ISSUE 61 – WINTER 2022

BASEM TODAY

ALLIED HEALTH PROFESSIONS IN SEM -

Identifying the bright spots and areas for future progress

THE NEWSLETTER OF THE BRITISH ASSOCIATION OF SPORT AND EXERCISE MEDICINE

BAsem
British Association of Sport & Exercise Medicine

THIS EDITION IS GUEST-EDITED
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CONSULTANT PHYSIOTHERAPIST
AND SENIOR LECTURER

BASEM TODAY

THE NEWSLETTER OF THE BRITISH ASSOCIATION OF SPORT AND EXERCISE MEDICINE

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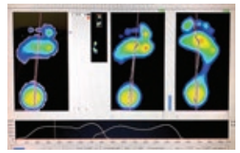
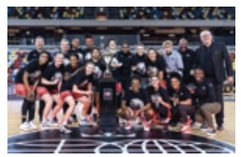
British Association of Sport & Exercise Medicine

WELCOME TO BASEM TODAY, ISSUE 61





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BASEM TODAY

A digest of news about the Association and its members

ALLIED HEALTH PROFESSIONS IN SEM - IDENTIFYING THE BRIGHT SPOTS AND AREAS FOR FUTURE PROGRESS

'Ally', the verb meaning to combine or unite a resource or commodity with (another) for mutual benefit, is very apt in this context. The collection of professionals who have eloquently contributed to this edition of BASEM today highlight the methods, and need, for unity to maximally benefit the athlete. It has been a great insight into the diversity of roles and skill sets that different individuals can bring to a multi-professional team, but also the methods that they adopt to ensure that they grow as individuals but also as valuable team members.

I am fortunate to work in multiple environments where I am part of a multi-professional team, working collaboratively to achieve the very best outcomes. Academically, as lead of the post-graduate programme in SEM at Queen Mary University, the team of clinicians and academics work exceptionally hard to ensure that the programme we deliver has a meaningful impact on the students (clinical professionals) that embark on this challenging programme of study. Clinically, at the University of East London, we look after high performance athletes and the London Lions professional basketball team. This phenomenal group of athletes are well served by an MDT comprising of physiotherapists, sports therapists, an osteopath, and an SEM doctor. The clinical-academic role at Pure Sports Medicine is the final highlight of my working work. An MDT in every clinic and a group of driven professionals to improve the care of our patients.

The demand for the highest quality allied health professionals, within sporting teams, managing sporting injuries and working within sports medicine facilities has increased significantly. The skills that this group of professionals have been developing is increasing, informed by the science and driven by athletes' pursuit of improvement. The purpose of the reports included in this edition is to identify the 'bright spots' that exist within the allied health professions and to understand where there is scope for future improvements.

I hope that you enjoy what they have to say.

Dr Simon Lack (PhD)
Consultant Physiotherapist and Senior Lecturer

THE BASEM NOTICE BOARD
Forthcoming Meetings - 2022 | 2023

BASEM Meetings
Further info at: www.basem.co.uk
(under Education)

- **BASEM Annual Conference**
  Emirates Old Trafford Cricket Ground
  5th-6th October 2023
  Pre-register your interest: *https://basem.co.uk/event/basem-2023-annual-conference/*

External SEM Meetings
Further info at: www.basem.co.uk
(under News and Events)

- **10th Podiatric Sports Medicine Conference**
  8th & 9th December 2022,
  Royal College of Surgeons of Glasgow
  Booking URL: *Royal College of Podiatry (rcpod.org.uk)*

- **Functional Rehabilitation for Return to Sport**
  10th and 11th December 2022, Essex
  Booking URL: *Functional Rehabilitation for Return to Sport - 10th - 11th December, Essex - Courses (physios-insport.org)*

- **International Conference on Sport Medicine and Sport Science (ICSMSS)**
  15th and 16th December 2022, Rome, Italy
  Booking URL: *International Conference on Sport Medicine and Sport Science ICSMSS in December 2022 in Rome (waset.org)*

- **ISENC 2022**
  18th – 20th December 2022,
  Manchester Metropolitan University
  Booking URL: *ISENC – International Sport and Exercise Nutrition Conference – Europe's premier exercise and sport nutrition conference*

2023

- **Professional Use of Social Media in Sport and Exercise Medicine**
  25th January 2023, Free Webinar
  Booking URL: *The Professional use of Social Media in Sport and Exercise Medicine - The Faculty of Sport and Exercise Medicine (fsem.ac.uk)*

- **The Royal Society of Medicine Musculoskeletal Examination Masterclass**
  27th February 2023, The Royal Society of Medicine, Wimpole Street, London
  Booking URL: *Sport & Exercise Medicine Section | The Royal Society of Medicine (rsm.ac.uk)*

BASEM NEWS

CEO BLOG - A YEAR IN POST

Article by **Lynda Phillips** Chief Executive Officer

A year ago, I stepped into an organisation as their first ever CEO. Having previously worked for a Primary Care Trust, I knew a little about the medical world, however I had a lot to learn. Once I got my head around a few of the many acronyms, I still needed to understand how everything fits together and where BASEM sat within the bigger picture. And this has posed a great challenge over the last year, mostly because SEM is constantly moving, developing, and with it, so do all the people involved. What has struck me is how supportive and inspiring SEM professionals are, to each other and to the sector. People in SEM work hard.

At my first interview, I thought there would be a mention of a huge team at BASEM. I was amazed to find that there were just two part-time employees (Lucy and Amanda), supported by a freelance marketeer (Ian) and graphic designer (Kevin). Their incredible achievements, supporting members, offering a great membership package, delivering quality events, managing awards, managing BASEM's buildings, liaising with partners, contract management, supporting the Board and committees – you name it, they were doing it. The strength of the staff at BASEM wowed me then, and still does now.

One of my first projects was to develop our strategic plan. Involving Board, staff and key stakeholders, the vision for the next three years was put in place. The challenge is always to keep everyone focused on strategy and vision, rather than the detail. This first year was focused around putting down firm foundations for us to build upon. I was keen to get structures in place to support the team more, and enable a dedicated, voluntary Board to focus on governance, rather than supporting day-to-day running. My first months were spent revising and establishing policies, setting budgets, sorting our accounts, and reviewing all contracts we had with partners and suppliers.

Due to COVID and time restraints, there were several activities that had been put on hold, so I was keen to review these and start working on them. It was clear that we needed additional staff support, so along came Debbie to support with accounts and the running of the office, and Jemma to work in membership communications. Additional processes were put in place such as regular reviews for staff, and policies to support working arrangements around family commitments.

With many of the foundations now in place, I am turning my attention to the next step of our plan, which is to start building. I always come back to two questions:

1. **What will best serve BASEM's mission and objects?**
2. **What actions will have the most impact, to members, to the development of SEM and to the public?**

I am keen to retain BASEM's history. BASEM has done so much for SEM; it would be very sad if any of its achievements were forgotten. Additionally, BASEM has learnt so much, which can be shared to support the worldwide development of SEM. I am a great supporter of collaboration to achieve mutual aims. Our members individually have much to bring to the table and BASEM needs to create opportunities for members to contribute to supporting BASEM's mission.

The vision is to be able to give members a voice, promote our members' work, promote developments in SEM, and influence SEM's future, making it more accessible to everyone.

BASEM is an organisation members can be proud to be associated with and staff and volunteers can be proud to work for.

Lynda Phillips, BASEM CEO

Twitter: @BASEMCEO
LinkedIn: lyndaphillipsbasem

OBJECTIVES FOR 3 YEAR PLAN

SPECIFIC	MEASURABLE	REALISTIC	ACTION-BASED	TIMED
Build our reputation as the 'go to' organisation for SEM careers support for members	We will measure this through membership growth and strategic partnerships	BASEM is viewed fondly by members and has a place in SEM. This can easily grow over the three years as we clarify our vision and promote BASEM's work	We will do this by clarifying our vision and promoting our work through specific marketing activities	2-3 years
Become member-focused, with all our resources and activities based around member needs	All resources will be linked back to member needs research, with business / strategic reasons for a resource being in place	The needs of the membership can be assessed through Board expertise in gaps in SEM resources, member feedback through surveys, SIGs, courses and events and partner agencies	Drawing on knowledge from Board and working groups, obtaining member feedback through a variety of means	0-3 years
Encourage greater member involvement, providing them with opportunities to further their learning through involvement at BASEM	This will be measured by the number of members involved in different aspects of BASEM's membership offer	We will go out to members to seek their support All new / joining members will be advised how they can get involved	The resources will be in place to ensure we can support members through this process	0-3 years
Have built the organisation to be able to adapt and be responsive to opportunities to further support members	We will have an offer that everyone is clear on All policies and processes will be mapped out Resources will be in place to achieve our aims New opportunities are put through a business case assessment	Appropriate research and planning, with actions taken based on plans	It takes time to lay the foundations, but if they are put in place at the start, they can be more easily built upon	3 years
Have developed a strong, well-led, driven organisation with a clear vision	Strategic plan developed Operational plans aligned with the strategic plan developed and worked to Structures, policies and procedures in place and being followed	Development of plans, policies, processes Clear communication Involvement of staff and Board in organisational development Promotion of what we are doing takes place	There is a desire for BASEM to succeed amongst staff, Trustees, volunteers and members. This makes this all the more achievable if the plans are in place and progress is reviewed	2-3 years
Understand and increase our impact	Promotion of our current impact Plans for increasing impact	Looking at our impact Vs organisational resource / effort Business cases for decisions Identifying and filling gaps where needed	Processes for assessing our offer will need to be in place to make this realistic	1-3 years

WE WOULD LOVE TO HEAR FROM YOU!

We would love to include your stories and experiences in the news pages of **BASEM Today**. This is the place to tell other members of your achievements and adventures. You can include weddings, births, holidays, opinions on current subjects, or, just let us know your thoughts on BASEM Membership and BASEM Today...
Please send your articles and pictures to Jemma at: **membership@basem.co.uk**

THE BASEM POETRY CORNER

GOLFING YIPS

His Tee shots were outstanding,
His bunker play 'top drawer',
Approach work others envied,
So who could ask for more?

But once upon the velvet 'Green'
His smile became a frown,
The 'Yips' would grab him by the. . .
His putting let him down.

Friends all tried to help him,
'It's just the way you stand!'
As he putted straight across the 'Green',
Into the waiting sand.

He'd tried with twenty different grips,
But nothing cured this ill,
They say that when you have the 'Yips',
You seem to lose the will
to ever sink a 'Birdie',
Let alone an 'Eagle' putt,
His card was marked 'If Only',
Left stranded in this rut.

The cure came unexpectedly,
"A 'Monkey' your next play",
He sank a forty footer,
And his friends still rue the day!

A Sandwich Man

image: drobotdean_freekpik.com

IN MEMORIAM

A TRIBUTE TO DR RICHARD USHER

Dr Richard Usher passed away in October from pneumonia secondary to Motor Neurone Disease. Richard was a great rugby man, team doctor and general practitioner in Macclesfield. Richard had a trial for England schools as a scrum half in 1976 and was an outstanding scrum-half for Macclesfield, scoring what is regarded to be one of the most important tries ever for the Club, when they beat Sale in the final of the Cheshire Cup – the first time Sale had ever been beaten in the Cup.

Richard started working with the RFU U16 side in 1997 and subsequently worked as the team doctor for England students and age-group teams for many years. He also worked for women's hockey. He was an Area Medical Officer for the 2015 Rugby World Cup and a key member of the 2016 U20 Rugby World Cup Medical team in Manchester.

In 2011 he joined Team Sky and led the Team Sky and subsequently the Ineos Grenadiers cycling medical service until standing down early this year. He led the medical support of the team during their years of unprecedented success in the Grand Tours and was always available for riders, team staff and their families.

Richard was a much loved colleague and friend to many in the rugby medical family. He was always professional, consistently empathic and had a wonderful sense of fun. He will be hugely missed.

