sport health

VOLUME 28 • ISSUE 4 • SUMMER 2010/2011

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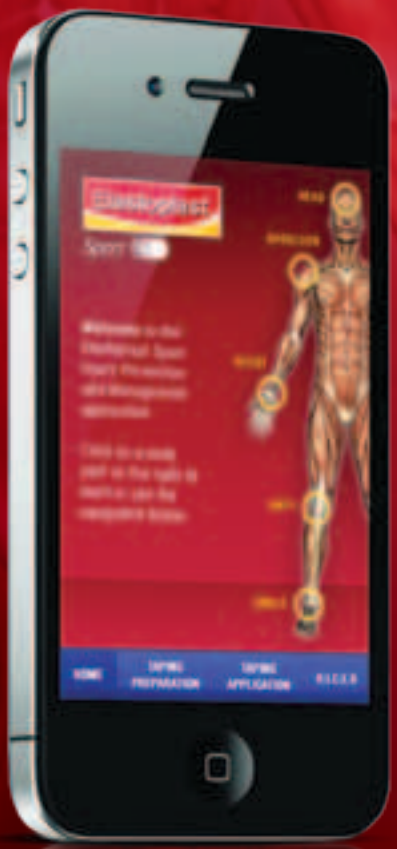

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Starting with Why…

Nello Marino is pictured with the SMA Injury Fact Sheet Series. Up to 50 of these fact sheets are available FREE to SMA members (plus postage). To download or for an order form visit http://sma.org.au

If you have a worthy cause or issue related to sports medicine or physical activity that you would like promoted in *Sport Health* via a promotional item, e.g. hat, t-shirt, mug, email **nello.marino@sma.org.au**

I was recently sent a link suggesting I view a particular leadership presentation online. My initial reaction was to believe this was just another motivational presentation from one of the numerous 'gurus' who seem to have their own theory on saving the world or finding fame and fortune.

Being the pragmatist that I am I usually watch a few minutes of these types of presentations and quickly lose interest at the syrupy enthusiasm that oozes from them. However this one for some reason was different. The presenter's name is Simon Sinek, and unlike many of the other similar presentations, there was very little hype and for some reason seemed to resonate with what was happening in my work life at the time. Simon Sinek's message is simple, he simply says 'Start with Why'. This also happens to be the title of a book he has recently written (which I am yet to read), but he insists that 'people don't buy what you do, they buy why you do it'.

During the presentation he tells a great story about the Wright Brothers and their rivals who were all trying to build the world's first successful airplane and make the first controlled, powered and sustained heavier-than-air human flight. The story is used as an illustration showing the reason why you do something can be far more important than what you do and how you do it.

Of particular note in the story is a rival of the Wright Brothers, Dr Samuel Pierpont Langley. Comparing Pierpont Langley and the Wright Brothers would suggest that he had all the necessary ingredients to achieve the goal of being first to fly. The comparisons are simple: Pierpont Langley had over $50,000 in funding from the US Military and others, which at the turn of the century was a great deal of money. He held a seat at Harvard, worked at the Smithsonian Institute and was very well connected to the great minds of that time. His team was made up of the best and most talented people that money could buy and his progress was frequently reported in the *New York Times*. Based on this you would expect that success was a mere formality.

Comparatively the Wright Brothers funded their program with the proceeds of their bicycle store, none of their team even had a college education, including Wilbur and Orville, and none of the media showed any interest in their progress. According to Sinek, 'It wasn't luck. Both the Wright brothers and Langley were highly motivated. Both had a strong work ethic. Both had keen scientific minds. They were pursuing exactly the same goal, but only the Wright brothers were able to inspire those around them and truly lead their team to develop a technology that would change the world. Only the Wright brothers started with Why'.

The Wright brothers' motivation was to believe that such a discovery would change the world, whilst Pierpont Langley was supposedly driven by fame, fortune and the personal outcomes derived from the achievement. The Wright brothers had a team of people who were prepared to give their all and follow a belief rather than be motivated by becoming rich and famous.

Further illustration of this was the fact that very shortly after the Wright brothers' announcement had filtered through to Pierpont Langley he quit without any consideration of improvement of the technology or other such embellishment of the great achievement.

I managed to see this online presentation around the time we were planning a review of the SMA Membership. Rather timely. On the surface SMA Members would appear to get pretty good value for their membership. This includes a bi-monthly *Journal of Science and Medicine in Sport*, a quarterly *Sport Health* magazine, endless amounts of member benefits which offer discounts for anything from home loans to health insurance. Not to mention discounts to professional development including a great conference, which continues to be lauded by those that attend.

But I have a pretty good hunch that these aren't the reasons why health professionals or anyone else for that matter, joins SMA. One of our goals at present is to find out WHY people choose to join SMA. Hence the reason why we've engaged a third party to ask this precise question, amongst others, of our members both current and lapsed.

Whilst all of the Board and staff at SMA has its hunch regarding the motivators for SMA membership, I'll reserve comment until the results are available and refrain from any possibility of skewing the results.

The feedback will hopefully give us a better understanding of our members and their major motivators for joining an organisation like SMA in addition to assisting us to design and tailor the services that we offer members in the future.

Incidentally the presentation can be found at http://sma.org.au/sport-health-summer-20102011-starting-with-why/. It's well worth a view if you have any interest in leadership.

Nello Marino

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5 mins with… Dr Peter Larkins

Sports Physician/Media Commentator

How many years have you been in this profession?

