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Why sports injury clinics?

Sport is a ritualised form of war, a competitive activity in which dominance by force is the objective. It shares with warfare the skirmishes, pitched battles, the wounded, and even the dead. Fitness and health are, by contrast, non-competitive and individual. One result of health education has been to blur, particularly for the active young, the distinction between fitness and health, and the ability to play sport. Two unfortunate ideas have followed: firstly, that you cannot be fit unless you play sport; secondly, that the way to become fit and healthy is to play sport.

Our recent review in Bristol showed that only 3% of local sports people are of regional or national class—the remainder play at club level or below. A quarter of those playing sport did so more than once a week, and, although a quarter of those playing sport get into condition to play sport, the remaining three quarters play sport to keep fit. It is of little surprise therefore that about one in 10 of the sporting population are injured every year (H E Robson and J G P Williams, communication to the British Association of Sports Medicine, 1961). Between 2.5% and 10% of attendances at accident and emergency clinics follow acute sport injuries (P G Stableforth, unpublished observations).^{1,3}

Sports people suffering acute injury rarely become dependent on others for activities of daily living, but we have found locally that one in two is in full time employment and that three out of four of these workers is losing on average 10 days from work. This fits with other studies and shows the need for prompt and effective treatment.^{2,3} To provide a specialist service nationally has been shown to be expensive,⁴ but a few patients do need immediate care by a sports injury specialist because of their calibre, their job, or the uniqueness of their lesion. Four fifths of the patients, however, have injuries identical to those sustained after home, road, or work accidents and require the same management. The perceived deficiencies in the care of those injured by sport⁵ should thus be a spur to improving general trauma care and providing injury prevention, counselling, and rehabilitation services. They should not be used as a justification for fragmenting care.

Those injured by sport may also present with chronic or relapsing musculoskeletal disorders that interfere only with their chosen sport, or with problems unique to particular training regimens or sporting activities. These patients may find general practitioners impatient when simple remedies fail, casualty officers too inexperienced, and hospital seniors dismissive. For this group clinics run by interested specialists have been shown to be effective. They lessen the number of conflicting diagnoses offered by the many "experts" who pack the dressing rooms of sports clubs.^{2,5,6} These patients deserve a specialist service that will give them accurate diagnosis and specialist treatment and advise on reconditioning, retraining in motor skills, and when to return to the sport.^{3,5,7} This national network of

interested doctors should advise sports people not only on sports injuries but also on general health and nutrition, training regimens, and sport programmes. They would be best able to advise people that the time has come to stop their sport altogether if progressive harm is to be avoided.

Who should offer this advice? Commitment to sports people and a thorough training in sports medicine are much more important than the holding of any particular post: general practitioners, surgical trainees, clinical assistants, and consultants in rheumatology and orthopaedics are already working in this discipline. Their primary requirements are time and access to well staffed diagnostic and treatment facilities. Those who are not working in specialised rehabilitation units or in hospital need the support of colleagues who do for referral of patients. The hospital based specialists should provide the academic background and should spread the new ideas and the proved methods of treatment that are necessary for the sports injury service to thrive.

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Understanding the causes of diseases

Epidemiological methods are used to indicate whether exposure to this or that is (or is not) implicated in the aetiology of this or that disease. Students of the published work in epidemiology will be aware that for some disease associations there is much more controversy than for others. This is not surprising because defining the cause from observational data, with all their opportunities for selection and bias, will rarely be straightforward.

Classic epidemiological method has therefore rightly emphasised the dangers of confounding in interpreting observed disease associations. Hence, though the chance of having a baby with Down's syndrome is unambiguously associated with parity, in that on average women of high parity have a much higher risk than those of low parity, it becomes immediately clear on standardisation for maternal age that parity itself has nothing to do with the risk. Similarly, in all other comparisons of incidence with time, place, and any other interesting characterisation of groups of people it is necessary to standardise for age at least. All diseases have some relation between incidence and age, and comparing rates of any disease between elderly and middle aged people is rarely interesting from an aetiological point of view, except to illustrate this age association.

Hence most comparisons of the incidence of disease are made after age standardisation. Typically this means comparing standardised mortality or morbidity ratios, which are summary statistics using indirect age (and sex)