SPORTS TRIVIA QUIZ

PARIS 2024

PARIS 2024

The IOC is keen to set a new standard for inclusive, gender-balanced and youth-centred games. So for any budding athletes who want to prepare for Paris 2024, the questions in this edition are centred on the Olympics.

Question 1.
What are the new sports to be included in the 2024 Olympic Games in Paris and which one has not appeared as a demonstration sport in previous Games?

Question 2.
Where does Great Britain stand in the overall Olympic medals table?

Question 3.
Why was the 1904 Olympic Marathon so contentious?

Answers can be found on page 40

BASEM PEOPLE

A short report on Golf and Health Conference -July 2022

ARTICLE BY **DR JANE DUNBAR**

On 18th & 19th July I attended the 2nd International Congress on Golf and Health, this time held at the Royal College of Surgeons in Edinburgh

As a golfer from a golfing family I have always been aware of the health benefits of golf and was interested to hear not only about the new evidence, to prove what we already knew, but how the industry and government were working to increase physical activity, and how they think they can increase participation at non elite level outwith elitist clubs.

One of the best aspects of this short conference was the networking of the R&A, DP World/European Tour Golf Doctors, Scottish Government and W.H.O. highlighting golf's health and wellbeing benefits and golf's contribution to global health, injury and illness related to golf, and high performance aspects of golf. The Congress feature speakers included:-

- **Prof Fiona Bull-** World Health Organization Head of Physical Activity/ Sport
- **Prof Margo Mountjoy** -IOC/ International Golf Federation
- **Prof Jiri Dvorak** – University of Zurich,
- **Dr Roger Hawkes** - Golf 4 Disability/ EDGA
- **Maree Todd**- Minister for Public Health and Sport- Scottish Government
- **Amy O'Donnell/ Graeme Close/ Dan Coughlan-** European Tour Health and Performance Institute

"The spectator studies confirmed that watching golf is one of the few spectator sports where you get your 10,000 + steps as a spectator."

- **Dr Andrew Murray** – DP Golf World Tour MO and researcher in Golf and health
- **Dr Chris Neville** - CMO the R&A, St Andrews

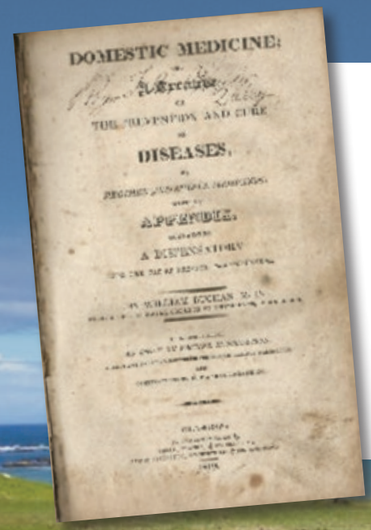
The talks were persuasive, but most of the audience who were there played golf and were probably aware of the health benefits of golf physically and mentally, especially in older age. The spectator studies confirmed that watching golf is one of the few spectator sports where you get your 10,000 + steps as a spectator. The update on injuries demonstrated the great deal of work being done in this area in the last 10 years and much is still ongoing.

It is good to have the evidence, if this brings money and initiatives to get non (or lapsed) players to have a go as part of Physical Activity prescription. It may prove more difficult in England to get prescription golf with non-members attending at elite private clubs.

There are fewer public courses in England and few *'Pay as you go'* opportunities. In Scotland we are lucky to have, especially in remoter areas with no other sports facilities, honesty box golf. (£10 in the box for 3-4 hours of fun)

The biggest obstacle with prescription golf may still prove to be access to courses especially after the limited period of introduction through prescription. This problem was passed on to the R&A and we watch this space for the future.

I too attended this excellent conference and was impressed not only by the passionate address by Maree Todd, but that she listened intently to the physical activity papers and stayed for most of the conference. The sort of support that SEM needs from Westminster...
BASEM Editor



"The diversions which afford the best exercise are hunting, shooting, cricket, hand ball and golf" - 1783

"Golf is a diversion very common in North Britain. It is well calculated for exercising the body, and may always taken in such moderation as neither to overheat nor over fatigue. It has greatly the preference over cricket, tennis and any of those games which cannot be played without violence" - 1819

BASEM UNDERGRADUATE SPONSORSHIP OPPORTUNITY

BASEM would like to thank Dr Richard Tingay and his team at England Rugby for sponsoring BASEM Undergraduate Student, **Eleanor Tresize**, to attend the first Team Physicians Course at Twickenham Stadium on 12th and 13th October 2022. Eleanor secured the place by submitting an excellent application.

She is writing a report for a future issue of BASEM Today, for her fellow members to learn about her experiences at the event and how she will use the new knowledge and skills in the future.

BASEM would like to thank all applicants for their time and England Rugby for the opportunity. It is hoped this sponsorship will become an annual opportunity for BASEM undergraduate student members.

Elle is a final year medical student and rugby player with a passion for sport and exercise medicine.

THE OSTEOPATH WITH 200 CAPS!

DR CARL TODD INTERVIEWED BY **DR SIMON LACK**

Since 2005, Dr Carl Todd has consulted as an osteopath for the medical team at The Football Association and in particular the men's senior football team. As a result of working for over 17 years with the England national team, in June 2022 he reached a remarkable milestone of covering his 200th game...

Above: Shirt presented to me for 200th game in 2022 next to Jordan Pickford's he was an unused sub

For this edition I had the privilege of interviewing Dr Todd whilst he was in Munich covering the Athletics European Championships, to get beneath the surface a little and understand what are some of the real highlights, and low-lights, of working in this elite environment.

Carl kindly took me through some of the exemplars of good osteopathy practice that he had been witness to, and also what he saw as the future of osteopathy in the elite sporting environment.

What have been the highlights?

Many of the successes that have been shared with the teams or athletes that Carl has worked with over the years have been described as highlights.

"Sharing in the successes of the team that I have been a part of is a real high".

Carl describes the privilege of being involved with such a talented group of players. He made particular mention to the Champions league title in 2012 with Chelsea FC, describing how the first champions league title was the most memorable.

What have been the low-lights?

The most salient point Carl raises is not to forget the pressure it brings to your family life. He described how it takes "a really special type of partner to 'hold the fort' whilst you go off and do the things that you do" particularly if you have a young family. The other reality is that your calendar is dictated by the sporting calendar! Time off is limited. But the enjoyment of the job outweighs the sacrifices that are having to be made.

The other reality of working in elite sport is that some performances do not go well. In these scenarios the heart break is felt throughout the whole team.

> **"Creating an environment of 'belonging' within the medical, performance and coaching team, really helps to draw the athlete along with them."**

Above: Shoulder girdle mobilisation techniques

Left: Celebrating from the bench winning my first penalty shootout England v Columbia, Russia World Cup 2018

After these losses, the transition from the sporting environment or 'family' back to real life is hard. Carl stopped short of describing this as depression, but certainly did feel that it represented a period of lower mood as you come to terms with what this outcome means.

What are the bright spots of exceptional clinical practice – through your osteopathic lens?

When in elite sport, it is not about any one profession, it is about the MDT was Carls clear answer to this question. He took me through a fantastic example of this working well, where he described a player with a significant hamstring injury. When they arrived on camp, the optimal management saw them back on pitch playing 90 minutes without reaction after only a couple of weeks. Carl describes the role of nutrition, optimising sleep, from an osteopath perspective looking holistically at spinal-pelvic mechanics, hip, ankle & knee mechanics, whilst working alongside the physiotherapist as the player starts to load the affected area. Backed up by the soft tissue therapists to aid recovery and the strength and conditioning coach taking the progressions going forwards. Couple this with constant communication between the medical team and the performance director and coaching staff, to ensure all are singing from the same hymn sheet.

Creating an environment of 'belonging' within the medical, performance and coaching team, really helps to draw the athlete along with them.

> **The real strength of the practitioner comes from effectively finding the balance of doing your job and then stepping back, not creating a reliance on the intervention, but rather providing effective interventions and then helping the athlete to realise that they can cope without you.**

Above: Spino-pelvic manipulation techniques

Right: The bench singing the National Anthem

A team with great experience and credibility also promotes buy-in from the injured athlete, trusting the process that underpins the decision making and management approaches. The real strength of the practitioner comes from effectively finding the balance of doing your job and then stepping back, not creating a reliance on the intervention, but rather providing effective interventions and then helping the athlete to realise that they can cope without you.

Where are the areas for progress for Osteopathy?

Historically you were trained as a primary healthcare practitioner, he describes. What was not that well highlighted within undergraduate university programmes is working effectively within the team. Carl feels this may be the demise of post graduate education, providing the insight in where the skill sets that you have developed fits within the wider MDT.

"Understanding and acknowledging your strengths and limitations as you start to work your way into a sporting team or club is critical"

Left: Gareth Southgate presenting my montage for 150th game against Nigeria, my son was a mascot for this game

One aspect Carl presented as an example was that, whilst an osteopath may have excellent manipulative skills and works with the team once a week, they are unlikely to be the first choice clinician for a player who receives treatment on a daily basis from the club physiotherapist. It is important not to be "put out" by the player not going to you, but rather provide the specific hands on skills when required or asked of you. Carl described nicely this aspect of working within your boundaries, but that progress for osteopathy will be to further integrate the manual therapy skills into the improvement of movement quality and onto strength and conditioning.

What is next for you Carl?

A holiday! Before getting back into clinic in September. Carl then has his hands full once again as he looks set to travel with CFC and then on to the World Cup preparation for Qatar.

If the clinical work has not kept him busy enough, Carl has managed to get pen to paper in writing a Clinical text book that is getting published in November. In the book, Carl presents the reasoning that underpins his treatment approaches, with a nice framework of the 5 'ATEs' to help focus this approach (EvaluATE, EducATE, ManipulATE, ActivATE and IntegrATE). Look out for his textbook if you would like to know more!

BASEM MSK QUIZ

PROVIDED BY JOHN TANNER

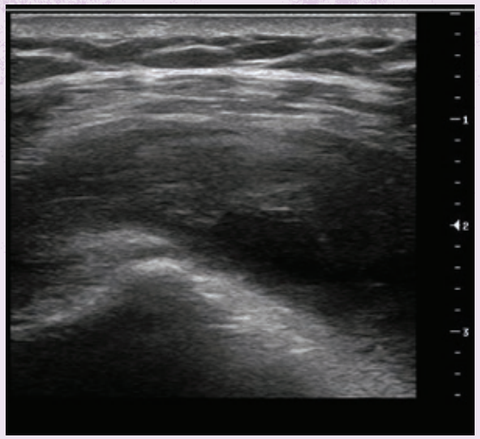


Fig 1: ant deltoid

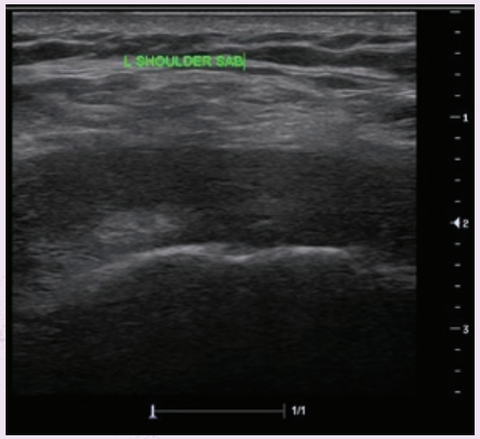


Fig 2: lat deltoid

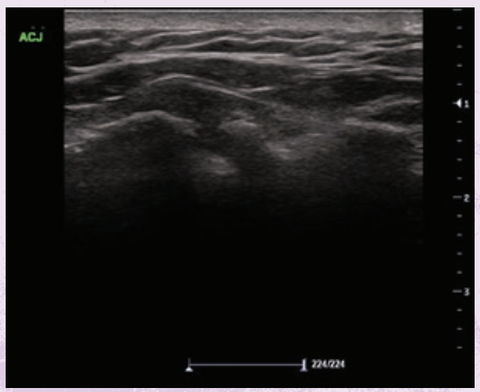


Fig 3: ACJ

Image: Claude Peladeau on Unsplash

CASE STUDY: ‘A FISHY SHOULDER’

A 70 year old previously well man presents with one month’s suprascapular shoulder pain following some unaccustomed exertion dredging his pond, netting some fish, followed by a round of golf, and steering a narrowboat on subsequent days.