30+ years.

Where do you work?

Melbourne – based at Epworth Sports & Exercise Medicine Group in Richmond. It is a specialised sports medicine centre for all ages and levels of activity. We provide injury and fitness advice to a very wide selection of patients.

What does your typical day consist of?

Consulting with patients (aged 8–88) or in the operating theatre as an assistant surgeon. In winter I also do weekends broadcasting AFL games with Triple M radio as a specialist medical and sideline commentator.

What is your favourite aspect of your job?

Sorting out problems for people who have had troubles for a long time and educating the public on health topics.

What has been the highlight of your career?

Attending multiple Olympic Games.

When, why and how did you become involved with SMA?

I began as a student member through the advice of my mentor (Dr Howard Toyne) – it was the only way to mix and learn from other sports med folk.

What are you passionate about?

Educating and promoting health and fitness through healthy living – including sensible activity and nutrition.

What's the best piece of advice anyone has ever given you?

Believe in yourself and set your goals high.

Name four people, living or not, you would invite for a dinner party and why?

Robin Williams (eccentric genius)

Cameron Diaz (for her cooking skills!)

Mark McCormack (IMG founder – sport marketing guru)

Mark Doherty (Asics) (he wouldn't drink my cellar dry)

Favourites

Travel destination: Noosa (if local)… Italy (if exotic)

Sport to play/watch: Track & field… AFL

Cuisine: Italian

Movie: A Beautiful Mind

Song: While My Guitar Gently Weeps (The Beatles)

Book: The Perfect Mile (Neil Bascomb)

Gadget: Kitchen knives/parmesan cheese grater

The end of the beginning

In this issue, *Sport Health* takes the opportunity to concentrate on a genuine theme of contemporary importance – the impact of Sport and Exercise Medicine (SEM) in Australia becoming a specialty under Medicare. The failure over the past two decades for sports medicine to be properly recognised has been a staple 'go to' play for Dr J columns in a slow news season. Along with my almost annual bag the surgeons for ripping off the system, it has always meant there has been something substantial for me to whinge about. Does this now mean I will need to retire or hibernate, a la the Chaser when the Howard government was thrown out and they were only left with kids with cancer as a source of parody? It doesn't appear that complaining about the status of sports medicine under Medicare is actually going to disappear as a potential topic. The official status of sports physicians has merely changed from being considered second rate GPs to being considered second rate physicians (see Table 1). Rather than permanently move on to more productive issues like how to increase the number of Australians who exercise, the Australian College of Sports Physicians (ACSP) risks being stuck on Groundhog Day trying to get equal treatment under Medicare. However, one hurdle (about whether the ACSP actually deserves to exist) will have been cleared. It is the end of the beginning.

The most important thing about deciding to train as a sports physician is that I can honestly say that I have never regretted my choice of career. Much as it has taken two decades to get the official stamp of legitimacy, the demand both in the community and amongst elite athletes for services gives the specialty legitimacy every day. It would be a foolish choice to wish instead for me to have undertaken a career inserting colonoscopies into anuses simply on the basis that both the Medicare rebates and take-home pay are far more lucrative. Although we are justified in seeking equal consideration under Medicare to other specialties, many of these specialties would struggle to provide equal job satisfaction no matter how lucrative the financial rewards are. We are fortunate to work in sports medicine.

Similarly, the recognition of SEM as a specialty under Medicare has far more positives than negatives. The biggest positive is that we have an official place in the medical system. It has been a little known fact that a group of younger sports physicians has – for the last decade – only been allowed to practice at all under Medicare due to legislation which was the health equivalent of a Temporary Protection Visa. Since 1996, new doctors have only been allocated provider numbers under Medicare if they have trained in General Practice or an officially recognised specialty. Sports medicine had a special amendment to this passed about a decade ago stating that sports physician trainees or Fellows could annually have a temporary provider number renewed until a decision was made on whether SEM was actually to become a specialty under Medicare (in which case they would finally have a permanent right to a provider number). If specialty recognition was officially not granted (rather than the state which existed for roughly 15 years where a decision had simply not been made either way) then these doctors could have completely lost their right to practice under Medicare. It is a complete and utter disgrace that someone could have spent 15 years training and practising in what we now have had established as a medical specialty, without a guarantee that this training would ever be recognised permanently. It would be an almost identical situation to taking a university course and doing four years of study and then having to wait for years after you finished for bureaucrats to decide whether you would be awarded the degree. No other group of doctors in the history of medicine in Australia has had to put up with this situation and it is almost certain that none ever will again. The other emerging specialties (such as addiction medicine) have required doctors to already have a provider number from another qualification in order to train in that specialty. Sports medicine has been in this unique situation because our training program predated the 1996 provider number legislation.

