

Bitter contemplation before the road to specialist sport and exercise medicine recognition... and the challenges ahead?

David C Hughes

It was May 1991 and I was sitting in 'The Good Samaritan', a pub behind The London Hospital in Whitechapel. I was staring into my pint of 'Bitter' with a sense of a brooding contemplation. With me were the three other members of my study group, British doctors Mark Batt, Ian McCurdie and Phil Bell. We had just completed the graduation ceremony for our Diploma of Sports Medicine. The elation and euphoria of having successfully completed a formative year of study was giving way to more serious thoughts of the future. For each of us, the unsettling question kept raising its head. 'What's next?'

In 1991, there was no clear pathway in the UK for sports medicine specialist recognition and certainly no pathway that included recognition within the National Health Service. In Australia and New Zealand, the Australasian College of Sports Physicians (ACSP) was just about to hold its first Part II Fellowship Examination, providing its inaugural cohort of Foundation Fellows but there was no formal training programme and also no recognition of Sport and Exercise Medicine (SEM) under the Australian or New Zealand medical systems. The year of study in London had given each of us a tantalising taste of what could possibly be. A career in sports medicine was the goal but the path ahead looked uncertain and insecure.

We each sought further training, ending up on very different paths. Mark Batt headed across the Atlantic for a Fellowship in Sports Medicine at the University of California, Davis. Ian McCurdie retrained as a Consultant in Rheumatology and Rehabilitation with the British Army and Phil Bell headed off into the private sector, starting with a training position at the

London Bridge Hospital, before becoming Clinical Director of Musculoskeletal Services at Barbican Health and then joining BUPA Wellness. I headed back down under to a research position at the Australian Institute of Sport, finding myself unexpectedly in the right place at the right time to gain entry as part of the first intake of the new ACSP advanced training programme.

2011 – SPORTS AND EXERCISE MEDICINE LANDSCAPE

Twenty years on and the landscape has changed considerably. In both hemispheres there has been a lot of toil and sweat. There have been times of heartache and despair as huge amounts of work have seemingly come to nothing down bureaucratic blind alleys. But the determination of SEM pioneers in Australasia and the UK slowly but surely chiselled a path forward. The same Fellowship of the ACSP is awarded to Australians and New Zealanders but it was the Kiwi brethren who first struck the mother lode with specialist recognition by the Medical Council of New Zealand in 1999. Those of us on the wrong side of the ditch (depending on who you are talking to), despite being awarded the same Fellowship as the New Zealanders, could only look on in admiration (and perhaps a little envy) as the Kiwi SEM Physicians engaged with the New Zealand health system as fully fledged specialists. At the same time, the Australian Fellows continued to negotiate with an endless merry-go-round of health bureaucrats who ducked and weaved to avoid answering the difficult questions.

I had the good fortune to work as an SEM physician in the UK in 2003 and 2004. Again my timing was fortuitous, as it was shortly after my return to the 'old dart' that UK Sport set up a Working Group for the recognition of SEM as a medical specialty in the UK. This was a time of great activity and progress for SEM in the UK. The incorporation of

representatives of the Department of Health and the Department of Culture, Media and Sport into the working group was a stroke of genius. The progress from the initial discussion group meeting in early 2003 to specialist recognition in 2005 was astounding. In Australia, the government finally saw fit to recognise SEM as a specialist area of medical knowledge in 2009 with Fellows of the ACSP gaining specialist recognition under the Australian Medicare system on 1 November, 2010.

It would be nice to think that we could all sit back and enjoy our new-found specialist status but it is abundantly clear to anyone involved in the governance of Faculty of Sport and Exercise Medicine (FSEM) (UK) or ACSP that we have really just have finished 'the beginning' and are commencing the next phase in the evolution of SEM. Chris Milne¹ (*see page 945*) provides us with a timely reminder that practicing as an SEM specialist is not a matter of remuneration or status but a matter of professional conduct.