He complained of inability to elevate the left arm and too much pain to lie on that side at night. He described the pain as ‘terrible’ at 8/10 on a NRS. He was taking 400mg ibuprofen tid without much relief and had been to a local physiotherapist. His past medical history included treatment for a ‘frozen’ shoulder with steroid injection giving a successful result 20 years ago.

Examination revealed some anterior deltoid swelling with warmth but no redness, limitation of all active and passive movements of the L shoulder, resisted isometric tests of the rotator cuff with arm by the side were of full power. He was tender over the acromioclavicular joint (ACJ). The patient was afebrile, good colour, in sinus rhythm with no tachycardia.

A diagnostic ultrasound was performed with a linear 14-6N probe over the anterior and lateral deltoid region.

The images are shown left:
(Doppler negative for hypervascularity in all areas)

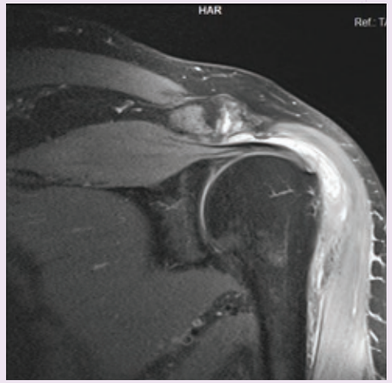
QUESTIONS:

1) Describe the findings. What is their significance?

Aspiration of the anechoic region was attempted with 60mm 21 G hypodermic under ultrasound guidance. No fluid was obtained.

2) What would you do next?

An MRI was requested and bloods taken for FBC, ESR and CRP.
Hb 147g/l; WBC 10.7 (4-10) 10*9/l; Slight monocytosis, neutrophils 6.9 (2-7) 10*9/l the remainder of the count was within normal range; CRP 91mg/l *Selected MRI images are shown below:*



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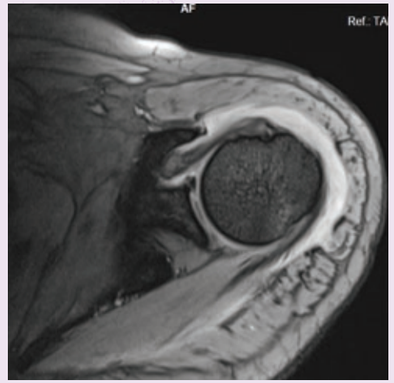

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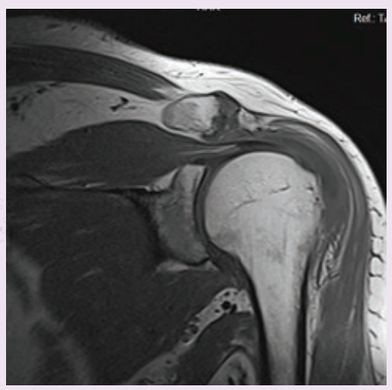

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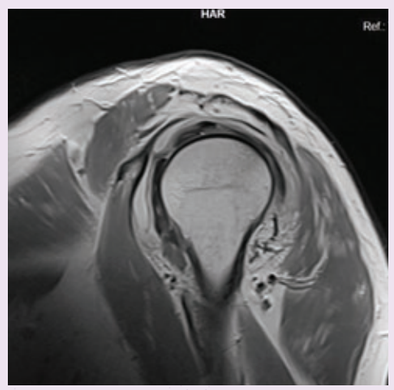

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3) What do they show?

The report recommended aspiration. A week later further bloods were sent for FBC and CRP
Results of the FBC all within normal ranges; the CRP was 39mg/l
Aspiration with large bore needle under US guidance obtained 3mls blood stained lightly yellowish, turbid fluid, non odorous.
WBCs +++
RBC ++

No crystals seen 48 hour culture showed staphylococcus aureus which was sensitive to flucloxacillin, doxycycline, and clarithromycin.
Patient commenced on 500mg flucloxacillin qid and slowly improved over subsequent weeks.

4) What might have caused this pathology? What further management would you consider?

Answers can be found on page 41

BASEM REPORTS

Guest Edited by **Dr Simon Lack,** Consultant Physiotherapist and Senior Lecturer

PODIATRIC SPORTS MEDICINE

Motto: *Inspiring Clinical Excellence through Science & Innovation, thinking beyond Biomechanics*

Ethos: Collegiate

ARTICLE BY **PROF NAT PADHIAR**

image: pch.vector_freepik.com

Physical activity and sports participation have been on the increase over the last 4 decades[1]. Physical activities include walking or cycling for everyday journeys, active play, work-related activity, active recreation such as working out in a gym, dancing, gardening or competitive sport[1].

It is estimated that each year approximately 1.5 million people attend accident and emergency (A&E) departments in Britain [2], and 3.7 million people present to emergency departments in the USA [3], with an injury related to sport and exercise. Most of the injuries were soft tissue (70%); the lower limb was involved in 141 (60%) of the cases and 88 of these were related to foot and ankle.

PODIATRIC SPORTS MEDICINE

Podiatric Sports Medicine (PSM) as a formal specialty within the Podiatry profession is relatively new and still in its infancy. Historically, clinicians have referred to themselves as 'Sports Podiatrists' due to their association with sportsmen as their patient group, but have had no formal qualification or training in PSM. The London 2012 Games acted as a catalyst to an idea that was floating around for many years, to set up a specialism in PSM within our profession. I was fortunate enough to be member of the Medical Services of LOCOG 2012 and learnt a lot from colleagues from multi-disciplinary specialities. I was also the clinical lead for Podiatry and had a team comprising of 4 Podiatric Surgeons and 12 Podiatrists of varying experiences who took part as volunteers and delivered excellent care for the athletes during the London 2012 Olympic & Paralympic Games. The question was repeatedly asked as to whether PSM as a speciality existed in the UK? It became very clear that in order to provide podiatry care at this level, there was a great need to establish a specialism and specialty in this field.

Sports Medicine in the UK exists as a speciality in Medicine and an academic qualification in Sports & Exercise Medicine (SEM) has been offered for the last 4 decades. In order to identify and differentiate from SEM, which is primarily practised by medical

FOREFOOT: Plantar and other bursitis, Morton's neuroma, Metatarsal stress fracture, Plantar plate tear, Freiberg's infraction (avascular necrosis of metatarsal head), Sesamoiditis, Sesamoid stress fracture, Hallux Rigidus/valgus (bunion)/limitus, Tailor's bunion, Metatarsal and Phalangeal fractures, Ingrown toenail and osteoarthritis of joints.

MIDFOOT: Lisfranc disruption, Stress fracture of the navicular, Crisp-Padhiar Syndrome (Os naviculare syndrome), Tibialis anterior and posterior enthesopathy, Midfoot osteoarthritis, Cuboid compression syndrome, avulsion fracture of the styloid, 5th metatarsal base fractures, Osteoarthritis and Stress fracture of the metatarsal base.

HINDFOOT: Plantar fasciitis, Partial tear of plantar fasciitis, Stress fracture of the calcaneum, Flexor hallucis longus tendinopathy, Tibialis posterior tendinopathy, Tarsal tunnel syndrome, Medial calcaneal nerve entrapment, Deltoid ligament strain/partial tear, Medial malleolus stress fracture, OCD of talus, Anterior impingement syndrome, Posterior impingement syndrome, Sinus tarsi syndrome, Lateral ligament strain/tear/laxity, Peroneal tendinopathy, Peroneal tendon subluxation and Lateral malleolus stress fracture.

ACHILLES: Haglund's deformity, Classical mid-portion Achilles tendinopathy (AT), Insertional AT, Musculo-tendon AT, Intra-substance tendon tears, Achilles tendon ruptures.

EXERCISE INDUCED LEG PAIN (EILP): Stress fracture of tibia/fibula, Medial Tibial Stress Syndrome (MTSS), Chronic Exertional Compartment Syndrome (CECS), Superficial Peroneal Entrapment Syndrome (SPNES), Radiculopathy, Muscle hernia, Myopathy and Anterior tibial muscle syndrome.

Figure 1: Common foot, ankle & leg conditions encountered by Podiatrists

doctors, Sports Medicine practiced by a podiatrist has been termed Podiatric Sports Medicine in order to have our own identity.

There was a 10-year plan to establish PSM as a speciality and there are 5 facets to this plan.

(1) Defining the Scope of Practice.
(2) Post-graduate education which is specific to podiatrists who want to pursue a career in PSM.
(3) Set up a Specialist Advisory Group (SAG) within the Royal College of Podiatry.
(4) Annual conference.
(5) Employment with NHS and Private sector.

(1) Scope of Practice

This includes management of common and uncommon musculoskeletal foot, ankle, and leg disorders (Fig.1.) encountered in sport as well as within an active population. The main skill and expertise is required to make a diagnosis & differential diagnosis based on the knowledge of the conditions, knowledge of anatomy, good history taking, clinical examination, ability to request and interpret various investigations and then having a structured plan of management. Justification is based on evidence thus encouraging evidence-based practice.

The decision-making process is also an important part of the scope, especially at the elite and professional end of the sport spectrum.

(2) Qualification in Podiatric Sports Medicine

There now exists a Post-Graduate Diploma and an MSc in PSM offered by Centre for Sports & Exercise Medicine, Queen Mary, University of London. This is the first academic course offered to podiatrist in the UK & Ireland. The delivery, since the pandemic, is hybrid with a mixture of online lectures, face 2 face workshops/demonstrations, both virtual and actual clinical attendance. There are 9 level M modules (270 hours). ***https://www.qmul.ac.uk/postgraduate/taught/coursefinder/courses/podiatric-sports-medicine-msc/***

Podiatric Sports Medicine remains popular with most graduates as it poses a diagnostic challenge and treatments that are rewarding and very gratifying.

Vasyli-College of Podiatry Award available to prospective students to cover some of the cost of the course fee only. https://www.qmul.ac.uk/scholarships/items/podiatric-sports-medicine-scholarship.html

(3) Specialist Advisory Group, Royal College of Podiatry

PSM at present exists as a Specialist Advisory Group (SAG) within the Royal College of Podiatry (RCoP)

> **"Podiatric Sports Medicine remains popular with most graduates as it poses a diagnostic challenge and treatments that are rewarding and very gratifying."**

with a plan to in the future to establish a Faculty of PSM with Fellowship and Membership examination which reflects the scope of practice.

The Faculty of Podiatric Medicine, Royal College of Physicians & Surgeons of Glasgow (RCPSG), at present also offer either an Associate member or Member, status to eligible PSM graduates.

(4) Podiatric Sports Medicine Annual Conference

This is a valuable part of the specialty and all members involved in musculoskeletal care of patients will benefit. This is a two-day conference which includes lectures, workshops and informal discussions delivered by experts from across Europe and

the world. The first conference was organised in London 2012 to coincide with the London Games and this year we celebrate the 10th Anniversary at the annual PSM conference to be held at The Royal College of Physicians & Surgeons of Glasgow. For more information contact ***patrick.thornton@aesculap-academy.com***

(5) Employment prospects in PSM

At present, most jobs in PSM are likely to be in the private sector and mostly created by clinicians themselves. There are no formal jobs within the NHS in PSM, but discussions are taking place with Podiatric Surgery departments to create a tiered care by employing PSM podiatrists. Similar discussion is taking place with Primary Care Network.

CONCLUSION

The foundation stone is laid and even though PSM is still in its infancy and there are many challenges ahead, the 10-year plan is working. At present nearly 55 podiatrists have graduated with PSM qualification and it has had an appreciable impact on changing careers and practices for several colleagues.