Although most other practitioners in proximity to sports physicians would need to have been living in a cave to have missed our whinging about it, the downside to specialty Medicare recognition has been that Medicare consulting rebates for patients of sports physicians have actually decreased (see Table 1). It is the first time ever under Medicare in Australia that a group of doctors has taken a hit in absolute terms for consulting rebates. How has this happened? Specialty item numbers are not timed like primary care item numbers are. They probably should be, but the current system is that they aren't. One assumption is made, fairly, that initial consultations take longer than reviews. Another assumption (which is generally but not always correct) is that physicians provide longer consultations and surgeons provide shorter consultations. Physicians therefore generate high Medicare consultation rebates and surgeons (or 'proceduralists') generate low Medicare consultation rebates. The surgeons have generally not complained or needed to complain because many of their consultations are merely an annoying distraction from their core business of operating, where they earn their real money. It is the physicians who need to generate income from their consulting sessions. The essence of the problem for sports physicians under Medicare is that we have been classified as surgeons rather than physicians. This would seem to be a basic error but not necessarily one which is easy to have corrected. The 'motivation' for the Health Minister to make the error is that Medicare will pay out a lot less money to patients of sports physicians by considering us to be surgeons rather than physicians. The government has already overseen a gross injustice that it has taken 19 years for the ACSP training program to finally be approved under Medicare, so a realistic/cynical viewpoint may be that it could take equally long for the 'error' of sports physicians being misclassified to be corrected.

Table 1 – 2011 Medicare rebates for consultations

(*) Referred for specialist physicians, un-referred for primary care physicians.

Specialty/area	45 minute complex initial consultation (*)	35 minute initial consultation (*)	25 minute review consultation (*)
Rehabilitation medicine (specialist)	$215.85	$123.45	$61.80
Rheumatology (specialist)	$215.85	$123.45	$61.80
General practice	$99.55	$67.65	$67.65
General practice registrar (trainee)	$99.55	$67.65	$67.65
Sports physician (specialist) (after Nov 1 2010)	**$70.00**	**$70.00**	**$35.15**
Sports physician registrar (trainee)	$61.00	$38.00	$21.00
Sports physician (prior to Nov 1 2010)	**$96.00**	**$65.20**	**$65.20**

About 10 years ago, Jeff Steinweg was in the middle of his second term as ACSP President and had been lobbying for specialty recognition (as all recent Presidents have done). He told me that whilst he was frustrated at the massive roadblock that was placed in front of the ACSP by the AMC (Australian Medical Council) recognition process, at least it appeared to be an objective and transparent process. Prior to the AMC process, a new specialty was admitted into the 'club' by simple vote of the existing specialties. Such a system was obviously flawed and has been appropriately replaced by an objective measure to decide whether a medical discipline and its training program is of 'specialty' standard. The problem is that we have almost come full circle. There is no formal process for determining whether a specific physician group is officially a 'consulting physician' under Medicare. It has long been accepted that the traditional non-surgical specialists (e.g. cardiologists, gastroenterologists, rheumatologists) are consultant physicians and that surgeons, obstetricians, anaesthetists and radiologists are 'proceduralists'. Apparently the process for determining whether sports physicians were to be considered physicians or proceduralists was not something objective (i.e. how many consultations per hour are typically done and how many procedures per week are typically billed for under Medicare?). The process was apparently a throwback to the Byzantine days of Medicare, whereby the Royal Australian College of Physicians (RACP) was asked by the government "Do you want sports physicians in the consultant physicians 'club'?"

The golf club membership ballot approach suits the RACP a lot more than the alternative, because if it is ever replaced by an objective approach, there would be some so-called consultant physicians who would not survive a re-assessment. The gastroenterologists who spend half the week doing endoscopies and a significant portion of their time screening new patients with short consultations to see who is suitable for an endoscopy have a practice profile which is indistinguishable from a typical surgeon's practice. They are not working as consultant physicians (non-proceduralists), but they benefit from the higher rebates because they have been afforded this status by the 'old boys club' determination system which is in place. As the system now stands, a 10 minute consultation with a gastroenterologist as a pre-scope work-up generates a much higher rebate than a 40 minute consultation with a sports physician for multiple complicated musculoskeletal problems and their co-morbidities, simply because the RACP has a 'Royal' in its name.

In the last few months I have been party to some fruitful communications with the AMA about the status of sports physicians. I resigned from the AMA in the year 2000 because of their refusal to recognise sports medicine as a specialty and I can't see myself thinking about re-joining until sports physicians are treated equitably by their organisation. The AMA finally has SEM on the agenda because according to the 'system' the specialty now officially exists. This is an improvement. It is important to note that the current AMA President, Andrew Pesce, appears to be fair minded and progressive. He is aware of the misclassification of sports physicians and also that the AMA needs to gain a foothold on the massive public health issue of obesity and inactivity. There appears to be a good chance that the AMA will finally give sports physicians a fair hearing with the possible result – believe it or not – of the AMA classifying sports physicians as physicians rather than surgeons! There are two legitimate arguments against a group being given consultant physician status – that the doctors aren't specialists or that they are proceduralists (i.e. not physicians). There is a third, non-legitimate reason, for some doctors wanting to deny a group such status – that you are a competitor (e.g. rehabilitation physician or rheumatologist) and don't want your competitors to have the same rebates that you enjoy. For anyone in business, the next best thing to favourable government treatment for your own business is unfavourable government treatment for your competitors. It is fortunate that the incumbent AMA President has a broad outlook and is forward looking. The fact that the AMA has never treated sports physicians equitably to other doctors (and that therefore the vast majority of sports physicians are not currently AMA members) means in the AMA we are massively outnumbered by members of colleges (RACP, RACS) that may not want sports physicians to be considered equitably. If you are a rehabilitation physician, rheumatologist or orthopaedic surgeon, a sports physician may now be competition that might potentially take a musculoskeletal patient away from you.

