SPORTS INJURIES – THE CASE FOR SPECIALISED CLINICS IN THE UNITED KINGDOM

J. G. P. WILLIAMS, F.R.C.S., D.Phys.Med.

Secretary General F.I.M.S., Farnham Park Rehabilitation Centre, Slough, Bucks.

Introduction

It appears to be a matter of Government policy to encourage participation in sport at all levels throughout the United Kingdom (1). This is perhaps not surprising in view of the universal movement towards what is known colloquially as "health sport for all". Increased participation in sport is reflected in figures collected by the Central Council of Physical Recreation (2) and more recently by the Sports Council. Inevitably, with increased participation in sport, there has been a commensurate increase in the number of injuries produced. It is therefore necessary to consider whether any further provision needs to be specially made for the treatment of injuries arising from sport.

Incidence

It is difficult to arrive at an accurate figure for the incidence of sporting injuries in the United Kingdom. Various pilot studies have been undertaken, including those of Robson and Williams (3), Morris (4) and more recently Weightman and Browne (5). It appears that approximately five percent (5%) of all cases seen in accident departments of British hospitals are due to a sporting injury. It has been estimated that the annual injury rate throughout the United Kingdom is of the order of magnitude of two million injuries of sufficient severity to preclude the victim from participating in sport for at least one week. Of these it is estimated that some ten percent (10%) involve time off work. The size of the problem is therefore quite considerable.

Injury type

Injuries in sport may be classified in a number of different ways. A recent classification is of interest in the present context since it relates injury to aetiology (6). Not surprisingly the aetiology of the injury largely determines its pathological type and severity.

From a logistic point of view sporting injuries may be divided into two basic groups. The first group includes all those injuries which are common to other activities as well as to sport. The fact that many of the injuries produced in sport are similar to those encountered in normal casualty practice has given rise in the past to considerable confusion; a number of well-known orthopaedic surgeons, including for example Smillie (7) and Wilson (8), have in all good faith erroneously described such injuries as "sports injuries" rather than as

"injuries occurring in sport", thereby unconsciously contributing to false assertions of adequacy with regard to the treatment facilities for those true "sports injuries" which in fact they may seldom see!

The second group includes the injuries which are peculiar to sport alone and which occur as a result of those stresses and strains applied in sport (or in training for sport) which are not generally applied in other areas of human activity. This second group specifically includes the injuries falling within the category of "overuse injury", together with a number of rather specialised acute incidental injuries arising from biomechanical stresses involved in certain specific sports activities (9). It is relatively less common for injuries in this latter group to present in general orthopaedic clinics, so that orthopaedic and casualty surgeons tend to get an unbalanced view of the spectrum of injuries in sport. It is to this latter group only that the term "sports injury" should properly be applied.

The relative sizes of these two groups is not easy to assess and will depend to some extent on selection, i.e. local patterns of sports activity. Another example of selection is seen in Sperryn's figures where, as he himself admits, he has a particular interest in the injuries arising from track and field athletics (10). The most useful source of general statistics, although somewhat out of date is La Cava (11) whose figures are derived from the Italian National Insurance Institute for Athletes. Of other figures published in the United Kingdom those of Bass (12) are too small and selective to be of any significance while those of Newman and his co-workers (13) are meaningless in the context of incidence, although of great importance in one other aspect (q.v. below). The fact that the victim of injury is a fit trained subject rather than an unfit sedentary one may to some extent influence the clinical behaviour of the injury (14).

Perhaps the most significant figures in the present context are however those of Sperryn (10) and of Newman and his co-workers (13). In Sperryn's series the time lag between injury and attendance at a specialised sportsman's clinic was over three months in about one-third of all cases (29.7%) whilst in Newman's series this figure was as high as fifty-four percent (54%). This discrepancy can be explained on a basis of the way these two different clinics are run. What is significant is that so many sportsmen and women come to specialised clinics late after failing to obtain effective treatment in

ordinary N.H.S. clinics. This is important not only in terms of human suffering but also in terms of cost effectiveness. For example, recently a county rugby player attended a special Sportsmen's Clinic. He had previously attended a well-known orthopaedic hospital for several months following a knee injury diagnosed as "I.D.K.". Following failure to respond to physiotherapy, plaster cylinder, etc. he had been threatened with an arthrotomy. When he came to the Sportsmen's Clinic he was seeking advice as to whether to submit to this procedure. It transpired that he actually had a chronic biceps insertion strain (15) and one week after a single injection of hydrocortisone and local anaesthetic he was back in full training, symptom-free! It is interesting to note that a high proportion of patients eventually require only very simple remedies and advice and this experience is borne out by Sperryn (10).

It has been argued that it is for the sports themselves to provide medical cover for their own participants, but this of course they cannot do unless the specialist advice is available. From a study of all available published material, together with figures from local hospital casualty departments and sportsmen's clinics it appears reasonable to suggest that on average about one quarter (25%) of all injuries in sport fall into the latter category of true sports injuries. For the present therefore it seems also reasonable to suggest that the development of clinics where special advice and care can be given for these peculiar and special conditions should be encouraged, and to invite the Department of Health and Social Security to lend support to clinical services of this type where they exist already on the "centres of excellence" basis.

Recruitment of Special Services

Nowadays there is nothing whatever to stop almost any clinician in consultant N.H.S. hospital practice from developing an interest and a clinical service in the area of sports medicine. In practice however, there are very few clinicians who have developed this interest.