The academic curriculum of PSM at Queen Mary, London has a clinical element based on evidence which should be beneficial to all podiatrists, thus enhancing their scope of practice and provision of benefit to their patients. Within sport, it is invaluable.

For further information contact Prof Nat Padhiar ***n.padhiar@qmul.ac.uk***

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CAREER IN PODIATRIC SPORTS MEDICINE – INSPIRING & PREPARING FUTURE PODIATRISTS

My name is Caoimhe Hoey and I am a Clinical Specialist Podiatrist in Sports Medicine and Orthopaedic Surgical Assistant.

I graduated with a Bachelor's degree in Podiatry in 2018 from the National University of Ireland in Galway. This is a four year degree with over 1000 clinical hours throughout the four years in Merlin Park Hospital in Galway.

I always knew I wanted to work in sport and applied for an MSc in Physiotherapy in Edinburgh but unfortunately (or fortunately!) was not offered a place. I worked for a year after graduating in a high risk diabetic clinic in Clare in the West of Ireland while trying to decide what my next move would be. None of the Republic of Ireland Universities would accept a Podiatry degree as a suitable entry requirement for a Sports and Exercise Medicine masters which thankfully led me to start looking overseas.

It was then I came across Queen Mary University of London and the Podiatry route they offered on their MSc in Sports and Exercise Medicine. I did some research, met with one of their fantastic members of staff on a quick visit and never looked back. I moved to London in August 2019 and studied my MSc full time for one year. Unfortunately Coronavirus cut this slightly short but it was the best decision I made. I enjoyed every lecture, module, clinic, and placement opportunity. I would do it all again in a heartbeat!

I moved back to Ireland and started working for the health service again for 12 months in an MSK role when the opportunity to work in Galway came up. This is a specialised role working for a Professor of Orthopaedics and Foot and Ankle Specialist. This role involved assessing patients who have suffered an orthopaedic or sports injury and require treatment. I am involved in the conservative treatment of their care and also their triage through to surgery. I am also in the fortunate position to first assist in theatre, not only in foot and ankle surgeries but in all Orthopaedic procedures. This involves assisting the surgeon, suturing, giving nerve blocks and casting once the procedure is complete. I am grateful to be gaining superb experience in a unique role in Ireland.

I am also involved in ongoing research that began during my MSc and is awaiting to be published currently. The two topics are foot morphology and football boot fit in Academy soccer players.

Treating athletes and being involved in their care is something I have longed for since my early days in school. Being able to do that on a daily basis is a huge joy of mine and I hope to do it long into the future.

PODIATRY AS PART OF THE COMMONWEALTH MEDICAL TEAM

ARTICLE BY **DR ABID HUSSAIN**

I served as the sports podiatry lead at the Birmingham Commonwealth Games 2022. Being part of the games was an experience that myself and my fellow podiatry colleagues immensely enjoyed.

There were three polyclinics operating in three athlete villages; Birmingham University, NEC and Warwick with podiatrists on duty from 7am to 11pm on 8 hour shift patterns. As you can imagine it was challenging, but hugely rewarding, as working within a multi-disciplinary team of physiotherapists, osteopaths, chiropractors, sport medicine doctors, GPs, pharmacists, dentists, sport massage therapists, paramedics and radiologists, was amazing.

Podiatrists assessed and treated athletes from around the world. They presented with a variety of foot, ankle and lower leg sporting injuries including ligamentous, tendonous and muscular injuries to bone stress reaction injuries along with nerve entrapments. The predominance of injuries being overuse with fewer acute injuries. Some of the athletes had travelled to the UK with a pre-existing injury as the Commonwealth Games was a "once in a lifetime opportunity". The most injured athletes were from the discipline of athletics , however the sports podiatry team treated athletes from many disciplines including beach volleyball, squash, basketball, aquatics, hockey and gymnastics to mention a few.

THE ATHLETES' JOURNEY

One of the many benefits of working within this type of environment is that as a clinician you are part of the athletes' journey in real time with all imaging being on site and accessible. Many interesting cases come to mind, however a particular case of a female squash player with a lateral ankle injury is of note. A multi-disciplinary team of a physiotherapist, sports medicine doctor and sports podiatrist assessed the athlete. As the athlete was not able to weight bear post injury and tender around the lateral malleolus and according to Ottawa Ankle Rules (Heyworth 2003) the patient had an x-ray immediately which confirmed non cortical bone trauma. This was followed by a diagnostic ultrasound assessment which confirmed that anterior talofibular ligament (ATFL) and posterior talofibular ligament (PTFL) was intact but a query was raised regarding the calcaneofibular ligament (CFL). The athlete then had an MRI scan and an isolated full thickness CFL tear was confirmed. Lateral ankle injuries are a common occurrence for many sporting disciplines (*Herzog, Kerr et al. 2019*).

A meta-analysis also determined a higher incidence of ankle sprain in females compared with males (Doherty, Delahunt et al. 2014). However an isolated CFL tear is not so common (Le and Tiu 2022). The management of this injury included ice compression and a surgical boot to offload the injury. The assessment, imaging, diagnosis and management of this injury with a multi-disciplinary team with equal input from all members took place within a 2-3 hour time frame. As a sports podiatrist who does not practice in an acute setting, the contrast of assessment and subsequent management of such an injury was notable.

SHORT-TERM OBJECTIVE

It is of note that clinicians working within a polyclinic environment have a short-term objective with relation to the assessment and treatment of an athlete. We are essentially attempting to "fire fight' injuries which translates to in most cases providing remedial treatment in order for the athlete to compete in the next round or heat of their respective event. The long-term treatment and management of an injury is left to the athlete's home country medical team. As I discovered at the Commonwealth Games, there is a large disparity between the level of care between the nations. I would suggest that a post injury rehabilitation plan with input from a multi-disciplinary polyclinic team and the athlete's internal medical team may be the ideal benefit to the athlete.

> **"This was a once in a lifetime experience for myself and the team which we all enjoyed immensely. Working alongside experienced multi-disciplinary teams raised the profile of sports podiatry and our profession as a whole."**

The treatment provided at the polyclinics included the management of acute injuries as well as padding, tapping, manipulations and mobilisation, strapping, soft tissue release and the management of acute injuries. Future games may benefit from the use of extracorporeal shockwave and class 4 laser treatment.

NEW DISCIPLINE

Specialism within sports podiatry is a relatively new discipline with formal courses being offered at Queen Mary University, London. Prior to this, podiatrists that completed continual professional courses and had an interest within sports podiatry would pursue this area of specialism. As such the remit of sports podiatrists has not previously been well defined and is also not commonly known to the wider multi-disciplinary team.

I would suggest that in future games physiotherapy colleagues and sports podiatrists jointly assess lower leg, ankle and foot injuries to ensure a wide spectrum of input in regard to the assessment and management of such injuries during game times. In the longer term, our specialism as a whole would need to increase awareness of the role and scope of our members.

CONCLUSION

In conclusion this was a once in a lifetime experience for myself and the team which we all enjoyed immensely. Working alongside experienced multi-disciplinary teams raised the profile of sports podiatry and our profession as a whole. For me, it was a tremendous honour and privilege to be leading such a fantastic team of sports podiatrists at the Commonwealth Games in my home city.

ABOUT THE AUTHOR

Abid Hussain is a consultant fellow who qualified with a BSc (hons) in Podiatric Medicine in 1995 from the University of Westminster, London with continual professional development accreditations, including PGc in Podiatric Sports Medicine & MSc in Sports & Exercise Medicine, both from Queen Mary's University, London.

Abid is currently undertaking a PhD at Loughborough University at the School of Sport, Exercise and Health Sciences and is a member of The British Association of Sport and Exercise Medicine and the Royal College of Physicians and Surgeons, Glasgow.

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Podiatrists are the clinicians you didn't know you were missing in your SEM teams

ARTICLE BY **NICOLA BLOWER**

Working with athletes (recreational and professional) is one of the only times as a Podiatrist when you're unlikely to have to explain what you do. Yet, SEM teams are far less likely to have a Podiatrist embedded or adequately represented in comparison to other AHP's.

Podiatrists are the missing link between Physiotherapists, Biomechanists, SEM Medics and Coaches when it comes to dealing with foot and ankle, but also wider lower limb mechanical issues. Essentially, any sport where the foot contacts the ground would potentially benefit from Podiatric input. Throughout a Podiatrists' career, our main focus is the foot and ankle, how those structures are influenced by contact with the ground, interaction with footwear, compensations for structural anomalies intrinsic and extrinsic to the foot, and how kinetic and kinematic loading forces influence pain and dysfunction. Yet, career pathways into this field are ill-defined and few and far between.

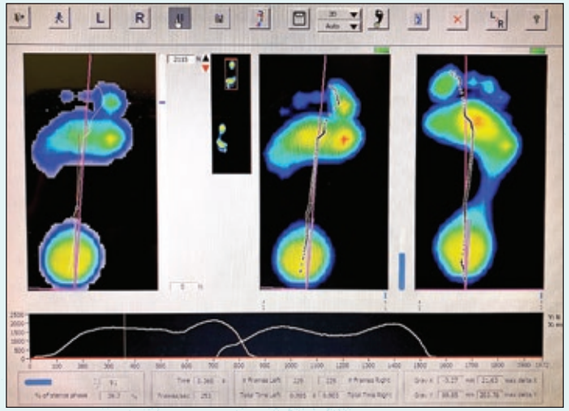
'As a Doctor in elite sport, I highly value the input of sports Podiatrists, who have a deep understanding of foot and ankle biomechanics and the relevance of this to high performance activity…they are very much part of the MDT, helping to reduce injury risk and facilitating prompt return to play'
Dr. Richard Collins, Chief Medical Officer, Badminton, England

LIMITED OPTION

Very few Podiatrists are directly employed within SEM and the exact number of Podiatrists working within this field is unknown, but most of us will be self-employed or employed within the private sector. In my own geographical area, there is no route into an SEM speciality via the NHS as a clinician or a patient, so private practice is the only option. Embedding Podiatrists within SEM teams means welcoming in experience and know-how that only clinicians that work with the foot and ankle every day can bring, such as whether the issue at hand is an intrinsic foot and ankle problem, an interface problem eg foot-to-shoe or shoe-to-ground, a loading issue extrinsic to the foot or an issue unrelated to mechanics and loading forces entirely.

Baseline assessment within a Sports Podiatry environment, following the usual history and non-weight-bearing examinations is 'clinical gait analysis' of different forms to ascertain the influences of loading forces. Commonly, this will include video gait analysis (treadmill-based or within the relevant sporting environment), plantar pressure analysis (either via static mats or in-shoe systems or both) and, in some cases, motion capture for more advanced kinematic analysis. Footwear and foot size will also be assessed, and a full understanding sought of the influences of body-to-foot, foot-to-shoe and shoe-to-ground.

Treatments typically consist of footwear changes (either in terms of sizing, suitability to task/terrain or appropriateness to function), foot orthoses, strapping, strength/flexibility programmes, gait re-training and the usual range of electrotherapies such as shockwave therapy. Podiatrists, however, also have local anaesthetics rights from the point of qualifying with a BSc(Hons) Podiatry degree, enabling the ability to perform superficial surgeries. Further post-graduate training also enables the ability to independently prescribe and carry out therapeutic joint infiltrations. Most Podiatrists will also work in a wider SEM team or with SEM contacts for onward referral to wider rehab programmes, surgery, counselling or nutritional advice.