There are indeed some 'consultant physicians' who work side by side with sports physicians in sports medicine centres. I suspect that even some of these doctors do not want sports physicians to generate the same rebates as they do, because they don't want to lose the competitive advantage of a much higher Medicare rebate than their colleague in the office next door with a similar practice profile. If the AMA officially decides to finally recognise sports physicians as consultant physicians, it would be a great step forward and

would hopefully pave the way for joint exercise promotion advocacy between the AMA, ACSP and SMA. The ACSP has had a specialty physician training program for 19 years (a date which I am certain of as that is when I started my own training) so although it would be terrific to achieve AMA recognition, it would not be before time. Sports physicians were recently the first doctor group in the history of Medicare to suffer a rebate cut for consultations, but the AMA has publicly said nothing. They were very vocal in their objection to proposed procedural rebate cuts for cataract surgery 12 months earlier. Any sports physician who is still an AMA member should consider writing to the President and asking him to explain the reason for publicly supporting one specialty whose patients suffered a rebate cut but not another. I have faith that Andrew Pesce understands the ACSP and is a good listener but he has inherited a legacy of the AMA excluding rather than representing what is now one of the specialty colleges.

Like all sports physicians, I am hopeful that our President can negotiate with the AMA to be afforded equal status and equal representation. Some sports physicians who previously resigned may wish to rejoin the AMA immediately if they finally decide we are equal to other physicians, whereas others like me would prefer to be a member of SMA – a professional body that has always fully valued sports physicians.

The ACSP needs to keep lobbying along these lines, but I would be hopeful that the focus of its lobbying will change significantly. All of the eggs needed to be in one basket previously. If specialty recognition was not achieved, the College would have needed to shut down, as its trainees couldn't be assured of a future. Specialty recognition had to be the sole lobbying priority for the ACSP. Lobbying to achieve 'consultant physician' status (or other reform of the specialist rebate system) is important but not as important. I would rather see the ACSP join forces with other bodies such as SMA and also the AMA to lobby for 'big picture' items such as a national target for physical activity and exercise participation and a national sports injury insurance and prevention scheme. The biggest public health challenge in Australia in the 21st Century is lack of exercise. Too many people – government and powerbrokers included – think that exercise is the domain of the individual and can't be altered by government/national policy. In C21 speak, they still don't 'get it'. Anyone who does 'get it' would understand immediately that penalising exercising patients under Medicare because their doctors' college doesn't have a 'Royal' in its name is very 'last century'.

Dr J

Dr J is a sports physician who does not hold an official position in the ACSP executive. This article contains his personal opinions which are not endorsed by the ACSP.

ACSP's take on specialisation

Twelve months ago, my predecessor Dr Andrew Garnham was able to announce that the government had recognised Sport and Exercise Medicine (SEM) as a new medical specialty. This was certainly welcome news after a circuitous journey which had lasted longer than 15 years. With the announcement many uncertainties remained. The Australasian College of Sports Physicians (ACSP) in their early dealings with the Department of Health and Ageing (DoHA) had been told very clearly that recognition of SEM as a specialty area of practice did not necessarily mean that SEM Physicians would automatically be provided with recognition as specialist practitioners. The Australian Medical Council (AMC) is the statutory body that assesses specialist medical training colleges to firstly ascertain as to whether the body of knowledge which they possess does in fact qualify as a specialist area of knowledge and secondly to decide whether the training program provided by that medical college is of specialist standard. The AMC had recommended to the Minister of Health and Ageing that SEM was a specialist area of knowledge and that the ACSP conducted the training program which was of specialist standard. Ultimately it remained at the Minister's discretion whether or not SEM Physicians would appear on the specialist register.

In May last year the Federal Budget contained the following announcement;

The Australian Government aims to enhance and increase the capacity of services in the medical fields of Sport and Exercise Medicine, Addiction Medicine and Sexual Health Medicine, by providing access to specialist items in the MBS.

This announcement effectively meant that SEM, along with the new specialties of Addiction Medicine and Sexual Health Medicine was officially on the list of medical specialties, as recognised under Medicare. Without doubt, this represented a major milestone in the history of the ACSP. Many generations of SEM Physicians had worked long and hard to bring about this change. Several times over the past 15 years, the campaign had gone close to success only to falter at the final hurdle. There was an enormous sense of relief and also a sense of pride and achievement, not just from current executive but from the many eminent SEM Physicians who had worked on the College executive in previous years and from the body of Fellows and Registrars on the whole.

Unfortunately, specialist recognition does not mean that our dealings with DoHA are over. The government has deemed to classify SEM Physicians and the other two groups as

procedural specialists rather than consulting physicians when it comes to rebates for consultations. This allocation is completely inappropriate and not consistent with the AMC's recognition of our style and scope of practice. Our negotiations with DoHA over this matter will continue for some time yet.

While we have been disappointed with the outcome of consultation rebate allocation, there have been many positive consequences to specialist recognition. Probably first and foremost is the formal recognition of SEM as a specialty in its own right. This represents a validation that the preventative and holistic approach to patient care which is inherent in SEM Physician practice has a role to play in improving the health care of the nation by increasing physical activity. The government has often expressed its desire to increase physical activity levels as it grapples with the chronic and burgeoning consequences of physical inactivity.

From 1 November 2010, patients being referred for an MRI scan by an SEM Physician are entitled to a Medicare rebate. This is a major breakthrough as patients of SEM Physicians prior to specialist recognition were financially penalised for having a valid MRI investigation performed. It recognises that the ACSP advanced training program provides doctors with the necessary skill and expertise to judiciously utilise MRI in medical practice. It removes the anomaly that existed prior to 1 November where an SEM Physician could not refer a patient for a rebatable MRI for an acute knee injury, but a psychiatrist could. This is no slight against my psychiatry colleagues as they themselves are happy to acknowledge that this inconsistency was ludicrous.

