in the UK. Whilst the orthopaedic and musculoskeletal aspects of sports injuries have been the traditional focus of sports medicine, there arises the key question as to whether this will be appropriate into the future.

Having received the governmental seal of approval that SEM will be a stand alone specialty, the view of most sports physicians at the meeting was that they could see themselves seeing sports injuries either in a referral based consultant practice or a NHS funded outpatient clinic. The aim therefore is to get as many training positions as possible within the NHS.

Is this medical view of SEM as sports traumatologists likely to be the final product of what an SEM physician will be? I doubt it. I suspect that the SEM physician five or ten years from now will be a radically different beast from what exists now.

What will drive this change? The UK government through its various agencies has clearly been looking at the role of increasing exercise and physical activity as a solution, at least in part, to the spiralling burden of chronic illness in society.[1] One of the fundamental gulfs that exist between the sports physicians and governmental mandarins is that sports physicians are still thinking in an injury model of sport rather than a model of physical activity and health.

Why so? To the government it is clear. Obesity has increased to the point where nearly two thirds of men and over half of women in the UK are classified as overweight or obese. By 2010 it is estimated that one in four adults will be obese. In 2001, the UK National Audit Office estimated that obesity accounted for 18 million days of sickness absence, 30 000 premature deaths, and annual health costs of over £2.5 billion.[2]

We see the same problems in children. The year on year increase in childhood obesity and the fact that the UK ranks below the EU average in terms of meeting minimum physical activity targets of 2 hours per week in school has the potential to result in an epidemic of chronic disease in the future.

In 2002, the UK General Household Survey revealed that only 15% of adults met the target of sports participation three times per week. A staggering 66% managed sport only once per year. The trends from 1990 to 2002 also suggest that sports participation is falling rather than increasing.

Why then should we be surprised if the government, who in the end determine the funding for SEM, dictates the manner by which SEM physicians develop? It should seem fairly obvious to civil servants and their political masters that encouraging physical activity (rather than organised sport) has to be the way forward. Campaigns in Finland and other countries have demonstrated that community campaigns can significantly increase exercise participation and reduce the burden of medical disease and in turn health costs.

The idea that ''sport'' is the answer is shortsighted. Sport, by its very nature, is inherently restrictive. By sport, I mean where rules and organisation applies to the performance of the activity. Only a small percentage of individuals will ever participate in sport and this is even more limited at the elite end of performance. Strange isn't it that virtually the whole focus of sports and exercise medicine currently is devoted to the top few percent of gifted athletes.

Physical activity by contrast is what the population at large need. This ideally should be low cost, available to all, easy to access (eg walking), cause minimal injuries, and have beneficial health effects. It has been estimated that for every 1% increase in physical activity at a population level, £3.6 million could be saved in direct health care costs of the three major diseases (coronary artery disease, Type 2 diabetes, and colon cancer). Why then would we not do this?

So what to the government need? They need a cohort of SEM practitioners who can prescribe exercise both to healthy children and adults but also are capable of exercise prescription in disease states (as well as in the overweight and obese). They will need SEM practitioners to be advocates for a healthy society where school, primary care trusts, and local governmental initiatives can be incorporated into national health priorities. The role of sports injury will certainly need to be dealt with and as more people hopefully increase there exercise then there will be more injuries to deal with. This, however, becomes a secondary issue in the bigger picture.

So what does SEM need to do? Firstly, they need to change their thinking model from sport to activity, from disease to health, from injury to exercise. Only then will they start to be seeing the problem from the same view as the government. SEM, through BASEM, needs to equip it's practitioners with the tools to be able to provide exercise prescription, to advocate at community levels for health initiatives and to teach other practitioners (eg GPs) how to provide exercise referrals. Annual conferences need to focus on these areas and we all need to interface more with governmental decision makers in order to be seen as the vehicle for change and not the obstacle.

Sports medicine was largely born out of orthopaedic medicine and to that extent, I think we are witnessing the end of the beginning not the beginning of the end. The future may be bright but will still take a lot of hard work to change the hearts and minds of those involved to realse that our future marketplace is in health not sport.

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REFERENCES

1 **Raising the bar**. The final report of the independent sports review. September 2005. (www.independentsportsreview.co.uk).
2 **UK National Audit Office**. Tackling Obesity in England. February, 2001.