Case Study #1
Surviving the Marathon des Sables – Patient A

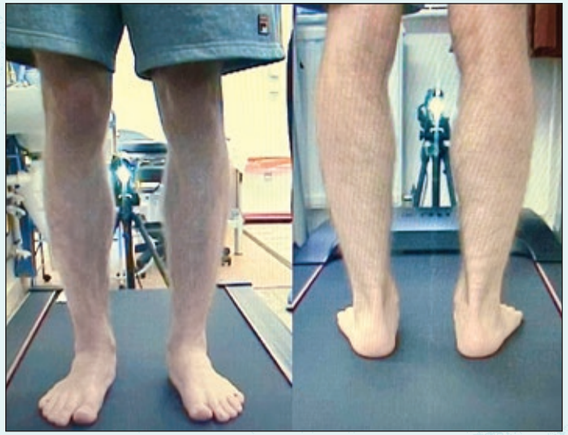
Presenting issue: Needing to complete at 250km desert race in 7 days.
Objective: Patient A has no current injuries but structurally flat feet, which have never been problematic. He has completed other endurance races with very little issue but has never had to race through the desert in extreme heat, carrying supplies, for 7 consecutive days.
Approach: The approach here was to maintain foot integrity during the race via preventative techniques rather than mechanical changes (a foot-to-shoe interface issue) by:

- Ensuring current footwear is not already causative of compressive or shearing forces that could cause blistering and potentially end patient A's race
- Pre-emptively strapping areas of potential pressure and practice taping techniques prior to race
- Purchase and practice with anti-friction cream
- Manage any excess sweat with anti-perspirant and natural wicking fibres within hosiery
- Patient directed to information from previous MDS participants with respect to gaiters to prevent entry of sand into shoe

Results: Successful completion of MDS with no blisters!

Case Study # 2
Rehabbing back into track running (400m and hurdles) following navicular stress fracture – Patient B

Presenting issue: Pain from site of navicular stress fracture, exacerbated by full-intensity running in spikes
Objective: Excessive kinematic and kinetic loading forces at navicular secondary to structurally shorter 1st metatarsals, compensations for proximal asymmetry and excessive hip adduction in running gait.
Approach: Gait re-training to reduce hip adduction angle on affected side; foot orthoses to address altered forefoot mechanics and to change loading forces into navicular; continued S&C; progressive re-introduction to running staged in trainers prior to spikes.
Results: Currently symptom-free and running at full intensity. Considering a career in Podiatry!



'As an athlete, there is nothing worse than being side-lined due to injury…Nicola watched be walk and run on a treadmill, looked in detail at videos of me running in training…and was given a full understanding of why my injury occurred…. (following treatment) if have had no foot injuries and my athletics career has taken off….it has even resulted in my applying for a Podiatry MSc 3 years later!'
Patient B

> **From a Podiatric perspective, we have to do much more to keep encouraging Podiatrists to pursue formal qualifications in Podiatric Sports Medicine in order to standardise competence, scope of practice, and employment desirability with teams.**

THE FUTURE OF PODIATRY IN SEM

The future of Podiatry in SEM is hopefully bright with the development of an MSc in Podiatric Sports Medicine at Queen Mary University London, but the Podiatric and SEM community will need to work together to ensure that the valuable skills of Podiatrists are not lost from SEM teams. Work is ongoing within the profession to develop opportunities within sport as elaborated upon by Prof. Nat Padhiar in his article *'Podiatric sports medicine a future career choice'* on consultingfootpain.co.uk, but there is currently no formal route into sport. From a Podiatric perspective, we have to do much more to keep encouraging Podiatrists to pursue formal qualifications in Podiatric Sports Medicine in order to standardise competence, scope of practice, and employment desirability with teams. From the perspective of the wider SEM community, it would be beneficial if employers in sport could consider if their athletes are missing out by not having routine access to a Podiatrist. If a need is identified, please reach out to clinicians that players or staff have previously worked with, or go direct to Podiatric membership organisations. Together we can work to embed podiatry into sporting environments, improving progression into this field for existing clinicians, new graduates and would-be Podiatry students alike.

ABOUT THE AUTHOR

Nicola Blower graduated in 1999, from The University of Huddersfield, with a 1st class BSc(Hons) Degree in Podiatry. She specialises in Musculoskeletal (MSK) Podiatry and works with both recreational and elite athletes. She works in private practice and is Co-Director of Walkrite in Peterborough.

Quality-assuring the contribution sports chiropractors make to the medical team

WHAT'S THE CRAIC?

ARTICLE BY **NICK METCALFE**

Nick Metcalfe is Chair of the Royal College of Chiropractors Sports Faculty, has worked at Fulham FC for five seasons and owns two private multidisciplinary clinics in South-West London. He explains the role of chiropractors in sport and describes developments that are improving the quality of sports chiropractors in the UK.

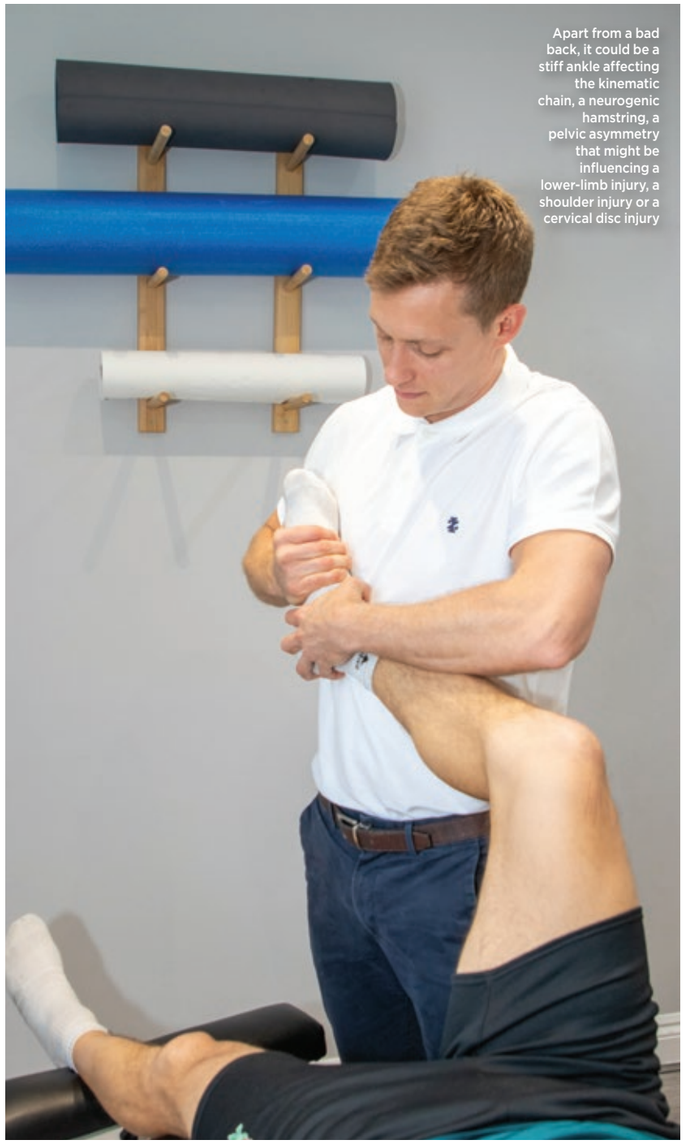
Assessment of the spine will look at elements of flexibility, strength and control. Treatment is likely to involve manipulation but they will understand when it's not appropriate. It might be soft tissue release, exercises in the gym and drawing upon the expertise of others in the medical team

"No bad backs round here mate" was a comment on my first day volunteering at my local football club. Back then, if you wanted to work in sport as a chiropractor, the advice was to start by volunteering at your local club and work your way up. It was me and my portable bench in the changing room and I was the sole person on the medical team. It took an ankle or knee injury before the players realised I could do more than help a bad back. And it took an amateur tape job and some massage before they realised that I didn't just manipulate. But then they called me "physio".

Many chiropractors have started here. After a couple of seasons volunteering at one club, a contact from the previous gig or an email leads the chiropractor to the league above or a side-step into a different sport. A few seasons later, through a combination of what seems like luck or knowing the right people, the sports chiropractor might get an opportunity in professional sport. The route is tortuous and the ignored emails, the closed doors, the reliance on 'who you know' is hard to take. This process doesn't identify the bright sparks in our profession, it risks extinguishing them. The attrition rate in sport is high and it's much more comfortable to stick to private practice.

WELL-DEFINED COMPETENCIES

Fast forward to the present day and The Royal College of Chiropractors has a Sports Faculty and its members - sports chiropractors - now have a formal framework and well-defined competencies that they strive to achieve over time to progress their career in sport. It's not only about qualifications; it's also about reflective learning and logging cases. It's interview-based learning where experienced sports chiropractors are involved in nurturing more junior chiropractors. Yes, the entry point is likely to still be volunteering at a local club but now there is a pathway and support along the way. The hope over the coming years is that the attrition rate is lower and the bright sparks are identified.



Apart from a bad back, it could be a stiff ankle affecting the kinematic chain, a neurogenic hamstring, a pelvic asymmetry that might be influencing a lower-limb injury, a shoulder injury or a cervical disc injury

"Most of my time involves assessing and treating non-injured players before training. My spinal assessment looks at elements of flexibility, strength and control and I'll draw on the expertise of others in the medical team when a player requires it."

SPORTS FACULTY

The Royal College of Chiropractors

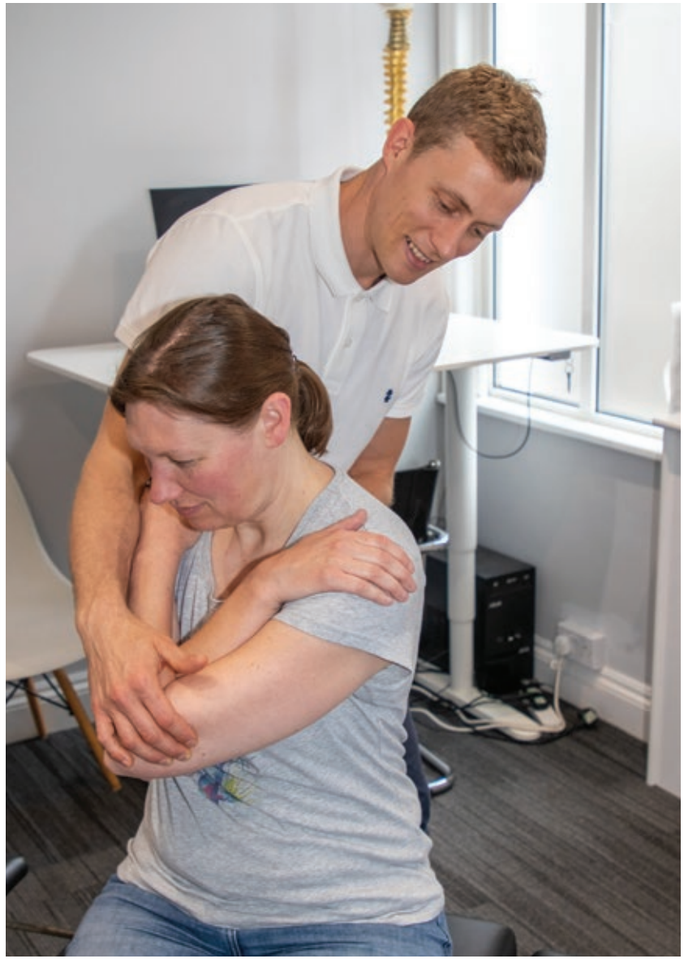
As a lone chiropractor in a physio-dominated environment, I used to feel the need to prove that I was the same as them. I wanted to fit in. But as my journey in sport progressed and I gained experience and confidence, I realised that my real value came from being different. Sometimes not right away and not too different, but just the right-amount-different. It reasons that if everyone on the medical team brings a different lens then, as long as communication is effective, then less gets missed and the athlete benefits.

MY POINT OF DIFFERENCE

I was one of the "lucky" ones that made it through that old tortuous route into professional sport. Most recently, I've been at Fulham FC for five seasons, working twice per week. *"Nick the click"* they call me; a nod to the fact that manipulation is my point of difference, which I'm comfortable with. I will still combine the manipulation with other manual therapy techniques. If it's a spine or pelvis it usually ends up on my treatment bench, but I'm comfortable giving exercises in the gym and when it's all hands-on-deck I'll "flush" the legs if the team requires it. I've given up on taping though.