Recently we have also had another major success in relation to diagnostic musculoskeletal ultrasound conducted by SEM Physicians. Medicare recognises two levels of diagnostic imaging rebate in relation to musculoskeletal ultrasound. Where a patient is not referred by another medical practitioner, the patient is entitled to a certain, lower level of rebate. If the patient is referred to a medical practitioner for ultrasound by another medical practitioner, a higher (referred) rebate is accessible by the patient. A clause in the Medicare legislation allows specialists, working in their field of specialty, to self-determine that an ultrasound is required, even if a specific referral for that ultrasound was not provided by another medical practitioner. This allows obstetricians to perform foetal ultrasounds, cardiologists to perform echocardiograms etc. DoHA has recently advised that SEM Physicians do indeed have the right to self determine the requirement for musculoskeletal ultrasound, with their patients accessing the higher 'referred' level of rebate from Medicare.

Vox pop

SMA took to the streets to ask members their opinions on the following question:

What should governments be doing to improve sport and musculoskeletal medicine in Australia?

"I think an intense campaign could be run to promote the importance of physical fitness, such as strength and physical working capacity, for health (including their link to a reduction in falls, greater chance of independent living, increased levels of energy for daily tasks and, of course, the reduction in a range of chronic diseases). This will assist in exercise adherence and setting appropriate longer-term goals for health improvements."

Kevin Norton, Professor of Exercise Science, University of South Australia

"They should recognise that ignoring the dis-benefits of active participation does not make them go away or mean they do not exist. Having population strategies that encourage participation in sport and physical activity that totally ignore the risk (albeit low) of injury in those activities will not make them safe. In fact, lifelong participation, with long term sustained health benefits across all segments of the Australian populations, will only be achieved if there is concurrent investment in the development and delivery of injury prevention strategies."

Professor Caroline Finch, NHMRC Principal Research Fellow, Sports Injury Epidemiologist, Australian Centre for Research into Injury in Sport and its Prevention (ACRISP), Monash Injury Research Institute (MIRI), Victoria

The transition to specialist practice has not been without challenges. There was significant anxiety as 1 November 2010 approached that SEM Physicians would no longer be able to see patients referred by allied health professionals such as physiotherapists, podiatrists, chiropractors, osteopaths and others. Medicare does however provide a group of consultation item numbers which are essentially a 'catch all' group of consultation items which apply, when no other specific circumstances apply. This means that if someone attends an SEM Physician, without referral from another medical practitioner, they will still get a Medicare rebate. In many circumstances the Medicare rebate for non-referred consultation is less than that where the patient is referred by another medical practitioner. The financial penalty however varies considerably depending on the length of consultation and the frequency of consultation for a particular presenting complaint. Some SEM Physicians have opted to switch completely across to a referral based practice such that all patients are required to have a medical referral. Other SEM Physicians have remained happy to see a mixture of referred and non-referred patients, on the understanding that the patient accepts they may receive a lower rebate from Medicare, if they are unreferred.

While the ACSP is on the whole delighted with specialist recognition, there is certainly no time to rest on our laurels. With specialist recognition comes added responsibility and additional requirements in terms of governance and compliance issues. The AMC is not only responsible for recognising specialist level of medical training but is also responsible for monitoring adherence with practice standards within specialist colleges. In late December, the ACSP formally met with the AMC to agree on a compliance strategy moving forward over the next 12 months. The ACSP is very pleased with the outcome of this meeting which should provide useful guidance for its executive in ensuring compliance, and more importantly in setting systems in place which deliver the required standards of specialist medical training. The ACSP will be formulating a strategic plan based on the goals and vision for the next five years.

The ACSP trains specialists within the private sector and has had a self-funded training program for the past 18 years. We currently are the only specialist training program in the country which does not receive government financial support for our training activities. Patients of our Registrars have access to the lowest consultation rebates in the Medicare system and one of my top priorities as ACSP President is to address this inequity. General Practitioners also train

their Registrars within the private system. In contrast to SEM Physician Registrars, patients of General Practice Registrars have access to the same level of rebate as fully qualified General Practitioners throughout their training. The ACSP is lobbying the government for fair and equitable treatment of our Registrars in this regard.

The ACSP is determined to be outward-looking and positive as it moves forward with its new status as a specialist medical training College. Now that the ACSP is recognised as being on an equal footing with peer specialist medical organisations in Australia and overseas, new opportunities present themselves. We have close but informal links with the United Kingdom Faculty of Sport and Exercise Medicine (FSEM(UK)) and very preliminary discussions have been had in relation to cooperative projects. We intend to explore opportunities with FSEM(UK) and other overseas specialist SEM programs for reciprocal training opportunities, sharing of teaching resources, guidance documents and other intellectual property. The ACSP sees great potential benefits from forming closer relationships and international partnerships with other specialist SEM training organisations. The ACSP is also obligated to contribute as a specialist College to national preventative health working groups and health initiatives, particularly where such initiatives are targeting physical activity levels.