Such conduct includes appropriate use of the healthcare dollar. Public perception of the ability of SEM specialists to deliver a quick fix high-tech answer for presenting complaints is driven by distorted media reports of events in the world of elite sport. Not only are SEM specialists beholden to make appropriate choices with use of expensive imaging modalities such as MRI, but as a specialist craft group, we must convince governments that the 'best buy in public health' lies in exercise-based preventive strategies² rather than hugely expensive novel ways to prolong life (or delay death).

While contemplating the future of SEM, one wonders whether there will ever be an SEM conference anywhere in the world where there is not a session devoted to treatment of recalcitrant tendinopathy. The paper by Creaney *et al*³ (*see page 966*) comparing PRP and autologous blood injections for recalcitrant lateral epicondylitis of the elbow is another step along the way to understanding the role of different types of blood product injections and whether one is superior to another. Moving down to the knee, Ryan *et al*⁴ (*see page 972*) present results of injecting patellar tendinopathy with dextrose. Decreased pain scores at 45 weeks is certainly better than no improvement but a total knee replacement would also improve the pain of patellar tendinopathy at 45 weeks. Yet this is not a treatment I would recommend for my patients. We need to keep pushing for studies with control groups. An example of a lovely

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randomised controlled trial study design comes from Germany, where investigators showed that a custom-made semi-rigid orthotic provided superior pain and comfort scores for runners with lower limb injuries⁵ (see page 959).

There has been much work on the links between repetitive pitching and upper limb pathology in baseball, and I appreciated Richard Saw *et al*⁶ producing hard data in relation to upper limb injury and throwing load in cricketers (last month's *BJSM*). One of the difficulties in converting these data into change of coaching practice will be the fact that many of the injured cricketers are able to continue playing despite the upper limb injury. As is the case in all sports, the injuries that cause athletes to miss games are those that grab the coach's attention.

COMPARTMENT SYNDROME – STILL UNRESOLVED

One of the first sports medicine-specific skills I was taught when I started working at the Australian Institute of Sport in 1992 was lower leg intracompartmental pressure testing for chronic exertional compartment syndrome. Almost 20 years later, there is still no clear agreement on appropriate protocol for conducting this common and important procedure. Debate remains as to (1) whether resting compartment pressures are required, (2) whether all four compartments need to be tested in the symptomatic lower leg and (3) whether both legs need to be tested if symptoms are similar bilaterally. Dr Matt Hislop and Professor Mark Batt⁷

(see page 952) put the case for reducing the numbers of needle insertions and combining the testing data with the clinical presentation to decide which compartments need decompression. On the other hand, Professor Mark Hutchinson⁸ (see page 954) takes the view that the more information one has from compartment pressure testing, the more certain one can be when deciding on the appropriateness or otherwise of surgical decompression.

INTO THE LOOKING GLASS

SEM has established itself as a medical specialty in UK, Australia and New Zealand over the past decade. Challenges in the coming years include establishing how SEM fits into the wider medical specialist network with equitable access to the consultant posts and training support enjoyed by other specialties. In the past, ACSP and FSEM (UK) have forged their own paths in parallel. When the UK's Mark Batt presented at the ACSP conference in Couran Cove in November 2010, it struck me that FSEM (UK) and ACSP are coming up against the same obstacles and having the same debates in a comparable but rather disconnected fashion. FSEM (UK) and ACSP have many common goals and aspirations and much to learn from each other. I suspect that our colleagues in the Netherlands (October *BJSM*), South Africa (June *BJSM*), Canada and the United States (AMSSM, November *BJSM*) share similar aspirations and challenges.

Specialist recognition of SEM is a big step forward but has brought with it a range of other issues, some of which were

unanticipated. There is enormous potential for collaboration and cross-pollination (perhaps poly-nation) in a range of areas. I strongly believe that FSEM (UK) and ACSP (with similar organisations from other countries) should travel the road ahead not as like-minded strangers, but as colleagues in arms.

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