Most of my time involves assessing and treating non-injured players before training. My spinal assessment looks at elements of flexibility, strength and control and I'll draw on the expertise of others in the medical team when a

Fellows of the Sports Faculty will have achieved well-defined competencies, they are evidence-led, have great manual therapy skills, are sound communicators and can integrate within a multidisciplinary environment



Above: At the Commonwealth Games, Chiropractic sat alongside Osteopathy, Physiotherapy and Sports Massage as part of the Core Medical Services, the same recipe used by the hosts of the past three Olympic Games

Right: It reasons that if everyone on the medical team brings a different lens then, as long as communication is effective, less gets missed and the athlete benefits

player requires it. I understand that manipulation is a great tool when applied safely and appropriately but sometimes mobilisation, massage, or exercises might have a similar effect and be more appropriate. Plus, a player's requirements might change depending on whether it's before training, after training or before a game.

Apart from the non-injured players, over the five seasons at Fulham FC I've assessed players with irritable hamstrings with a possible neurogenic component, pelvic asymmetries that might be influencing recurrent soft tissue injuries in the leg, disc injuries, stiff ankles following inversion injuries, rib injuries, shoulder injuries and... bad backs.

Recently, Chiropractic was part of the Core Medical Services at The Commonwealth Games in Birmingham. 16 chiropractors were stationed across 3 venues over the 11 days and performed 248 athlete encounters. The sports that utilised chiropractic the most were athletics, rugby and weightlifting. In this multi-sport environment, Chiropractic sat alongside Osteopathy, Physiotherapy and Sports Massage and it has been the same recipe used by the hosts of the past three Olympic Games. Many of the athletes who used the chiropractor would be used to receiving chiropractic care at home, but their nation's traveling medical team does not include a chiropractor. I've seen myself that a 'Head of Medical' might choose to bring in a quality-assured sports chiropractor part-time, rather than risk their players seeking an unknown chiropractor outside of the club.

Looking into the future, quality-assured sports chiropractic is something The Royal College of Chiropractors Sports Faculty is striving to provide. A "Fellow" of the Sports Faculty is the top tier of membership and they will be an expert in their field. They will have achieved well-defined competencies, they are evidence-led, have great manual therapy skills, are sound communicators and can integrate within a multidisciplinary environment. Chiropractic is a small profession, and sports chiropractic is a niche within that, but the benefit is that change can happen quicker. Expect to see many more highly competent sports chiropractors emerge over the next 5-10 years.

Nick Metcalfe
Contact*@nickjmetcalfe.com*

Life as a Sports Therapist Working in Womens Professional Basketball

ARTICLE BY **WURA IJELU** (SPORTS THERAPIST)

The excitement runs through to a cellular level as I start to unbox what is the order of the month. I grin from ear to ear as I hear 'your tape order is here.' Have I lost my mind? No, I have just taken a deep dive into the amazing world of a Sports therapist (ST) in Women's professional basketball.

My journey into this role started 5 years ago, during my undergraduate studies at the University of Worcester. My Initial Intention was to go to university to study Physiotherapy, as to be quite honest I had not heard of Sports Therapy before. At an Induction into the Physiotherapy course, they had highlighted the difference between the two courses. It was then I learned how broad Physiotherapy was, covering areas such as respiratory and neurological issues, as well as musculoskeletal (MSK) disorders.

THE RIGHT PATHWAY

Having come from a sporting background, I knew what I really wanted was to stay within the field and I had a great interest in the MSK system. I realised then that Sports Therapy was the right pathway for me. As part of my clinical placements, I worked within 3 different sports: Rugby, Football and Netball, all at various levels. I chose to do 3 different placements, not only to quickly check off the 200 hours that was needed, but to help me gain a better understanding of different sports and the common injuries experienced within them.

Even with the experience I gained through these placements and then working part time with a football club after graduating, I could not have anticipated what was behind the scenes of a Full time ST. The things they do not teach you at university. Your hours are not 9am-5pm like regular folk, but then again you would not be expecting that working in sport. They are more like 8am – 11pm! But I guess you were not expecting that either.

EXCUSES, EXCUSES

With someone that has a duty of care to these athletes, your work does not stop after you have left the gym, to be honest that is where it starts. *'I have a cold', 'I have a headache' and 'my cat stubbed its toe and kept me up all night'* are just examples of the text messages I have received at 10pm.

Above: WBBL League Winners 2021/22 - Photographer: @ Carol Moir

> **Sports Therapy as a profession is often overlooked, considered secondary to, or confused with physiotherapy.**

Above: Gameday Preparations with Paige Robinson - Photographer: @ Graham Hodges

Right: Wura Ijelu with League Winning Trophy 2021/22 - Photographer: @ Carol Moir

There is no better indication of the start of a shift than *'Hey, I hope you are enjoying your off day, but could you...'*. Weirdly enough I love every second of it. I dove into this world because of the love I have for the game of basketball and helping individuals optimise performance through looking after their bodies.

Sports Therapy as a profession is often overlooked, considered secondary to, or confused with physiotherapy. The lack of understanding as to what ST's do often creates a certain narrative. We do not just provide massage! We diagnose, rehabilitate, treat, and advise. Our focus is primarily on sport and the specific injuries that are sustained within it.

Working as a ST goes beyond first aid, taping and soft tissue treatment. There is a reason the word therapy is included in the job title because that is exactly what you provide. More often than not, it is not related to basketball or injury concerns. Your bed becomes an invitation for a rant session, a safe space, you become a friend to these women. They begin to put their trust in you and that is when the job becomes a whole lot easier.

STRONG RELATIONSHIP

The relationship that is developed between ST and Player is probably stronger than between the player and any other staff member. Every morning this individual gets on to your bed tells you how they are feeling emotionally, what they ate for breakfast and whether or not they really want to be there. They then begin to become more honest about how their bodies are feeling and do not try to push through niggles. This is when you become most effective, tackling a problem before it becomes a problem! "You are the most important person on this team, without you there is no us" was the most amazing feedback I ever received. What else do you need to hear to make your love for what you do grow even more!
As a Woman working in women's sport, I have begun to understand the importance of being that someone they can relate to, as a person of the same sex, who oversees their body. There is a lack of research into the real ins and outs of how the menstrual cycle affects women's performance in sports. Although we are fully aware of the 28-day cycle, as medical practitioners we must be aware of how this cycle is unique to each one of these athletes. This understanding can help prevent injuries by understanding the needs of the athletes at that time. Managing workload as well as giving nutritional advice during this time are a few things that I implement with the Ladies. By providing them with what they need we can help maintain the highest levels of performance.

The body is such a complex but beautiful system and working with a group of Women I have better understood that there is no one size fits all. Every individual should be treated as an individual and that comes from taking the time to know them. The one thing I have learnt is not to forget yourself in the process of helping others, you are important, you matter!

There are many brilliant ST's across the country that dedicate so much time into ensuring they can give their best to athletes. The future is bright for ST's as opportunities continue to become available, through the greater understanding of what we do and the role we play in athletes' lives. For the London Lions (Women) and me, we are working hard both on and off the court to continue our unbeaten streak and have another amazing season.

Wura Ijelu
wijelu@thelondonlions.com

Above: Gameday Preparations with Cassie Breen - Photographer: @ Graham Hodges

image: freepik.com

Fuelling the athlete to optimise outcome- A NUTRITIONIST'S PERSPECTIVE

ARTICLE BY **DAVID DIXON**

David Dixon is a SENr registered Sport and Exercise Nutritionist with over 10 years worth of experience having worked in professional football and basketball, semi-professional rugby and a ballet school along with working on TASS and athlete talent programmes.

OVERVIEW

The role of a sport nutritionist is to optimise the health and sporting outcomes of the athlete. In this case study, the input from the nutritionist is presented for a professional women's basketball player who had recently undergone ACL reconstructive surgery.

In February, a 21-year-old professional female basketball player was referred to the nutritionist by the multi-disciplinary team as concern was shown as to her dietary habits, especially as she was recovering from ACL reconstruction surgery.

During an initial meeting with the player, basic height and weight measurements were taken (W 68kg. Ht 185cm BMI 19.9 kg.m-2). At this stage composition was not thought to be appropriate and could be counterproductive.

At the time she was three months post-operative receiving physiotherapy, strength, and condition interventions. Her S&C consisted of three days working on lower body and abdominal muscles and two days on the upper body, with some additional soft tissue work and isometric exercises. At the time she was still in a brace and hoped to be back to some running in March of that year. She also reported that she had COVID in January of this year and that she had menstruated in ten out of the last twelve months.

In relation to her diet, she stated that she rated her cooking skills as four out of ten despite having lived in university accommodation for the previous two years. She liked to prep her food in advance as this fitted around her academic and sporting commitments. During her time injured she only ate once a day and spent 12 hours a day asleep. Blood tests for Iron, Vitamin D and calcium were still outstanding

DIETARY ANALYSIS

A 6-day food diary was completed (covering training, treatment and one rest day) using the software Libro where the athlete inputs details of their food via an app on their smartphone and a report is generated from the input in an analysis software (Nutritics, Dublin Ireland). The results are shown below;

	Average Intake	Recommended
Energy (Kcal)	1417 (60%)	2329
Carbohydrates	155 (54%)	284
Protein	115 (84%)	136
Fat	37.4 (52%)	72

On closer analysis it was apparent that the player only got close to her daily target once in the six-day diary and that she relied on protein shakes (morning, noon, and night) and sandwiches for her food intake. She was under the impression that eating less would keep her weight off during her injury.

ADVICE

A discussion took place about finding the time to pre-prepare her food so that on her busy days she would not have to come home a good, it was confirmed that her freezer was big enough for this not to be a barrier and supported her early thought of when she liked to cook. Her plan was set up to have five feeding opportunities a day based around breakfast, lunch, and dinner with a further opportunity to snack twice a day. Foods that were non-negotiable such as Latte's and Bagels were kept in the plan, but also cooking stir fry's, mixed vegetables, yogurt, and milk were added to cover the macro and micronutrients identified as missing in the analysis, such as Iodine.

In addition, a full recovery plan was put into place covering protein, gelatin, vitamin D and Glucosamine and Chondroitin were recommended along with food alternatives. This was shared with the athlete, physiotherapist and Strength and Conditioning coach, so that regular checks could be made with the player, so that everyone knew what was recommended and the any concerns could be shared.

FOLLOW-UP

The player was followed up six weeks later, having heard nothing, when it transpired that the programme had worked well at the start; a fact reported by the MDT who said the recovery was as planned and the player had more energy. However, with the onset of exams and the thoughts of returning home, adherence had dropped off. Therefore, a follow up meeting occurred to reset goals and offer advice on alternative home foods.

SUMMARY

The successful intervention directed at the athlete's nutrition, during a critical post-surgery phase, has been presented. In most cases as in this, the role of the nutritionist is not full time therefore it is imperative to not only fit in with the MDT but also to get them onboard so they can communicate the same message when the nutritionist is not around in person. In this case the S&C coach and physio were informed of the food plan and were tasked with helping to check on the athlete, to see how she was doing, and to report back any hurdles that needed to be overcome.

The team approach saw the athlete achieve all of their objective strength and function goals. After 10 months of rehabilitation she made a successful return to court and has been able to continue her professional basketball career.

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Part of the Lioness Family-

A PIONEERING PHYSIOTHERAPIST

ALICIA TANG INTERVIEWED BY **DR SIMON LACK**

As a part of this edition of BASEM today, with the objective to identify exemplars of practice and future areas for growth, I had the pleasure of interviewing Alicia Tang. A Physiotherapist who trained at La Trobe University – Australia - completing both undergraduate and Sports Masters programmes to obtain her APA Sports Physiotherapy title.

After her studies and working for sports teams in Australia, she took her skills overseas, heading to America, China and then on to the UK. She is now the head physiotherapist for the Women's England football team.

Above: Women's 2022 Euros winners – celebrations Wembley stadium

WHAT HAVE BEEN YOUR CAREER HIGHLIGHTS?