Much of the time and human resource capacity of the ACSP has been consumed over the past several years by the final drive towards specialist recognition. We have not lost sight however of the important and valued relationships that our College enjoys with like-minded organisations in Australia such as Sports Medicine Australia, the Australian Physiotherapy Association and Sports Doctors Australia. While we have many negotiating days in front of us, part of our strategic plan over the next five years will be to enhance and develop our important relationships. We aim to work co-operatively and synergistically with our partner organisations in promoting physical activity as a first-line tool in the campaign to deliver better health to the Australian population.

Dr David Hughes

President
Australasian College of Sports Physicians

"The Government's recent recognition of sports medicine physicians as medical specialists is very welcome. It is now necessary for other sports medicine health and allied health professionals to renew their relationships to preserve Australia's advantage of a multidisciplinary approach and Sports Medicine Australia is ideally placed to facilitate this.

I would like to see more teaching of sports and musculoskeletal medicine in medical schools and in the GP training course. I would also like to see recognition of the allied discipline of exercise and activity medicine and particularly more awareness of the potential vast preventative health benefits in encouraging the general population to be more active."

Dr Peter Nathan, GP and Sports Doctor, Western Australia

"To improve sport and musculoskeletal medicine in Australia the government should look to create an injury register for sports injuries and provide higher rebates for Sport and Exercise Medicine Physicians. They should also look to promote Sports Physiotherapists to health funds so they pay higher rebates as well."

Michael Kenihan, Sports Physiotherapist, LifeCare Health General Manager, Victoria

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SDrA's take on specialisation

The recognition of sports medicine as a medical specialty through the efforts of the Australasian College of Sports Physicians (ACSP) must be applauded. As President of Sports Doctors Australia, I commend the ACSP for what they have achieved, I commend their drive and resilience to obtain what is best for their Members and Fellows but ultimately what is best for their patients and for sports medicine within this country.

Those of us working within the field of sports medicine, irrespective of the discipline group we represent, must support and accept the specialist status achieved by the ACSP as this newly acquired status reaffirms what we have always known, that sports medicine does have a special body of knowledge with a special set of skills that are in addition to what general medicine possesses. It would indeed be hypocritical to denigrate what they have achieved as this recognition and status helps us, as sports medicine clinicians, attain our goals. What the ACSP has achieved can only have benefits to all involved in the practice and teaching of sports medicine.

Although with this recognition comes the realisation that sports medicine is indeed not solely for the elite, it is indeed for the vast majority of others, it also reaffirms that sports medicine is patient based and patient focused. The role it plays in illness and injury prevention for the general population is substantial and cannot be measured in only monetary terms. The evidence strongly suggests that every member of society irrespective of age or degree of health or ill health would benefit from appropriate physical activity and they are only able to be involved in physical activity if educated appropriately, guided and directed with the right exercise prescription and their injuries and illnesses either prevented or managed appropriately.

Fortuitously, the Australian Government has recognised the significant role sports medicine plays in the promotion of health and the prevention of illness and has rightfully recognised the ACSP with specialist status. This recognition also reaffirms to us that sports medicine is indeed a clinical art and science.

Let us not forget that the provision of high quality sports medicine care and education is multidisciplinary, the philosophy of SMA exemplifies this premise. As sports medicine practitioners we have the skills and ability to impact on health promotion and illness prevention as well as providing Best Practice management of activity related injuries and illnesses. We are indeed privileged to possess these extended skills, these skills and this knowledge which ultimately has the potential to make a substantial difference to individuals and societies.

As a group of multidisciplinary sports medicine professionals we must support the efforts and attainments of all our colleagues and work together as a united group, because it is only by pooling our skills, knowledge and resources that we attain power, influence and change for ourselves, our discipline, our community and ultimately our patients.

Dr Shane Brun

President
Sports Doctors Australia

Specialist care or team care – why do we need more red tape to achieve both? The APA's view

The move to the specialist medical register by sport and exercise (SEM) physicians is a positive sign for sports medicine teams, not to mention their patients. Ivan Hooper, Chair of Sports Physiotherapy Australia and an APA Sports Physiotherapist working at the Australian Institute of Sport has worked with sports physicians since the profession came into being some 20 years ago.

He says "Obviously the recognition of SEMs is great…they are a really, really important link in the chain." SEM physicians provide a completely different outlook on the management of a sports injury problem than other medical specialists. "I think that gaining specialist status probably will allow for more recognition of the place that they can, and should, play in the management of sports injuries."

But while the recognition has been welcomed by physiotherapists and SEM physicians alike, it has come with some serious shortfalls for patients seeking their care.

Many health professionals working with sports people will have heard about the move that reduces rebates for patients attending an SEM physician. This will increase out of pocket expenses for patients. It also runs the risk of reducing patients' ability to afford care from the right medical specialist at the right time.

Removing the sports physician specific Medicare rebates has reduced the cash benefit for patients, even with a GP referral. Rebates for subsequent consultations which would have been levels three and four under the 2009 Medicare Benefits Schedule have been significantly reduced.

In addition, the changes mean that physiotherapists cannot refer their patients directly to an SEM physician and the patient gain this rebate – even those co-located in the same sports medicine practice. Requiring a GP referral in addition to a physiotherapist referral, treatment could be delayed, risking a slower recovery period for patients. This in turn could necessitate longer term care, using up those few Medicare dollars saved by reducing the rebates.

This change has been put in place despite the Australian Medical Council's finding in 2006 that nearly a third of referrals to SEM physicians came directly from physiotherapists. Changing the way health teams work together and simultaneously introducing an extra level of red tape to the system isn't the best way to protect our world class sports medicine teams.