It is a fact that at the present time there is a considerable "fringe interest" in sports medicine. It must be accepted that on the whole the standard of medical care available for sportsmen and women in the United Kingdom is low, one of the reasons being that a number of medically qualified people have sought to provide advisory or treatment services which they are not properly qualified to undertake.

Countless examples of wasted effort and mismanagement of sports injuries come to light in sportsmen's clinics. The cause is not negligence or ill will, it is simply ignorance. The risk then in mushroom sports medicine services is of the upsurge of the "instant expert" who has so little background training or experience not only in the clinical aspects of the sport

but in the physiology of its training and in its biomechanics that he is in fact too ignorant to appreciate his own ignorance. Sportsmen treated by such so-called "instant experts" may in fact end up worse off than if they had received no "medical" care at all.

It would appear axiomatic therefore that official support, if it is to be given at all should be reserved for those who by any normal standards can clearly be recognised as offering a particular knowledge, experience and expertise (16). It is suggested that this expertise can be recognised by a number of features. They are:—

1. *Commitment* — a clinician with a genuine and continuing interest in the care and management of sports injuries will have committed himself or herself to the art to the extent of having already demonstrated over a period of time (years rather than months) his or her interest by the running of consultant clinics and by achieving a regular patient turn-over such as would clearly provide the experience required to support the claimed level of expertise.
2. *Academic activity* — this includes publication, teaching, lecturing (at pre- and post graduate clinical and also non-clinical level) and research. The committed clinician with an interest in sports medicine will have published work in this field either in one of the regular clinical journals or in one of the more specialist national or international sports medical journals. He or she will also have been involved in a regular series of lectures and other teaching activities and should also as a result of live personal interest and study have made some contribution to the art. It would be difficult to accept expertise in any clinician who has not achieved in this field at least some minimal participation in corporate sports medical activities. In the United Kingdom there has existed for nearly twenty years a national sports medical association (The British Association of Sport and Medicine) which offers membership on application to any qualified registered medical practitioner with an interest in the field. Participation in its activities and in other sports medical meetings, both in the United Kingdom and abroad, would indicate an expected level of interest in this field.
3. *Professional recognition* — this involves recognition by other individuals themselves known and recognised to be interested in the field of clinical sports medicine, both in the United Kingdom and abroad.

By these criteria the number of individuals who could immediately claim recognition in the United Kingdom is quite small. There are however enough of such individuals to whom initial support could be given to

provide for a fairly wide scatter of focal clinics at least as a first stage in the development of specialist cover throughout the country. It is suggested that the provision of such cover, combined with improvements in the level of the casualty service generally would have the effect of reducing the morbidity of injury in sport,

including particularly true sports injuries, from both the long and the short term. It would relieve also some of the burden of the N.H.S. caused by the prescription to sportsmen of inappropriate, expensive, time-consuming and ineffectual treatments.

REFERENCES

1. SPORTS COUNCIL (1972) "Sport for All".
2. BIRCH, J. G. (1968) "Current trends in sport and physical recreation in Great Britain", *C.C.P.R.*
3. ROBSON, H. E. and WILLIAMS, J. G. P. (1961) "Sports Injuries Survey", Communication to B.A.S.M.
4. MORRIS, M. (1963) "A Sports Injuries Survey of Greater Birmingham", *Phys.Ed.*, **55**, 41.
5. WEIGHTMAN, Doris and BROWNE, R. C. (1974) "Injuries in Rugby and Association Football", *Brit.J.Sports Med.*, **8**, 183.
6. WILLIAMS, J. G. P. (1971) "Aetiological classification of injuries in sportsmen", *Brit.J.of Sports Med.*, **5**, 228.
7. SMILLIE, I. S. (1969) "Knee injuries in athletes", *Proc.R.Society Med.*, **62**, 937.
8. WILSON, J. S. (1972) "Specific Injuries of Sport", *Physiotherapy*, **58**, 194.
9. WILLIAMS, J. G. P. and SPERRY, P. N. (1972) "Overuse injury in sport and work", *Brit.J.Sports Med.*, **6**, 50, (originally presented *Sec.Occup.Med.R.Soc.Med.*).
10. SPERRY, P. N. (1972) "Athletic Injuries", *Rheum.Phys.Med.*, **XI**, 246.
11. LA CAVA, G. (1961) "A clinical and statistical investigation of traumatic lesions due to sport", *J.Sport Med.Phys.Fit.*, **1**, 8.
12. a) BASS, A. L. (1966) "Rehabilitation after soft tissue trauma", *Proc.R.Soc.Med.*, **59**, 653.
b) BASS, A. L. (1967) "Injuries of leg in football and ballet", *Proc.R.Soc.Med.*, **60**, 527.
13. NEWMAN, P. H., et. al. (1969) "A clinic for athletes' injuries", *Proc.R.Soc.Med.*, **62**, 939.
14. WILLIAMS, J. G. P. (1962) "Rehabilitation of injured athletes and sportsmen", *Practitioner*, **189**, 335.
15. WILLIAMS, J. G. P. (1971) "Diagnostic pitfalls in the sportsmen's knee", *Proc.R.Soc.Med.*, **64**, 640.
16. NEWTON, D. L. (1975) "The future of sports medicine — Consultant Training", *Brit.J.Sports Med.*, **9**