Having posed this question to Alicia, the first answer could not have been more clear. As she acknowledged, early in her career it was not unusual for her to be the only female in the AFL locker room, or the only female on the medical team. The real career highlight was perhaps that she was among the first females to provide medical support for teams as a physiotherapist. She reflects on how, at the time, she was part of a larger group of female therapists who were breaking down barriers, and for this Alicia expressed her thanks to those who gave her a foot in the door – particularly in men's professional sport scene, which was all Alicia worked in when she started out in Australia.

The second highlight was getting overseas. A personal highlight perhaps as much as a professional one. This work/travel opportunity helped her to realise that despite language barriers, being able to communicate with an athlete who does not speak the same language as you was a massive opportunity for growth as a person and professional. Alicia described that is doesn't matter what sport they play, what culture they come from, how old they are, where you are in the world, an ACL injury is an ACL injury and the consequences of these injuries are massive for that athlete. As a result, the skills Alicia has developed are not just what you can deliver through your hands, but also how you can communicate, show compassion, and ask for help when you recognise that you do not have all the answers.

Performance highlights, for which Alicia describes she has been lucky to be a part of many, have been an amazing part of her career. Lots of Gold medals at Rio Olympics, when she was part of the Chinese medical team and then more recently our success at the Women's Euros! Hopefully more to come in the next few years with a World Cup and an Olympics coming up.

Above, left: Team GB Women's football – village visit at Tokyo 2020 Olympics

Above: Rio Olympics 2016 - Chinese Table Tennis Team – Gold medallist Ding Ning

Left: Celebration parade – commemorating the tournament success but also changing football for women/young girls across the country

WHAT HAVE BEEN THE LOW-LIGHTS?

The real sense of not being appreciated or recognised for the work that you do as a physiotherapist was discussed as being one of the biggest low lights of her career. Whilst there was a clear comment that this work is seldom done for the pay-check, the love of the job and the want to help people is a core motivator. If that work was not recognised, when you were not being respected for your role you played, even if the results were coming for the team, the last thing that you are wanting to do was pull on your team shirt and go and do your job. At that time you realise it is not physiotherapy that you are falling out of love with, but the team that you are working within. Not being able to get access, as was the situation Alicia found herself in in China, to the equipment, intervention or investigation, can be really frustrating. But she was quick to present how the situation could be spun to a positive, as you delve into your resourceful self and find solutions to the problems as they present.

Right: Training session with England Women's Team – previous Manager Phil Neville

Below: Australian Football League – Western Bulldogs – the "team behind the team"

Above: England – Men's U19s camp – helping support colleagues across the game especially in covid times

WHAT ARE THE BRIGHT SPOTS OF EXCEPTIONAL CLINICAL PRACTICE - PHYSIOTHERAPY?

Treating the person not the scan. As physiotherapists, Alicia eloquently describes how it is entrenched in our practice to get a lot of information using methods besides imaging. The communicational skills, the additional data from their match play stats, screening information, the objective examination, and observing performance on the pitch, all allow the physiotherapist to understand what is happening with the athlete and how we might be able to intervene to effect change. In China, particularly, where imaging was sparse, Alicia describes how it was incredible what pathology athletes were able to perform with at the highest level of competition. Specific examples of gold medals winners with stress fractures that they would have been shut down ages ago in Australia or tendons that would be a clear surgical candidate if running the programme by the textbook were shared. These experiences resulted in learning to really listen to the athlete and trusting your gut when making decisions about whether to send the player out to play or not.

Another bright spot Alicia highlighted were relationships. Not only with colleagues, but within the MDT, with coaches and with players. By 'relationships', Alicia describes the values of being vulnerable and open, to have trust in your colleagues, and to know your limitations and that others can cover for you if you are not there. The consequence of doing this well is a genuine environment for growth and progress. She describes how you can have the best clinicians in the room, but that these can be the worst MDT's if the communication and relationships that have been formed do not provide an environment that really allows for trust in each other to develop.

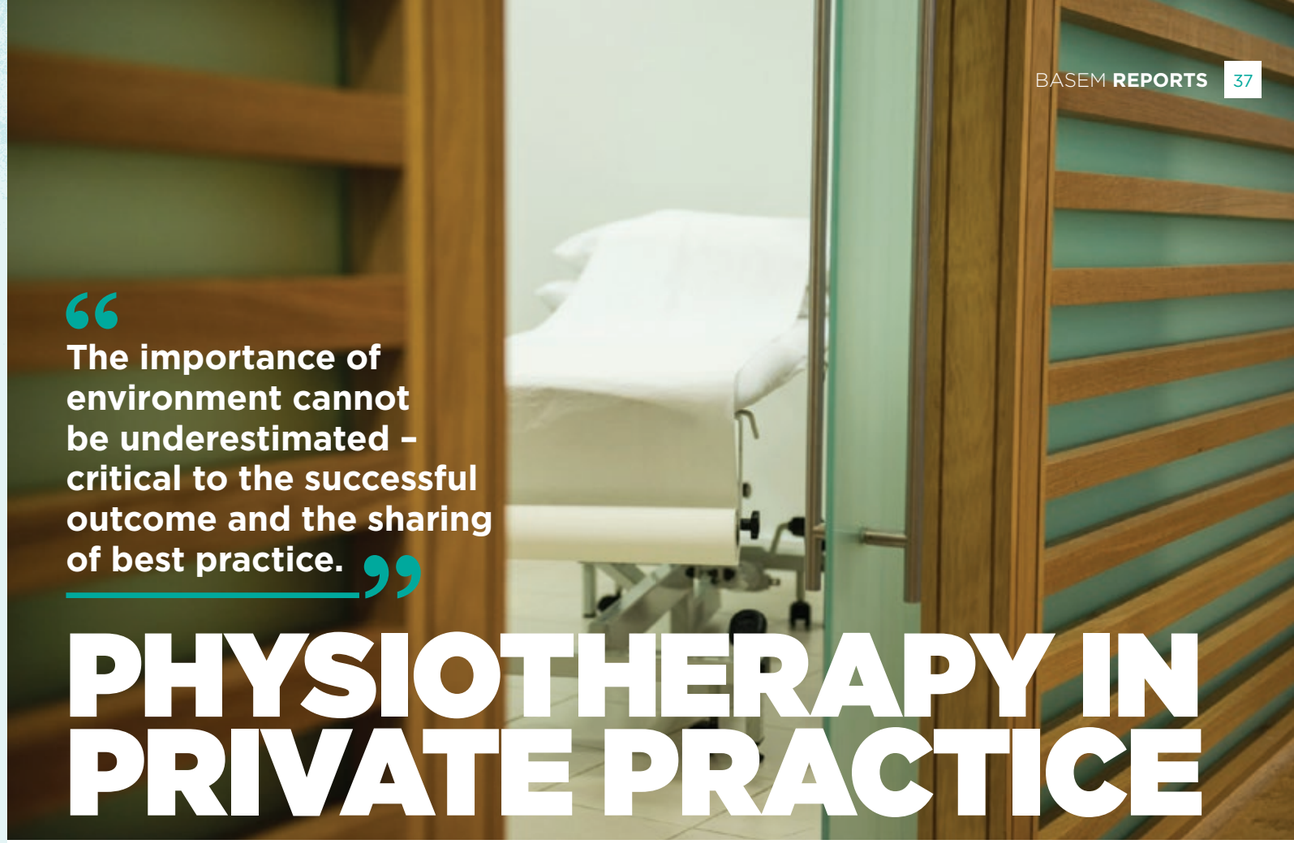
> "To appreciate what other team members can bring to the table when managing the player or athlete."

The last bright spot is the set of skills that you develop beyond the professional. To be a valuable team member is not often just your clinical skills. Alicia describes how you might be valuable due to the ability to offer a little bit more levelness to the meeting, to be in a position to bring the human factor to your conversations or that you develop confidence in others through the interactions that you have had with them. These skills can be a really important differentiating factor and see you really flourish as a physiotherapist in sport.

WHERE ARE THE AREAS FOR PROGRESS FOR PHYSIOTHERAPY?

The diversification of the skill set that a physiotherapist can develop means that we are on a good footing going forwards. As a result of a broad set of skills, the array of roles that exist within the medical teams are ones that Physiotherapists can fill. There are fantastic opportunities to further study and develop as physios, from independent prescribing to imaging and injecting, evaluating loading data, match statistics and training loads. Not with the objective to have physiotherapists taking over all roles, but much rather to have insight into all of these elements of player management. To appreciate what other team members can bring to the table when managing the player or athlete.

As a result of this understanding, the head of medical and head of performance roles can be filled by physiotherapists who have developed this wide array of tools or knowledge.



> "The importance of environment cannot be underestimated – critical to the successful outcome and the sharing of best practice."

PHYSIOTHERAPY IN PRIVATE PRACTICE

ARTICLE BY **DR SIMON LACK**

The bright spots of Environment, Communication, Outcomes and Research discussed in the context of physiotherapists within the MDT of private practice, before proposing a future vision for Physio in private practice.

Since the founding of Pure Sports Medicine in 2003, physiotherapists have formed an integral part of the multidisciplinary team of clinicians that work collaboratively to achieve the best possible outcomes for patients. From a single Kensington clinic at the beginning, the company has grown to 7 sites across London. Using the focus on delivering excellent clinical care and helping clinicians develop as excellent clinicians as the driver in growth.

ACTIVE APPROACH TO REHABILITATION

At each site private clinic rooms open out to a dedicated rehab space, promoting an active approach to rehabilitation. The carefully considered environment ensures an optimal patient journey and a facilitated MDT treatment approach. The transition from subjective and objective assessment, imaging, and adjunctive therapies in the clinic room, to exercise rehabilitation and performance training on the gym floor is smooth and easy. The presenting patient complaints are varied and sometimes complex, benefiting from a team approach that has developed the highest levels of professional ability. The clinic environment at Pure Sports Medicine creates an opportunity for problem sharing and solving, offering a space where clinicians can observe others at work and provide stimulus for asking questions about the treatment approaches being delivered. From both a patient journey perspective and a collaborative team approach, the importance of environment cannot be underestimated – critical to the successful outcome and the sharing of best practice.

Communication takes on many different forms in clinical consultations, but arguably the most important is that between the clinician and the patient. The 30% retention figure (amount of information retained by the patient in the initial consultation) is referenced frequently. Shared decision making and therapeutic alliance are considered essential in effective management, yet few tools exist to facilitate these.

If information sharing is considered important, implementation of methods to enhance this were deemed vital for what we do at Pure and so our Patient Management Plan was developed. This one-page document forms the focal point of patient-clinician interaction during the initial consultation.

Above: The private clinical rooms in all clinics are situated close to the rehab gyms to allow for ease of transition between spaces

Above: The clinician completing the patient management plan in collaboration with the patient

It centres around the patient's goals and presents the working diagnosis and predicted time frame for recovery/goal achievement. It also includes a discussion about the involvement of other disciplines that are considered to be important in optimal management of the patient, so the patient has a clear understanding of their plan and the engagement required from them to achieve their goals. Correspondence with the patient's medical team is still undertaken using a digital dictation system, but the Patient Management Plan focusses on communication, education and engagement with the patient.

PATIENT REPORTED OUTCOMES

It was presented to all members of the clinical team as one of the greatest opportunities to understand how patients have responded to their management. Patient reported outcome and experiential measures, collected via an online platform called Cemplicity, have been selected for their simplicity. Thirty plus question forms, whilst providing useful insight into the patient's problem, were deemed not a viable ask of our busy patient demographic, or considered relevant or important by patients. A more pragmatic set of questions have been used to gather information that was important to both patients and clinicians. Baseline measurement of pain severity and functional limitation using the Numerical Pain Rating Scale (NPRS) and Patient Specific Functional Scale (PSFS) respectively meant we could collect valuable information from two questions.