Ivan Hooper asks "Why should we overload a system that's already overloaded like the GPs? Are we just sending them [patients] there to get ticked off and get a letter and then refer on?"

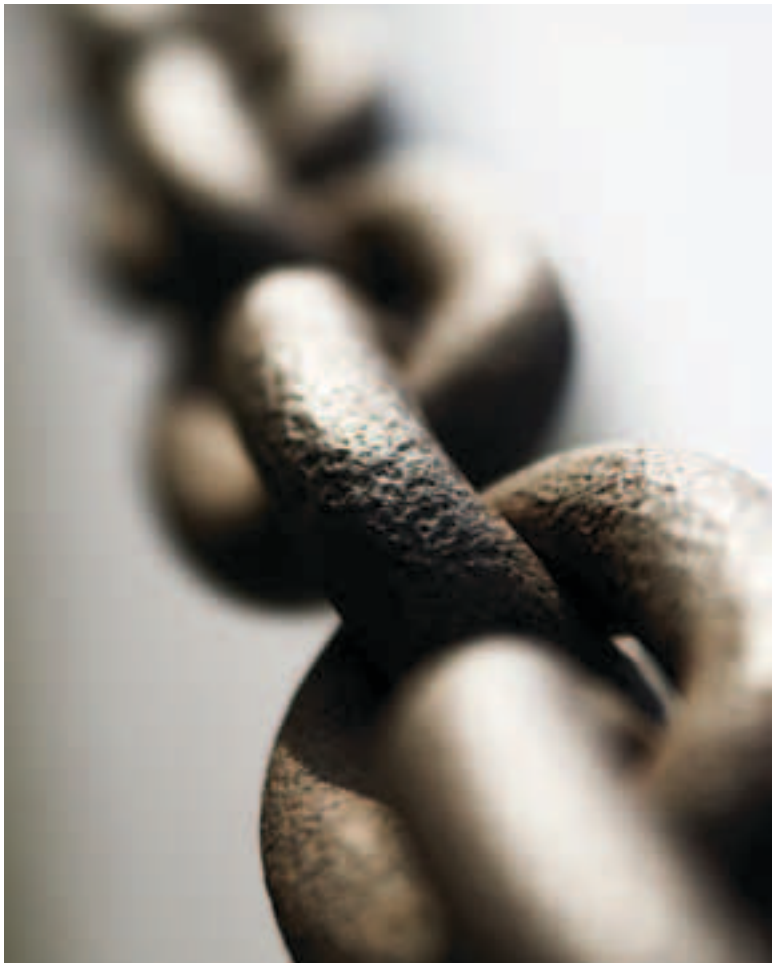
But in Ivan's experience, SEM physicians and physiotherapists are implementing a work-around which maintains the status quo and allows for physiotherapy referral under Medicare. SEM physicians can bill Non VR Medicare items to clients referred by physiotherapists. A 40 minute Non VR consult does not require a GP referral, and is rebated to clients not significantly less than a GP referred specialist consultation – particularly when the out of pocket expenses and the time costs of an additional visit to a GP are considered.

While this option is open to SEMs, it's not ideal. It fails to recognise the obvious relationship between the SEM and physiotherapy professions. Ivan says "Sports physicians came into being in what, '89 or '90, so it's a relationship that has existed for 20 years, and I think it's a relationship that works quite well, so obviously we want to try and preserve that." Just like SEM physicians wanted recognition of their expertise through government recognition as a specialist group, so too should physiotherapists be properly recognised for their expertise and contribution to the health system.

Sports medicine practices are multidisciplinary by nature. Not every injury needs to go to an SEM physician, just like not every injury should go through a GP before going onto a specialist. As Dr John Orchard said in his article in *Sport Health* last year, physiotherapists in Australia don't just follow doctors' orders; they manage injury and musculoskeletal conditions. That's because they are trained to manage conditions within their own scope of practice, and refer clients on who aren't within their scope.

The Australian Physiotherapy Association's President Melissa Locke, is concerned that the addition of more red tape will get in the way of team care. "The decision to mandate a GP consultation will lead to unnecessary frustration for patients treated in sports clinics. Currently, professionals such as physiotherapists, sport psychologists and dietitians work effectively and efficiently with their sports medical colleagues," she said. Melissa is extremely concerned that established sports clinics where physiotherapists work alongside SEM physicians won't be able to function effectively under the new Medicare referral requirements.

One of the things that governments making decisions about appropriate referral rights need to understand is that in many cases, a professional like a physiotherapist will treat a client, make an assessment that the client should see a specialist, write a detailed referral letter to that specialist, then send the person off to their GP for sign off. A GP will normally trust the judgement of a physiotherapist in the management of a musculoskeletal injury – an area where physiotherapists are recognised as experts. In fact physiotherapists are the health professionals most commonly referred to by general practice. The 2009-10 General Practice Activity in Australia survey shows that physiotherapists are the most commonly referred to health professional. 9% of all referrals (including individual medical specialties) go to physiotherapists.



Continuing direct referral from physiotherapists to SEM physicians won't stop sharing of information from occurring, nor will it stop GPs being the centre of care when it is appropriate – which is often the case. But no one could argue that entry level training for a physiotherapist doesn't cover the management of musculoskeletal injuries and conditions in great depth, so sports injuries can often be well managed by a physiotherapist. Many physiotherapists who have existing referral relationships with SEM physicians have a significant amount of extra training and experience in sports and musculoskeletal conditions. What physiotherapy referral rights will do is create a responsive and flexible model of care that places the most appropriate primary contact health professional (be it GP, sports doctor or physiotherapist) in the right place to refer for medical intervention as early as possible.