> **"It also includes a discussion about the involvement of other disciplines that are considered to be important in optimal management of the patient, so the patient has a clear understanding of their plan and the engagement required from them to achieve their goals."**

In subsequent progress tracking rounds at 6 weeks, 3,6 & 12 months, a global rating of change as well as a patient acceptable symptom state score is obtained. In the year to date, over 3000 baseline patient measures have been collected with 55% of patients achieving an acceptable symptom state at six weeks, 60% achieving an acceptable symptom state at three months, 65% at six months and 83% at 12 months. The system is constructed so that clinicians can review all patient's progress in a straight forward manner, but crucially they are also notified if a patient's progress declines. When coupled with experiential information and associated comments, the scope for reflective practice and identification of knowledge gaps is significant.

EVIDENCE INFORMED MEDICINE

Research activity and culture, nested within routine clinical practice, is never an easy synthesis but is essential to the true delivery of evidence informed medicine. With the support of funding organisations such as BASEM and PPEF, we have been able to embed research activity into day to day clinical activity. Our recent prospective cohort study published in The Knee, titled 'Variables associated with successful outcome after anterior cruciate ligament reconstruction in recreational athletes', is an example of such activity. Clinicians are supported in the development of research skills with the collection and aggregation of data part of standard practice within the organisation. While the dissemination of published articles is not novel, associated commentary from the Head of Research provides context for the research information within our specific clinical environment and facilitates company-wide discussions regarding best practice whilst openly acknowledging the challenges associated with its integration into the 'real world'.

These systems and processes demonstrate high levels of governance, quality, opportunity for reflection and for growth. There is a really positive future for physiotherapists and AHPs working within MDT private practices. The collaborative approach and evaluation of outcome ensures we are accountable for the care we deliver and the outcomes they achieve. With a wider NHS push for AHPs to develop advanced practice and first contact practitioner skill sets, the scope for individual professional growth is significant, but so too is the recognised role of Physiotherapists as experts in their specific area of management. Much of this is already firmly embedded within private practice, with a focus on removing unwarranted variation in care and ensuring the highest standards of patient management. Valid and reliable collection of patient report outcomes is integral to that process and we believe is essential in demonstrating what value based healthcare looks like.

If you are interested in the work we are doing or are keen to hear more, please do make contact. *simon.lack@puresportsmed.com*

pure™ sports medicine

Below: Our fully equipped rehabilitation spaces provides the necessary equipment for the complete recovery journey

SPORTS TRIVIA QUIZ - ANSWERS

Questions centred on the Olympics

Question 1:
What are the new sports to be included in the 2024 Olympic Games in Paris and which one has not appeared as a demonstration sport in previous Games?

Answer:
4 new sports have been included to increase the appeal of the Olympics to the younger generation.They include Break dancing (Breaking), Sport climbing, Skateboarding and Surfing. All four are easy to take up and participants form communities that are very active on social media.

Breaking
Breaking is a style of dance that originated in the United States in the 1970s. It took form in the lively block parties in the Bronx, emerging from hip hop culture, and is characterised by acrobatic movements, stylised footwork and the key role played by the DJ and the MC (master of ceremonies) during battles.

Whilst it appeared in the 2018 Youth Olympics, it has never appeared in the Summer Games. There will be Boys and Girls events held at La Concorde.

Sport climbing
Sport climbing made its demonstration debut at the Games at Tokyo 2020 and in 2024 will be held at Le Bourget Climbing Venue. Events will be Bouldering & lead climbing (combined), women's and men's events, also Speed climbing, with women's and men's events too.

Skateboarding
Skateboarding was a demonstration sport at Tokyo 2020 and will also take place in 2024 at La Concorde. There will be Street and Park events for men and women. Street events take place on a straight 'street-like' course with stairs, handrails, etc. set up to resemble the urban environments where skateboarding started out. The park competition takes place on a varied course combining bowls and numerous bends, which the athletes use to gather speed and perform tricks mid-air.

Surfing
Don't expect to see the surfing in France, this will be held in French Polynesia at Teahupo'o, on the island of Tahiti. In surfing there will be men's and women's shortboard events.

Question 2:
Where does Great Britain stand in the overall Olympic medals table?

Answer:
4th in the combined Summer and Winter Games

Nation	Gold	Silver	Bronze	Total
United States	1173	953	833	2959
Soviet Union	473	376	355	1204
Germany	305	305	312	922
Great Britain	296	323	331	950
China	284	231	196	711
France	264	293	332	889

Germany has fewer total medals but heads us because it has won more gold medals. If you include East Germany their total of golds is 438 with an overall total of 1386 medals.

Only five countries have participated in every Summer Olympic Games: Australia, France, Great Britain, Greece, and Switzerland. Of these, only Great Britain, France and Switzerland have also participated in every Winter Olympic Games.

Question 3:
Why was the 1904 Olympic Marathon so contentious?

Answer: Several reasons.

1. It was conducted in St Louis in the afternoon with 90˚F temperatures.

2. It was run over 40k with 7 hills on dusty roads churned up by automobiles carrying judges, doctors, supporters and the press.

3. The only drink station was at 10 miles.

4. Of the 32 starters, 18 collapsed with exhaustion. One was chased off the course by wild dogs.

5. First to cross the line was Fred Lorz after 3hrs 13mins. He was about to be presented with the gold medal when the next runner appeared. Fred had collapsed at 9 miles and he accepted a lift in a car. When this broke down 11 miles later he had recovered enough to jog to the finish. He was disqualified then given a lifetime ban which was quickly reversed and he won the Boston Marathon the following year!

6. The eventual winner was British born Thomas Hicks (*above*) in 3hrs 28mins 53secs. Also exhausted at 15 miles, and with a lead of 1.5miles, he wanted to lie down to rest but his handlers refused and dosed him with strychnine mixed with raw egg white and brandy. This was repeated several times and he finished in a stupor.

BASEM MSK QUIZ - ANSWERS

QUESTIONS:

1) Describe the findings. What is their significance?
Answer: The ultrasound images show diffuse homogeneous hypoechoic signal enclosed within the subdeltoid bursa. There is an anechoic area in deep aspect. The ACJ is severely degenerated. Normal surrounding muscle, fat, and tendon tissue. This appearance may represent blood, pus, soft tissue tumour, not synovial proliferation.

2) What would you do next?
Answer: Order pathology tests as indicated above, MRI, plain XR.

3) What do the MRI Scans show?
Answer: The MRI shows ACJ degeneration, considerable thickening and inflammation of the subdeltoid and subcoracoid bursa. Normal glenohumeral joint, long head of biceps and rotator cuff.

4) What might have caused this pathology?
What further management would you consider?
Answer: Previous surgery or injection in the area. Haematogeneous spread from a distant site. Infection following inflammation. Invasion through skin overlying ACJ (though no sign of cut or abrasion). Immunosuppression of patient. Infection of the bursa with no known cause is very rare. Patient requires medium term follow up 3- 6 months.

A SEASONAL CHAT...

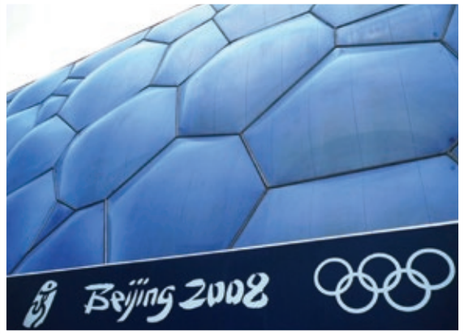
...WITH **GRAHAM ANDERSON**

Graham Anderson is a freelance physiotherapist who has worked in sports physiotherapy for over 28 years. He is a regular on the ATP Tennis Tour and is Lead physiotherapist for the Championship AELTC Wimbledon.

His career has seen him work at four Olympic Games (3 associated with Team GB) and 5 commonwealth games (Team Wales) as well as physio for many sports such as rugby, ABA Boxing, Korfball, Badminton, Triathlon, Cycling amongst others. He now focusses on long term solutions for the long term injury rehabilitator.

01: What first interested you in Sports Medicine?

I was always a frustrated sportsman, never victorious, but always wanting more and loving the competition environment. I had a short detour to other careers, and experimented with different choices in life.
But I came back, because I love sports and the medical sporting environment more than anything else in my life. I was lucky enough to have Jenny Brown (later, a chef de mission) as my physiotherapy manager when working in my early years in the NHS and I could see what role she played in Team GB and I immediately set out to get a bit of that!.



02: How and when did you get your current job?

I have always said yes to offers of any sports work. I have always given up my holidays to be available to work for some team or some event over my first 10-15 years of sports medicine. I was lucky enough to get into the University games, the World Games, and soon afterwards the Commonwealth games. Several Olympic Games later, I was lead Physiotherapist to the Wimbledon Championships. I was a familiar face to the tennis tour players and hence could slip easily into the ATP tour operations and medical services. So now I travel globally with the ATP tour providing physiotherapy services on and off court for all players on tour. I remain the lead physiotherapist at the Championships employed by the AELTC.

03: What is the best part of your job?

I am always learning; I work side by side with an array of international physiotherapists and sports doctors and consequently can learn and watch a multitude of skills often specific to that country. After 35 years of sports medicine, I still enjoy learning something new every day. Tennis is not a similar commitment as say football and rugby and hence it gives me time & opportunity to develop late-stage rehabilitation trouble shooting skills for a wide-ranging group of athletes.

04: What is the worst part of your job?

The hours I put in. An 8 hour day is a rarity. During an indoor tour event (particularly if on your own) you can leave the hotel at 08:00am and return to the hotel at 03:00am. This gets tough when repeating it for a full week plus. Tennis is a very flexible sport but you never know at what time of the day/night will you finish. However, based on events, the role may not put the demand on you to be involved for many weeks at a time.

05: By whom have you been most influenced in your professional career and why?

I have been influenced by many. As a sports physiotherapist working in a variety of governing bodies and multisport events throughout my career. I have been mentored and supported by Dr Nicola Phillips. I have been influenced by numerous SEM and orthopaedic doctors, physiotherapists, podiatrists, psychologists, nutritionists, soft tissue specialists – all who have taught me the importance of a teamwork approach adopted in sports medicine.

06: What do you do to relax?

I definitely don't watch tennis; ha-ha.
I do enjoy watching most sports, but my love is listening to music and finding new artists. Travelling the globe also remains a love of mine, be it tagged on to the end of a tournament, or just for fun.

07: What are the 5 things you could least do without and why?

- I need my hands and my thumbs; they have the many years of experienced feel and wisdom to assist my therapy.
- I would hate to work without space. Assessment and development of rehabilitation requires the space to perform what the athlete needs to do, often, at the speed they need to do it.
- I need my eyes to assess biomechanics and techniques of performance on top of simple orthopaedic testing etc.
- I cannot do without a great team around me (including the athlete). Sports medicine is not a solo approach. All in the multidisciplinary team have to be motivated under the same route /goals for success of recovery/return to play.
- The day I am without energy and enthusiasm to learn and share is the time I stop working in sports medicine.

08: What would be your top five desert island CDs or DVD's?

Heaven – *Talking Heads*
October - *U2*
Street Spirit – *Radiohead*
The Trap (The London Marathon Theme) – *Champions United*
God is a DJ – *Faithless*

09: If you could meet any historical figure (alive or dead) whom would that be and why?

David Bowie. To hear of his 5 decades of stories from his cultural influence in contemporary arts and lifestyle.

10: Would you like a second career and what would it be?

I would enjoy being a chef. But really, I'd love to have my career again, starting as a successful athlete.

11: What are your aspirations for your professional future?

I am lucky to have ticked most of the goals on my career bucket list. I now just look to sharing my knowledge and wisdom in a consultancy role. I look to set up short term consultancy for those athletes struggling with a stubborn lack of return to play following an injury.

What question would you like to ask our next seasonal guest?

How can the sporting medical profession clearly present to the patient/athlete similar treatment pathway information across all the involved allied professionals?

SAVE THE DATE...SAVE THE DATE...SAVE THE DATE

THE BASEM ANNUAL CONFERENCE

5th-6th October 2023

Emirates Old Trafford Cricket Ground

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