Physiotherapists will keep lobbying for more appropriate referral rights, even though the status quo seems to be maintained for now. Ivan Hooper, along with a great many other physiotherapists believe that to go through a GP to refer to SEM physicians is an inefficient system. Ivan says "I think that if the SEM physicians are successful in lobbying for the extra item numbers, then the difference [in Medicare rebate to the patient] may be greater".

Physiotherapists are concerned that their patients have been disadvantaged by the decision to remove referral rights to claim the full rebate, and if SEM physician rebates are increased without granting appropriate referral rights to physiotherapists, this disadvantage could increase.

For more information on the issue, physiotherapists and other sports physicians should go to **www.physiotherapy.asn.au/referral**. The website contains information about the APA's campaign to convince Medicare to change the MBS to better reflect the world's best practice model of care that has made Australia a leader in team sports care.

Paula Johnson

Senior Policy Officer
Australian Physiotherapy Association

Australia on the Move

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Greg

"It's been great getting that extra level of connection with my clients. They get to know each other too - and give each other support & motivation."

Greg is an exercise physiologist who is keen to build his business and utilise web-based technologies to communicate with clients.

He has recently heard about OzOM from one of his clients who was asking him for his opinion on some tips discovered on the OzOM website. Greg was not only happy to give his advice but also thought it would be a good opportunity to promote himself and his business to the members of OzOM.

Since he joined the OzOM community he has developed a regular group meeting once a week, in the gym where he works, for personal training sessions. OzOM provides them with a place to chat outside of the meetings and organise other activities with the group.

Greg has also managed to increase his client base as people have attached themselves to the group on OzOM.

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A case of mistaken identity: Administration and legal issues for misclassification of Sport and Exercise Physicians under Medicare

The recent recognition of Sport and Exercise Medicine (SEM) as a specialty under Medicare has been a mixed blessing for those practising in the specialty. It is certainly the long-awaited outcome of an assessment process lasting many years and requiring an enormous effort from many people at the Australasian College of Sports Physicians (ACSP). However, in contrast to the enormously detailed process of being assessed as a specialty, the decision to categorise SEM as a 'procedural' speciality under Medicare appears to have been made at the last minute and without reference to any objective criteria.

Essentially, SEM has been misclassified under Medicare. The result is that average patient rebates have actually fallen, and physician-length consultations (i.e. >20 minutes) are now below the equivalent rebates for GPs and their registrars. This has created further disincentives for Sports Physicians to bulk bill and provide physician-length consultations, together with increased out of pocket expense for patients.

Background

Prior to November 2010, no new medical specialties had been recognised under Medicare since the mid-1980s, when Medicare itself was introduced. On 1 November 2010, SEM, Sexual Health Medicine and Addiction Medicine were officially recognised as specialties under Medicare.

In the case of SEM, this was the long-awaited outcome of an application for speciality recognition originally lodged in the early 1990s. Part of the reason for this extraordinary delay in assessing SEM was that during this period the Federal Government put 'on hold' all existing applications (late 1990s) and then decided to appoint the Australian Medical Council (AMC) as the relevant body to assess applications for specialist status (in 2002).[1] The AMC then set about a process of determining the required attributes of a speciality, before assessing all existing colleges prior to pending applications for recognition. The AMC adopted a thorough process, involving submissions and opportunity for public comment. In 2008, the AMC completed its accreditation of SEM as a specialty.[2]

It was not until November 2009 that the Commonwealth Minister for Health and Ageing, Nicola Roxon, announced that the Government had decided to recognise SEM as a specialty.[2] It then took a further 12 months, until 1 November 2010, for SEM to be listed as a specialty on Schedule 4 of the *Health Insurance Regulations 1975* (Cth) and thus to be officially recognised as a specialty under Medicare.

Consultant physicians vs surgeons/proceduralists under Medicare

Essentially, there are two broad types of specialists under Medicare: consultant physicians and proceduralists. The determination of what the criteria are for being considered a 'consultant physician' under Medicare is not clear, and has not been set out by the Government or the AMC.

It appears that the existing specialties at the time of Medicare's creation (mid 1980s) were simply divided into 'procedural' and 'non-procedural'. The proceduralists were considered surgeon-specialists (with the assumption that they gave short consultations, but did a substantial number of 'procedures', for which other item numbers were created) and the non-proceduralists were considered consultant physicians (with the assumption that they gave longer consultations, and did not perform many procedures). Thus, the distinction means that patients receive much lower Medicare rebates for seeing a surgeon (but will receive a separate, higher rebate if they go on to get a procedure), compared to a consultant physician. However, the consultant physicians generally do much longer and more complex consultations, which is how physicians traditionally tend to practice (in lieu of performing procedures, although there has been a recent trend for some consultant physicians to perform some procedures). There has never been any suggestion that the distinction between consultant physicians and proceduralists is based on length of training, difficulty of the Fellowship or any other objective criteria.

Unfortunately, despite the extremely long and detailed process for specialty recognition, very little time was devoted to looking at how Sports Physicians should be categorised for the purposes of Medicare rebates. The AMC reported that 'recognition would presumably allow patients to claim a higher rebate', and presented some brief costing analysis of three possible scenarios. The AMC forecast that if Sports Physicians received consultant physician rebates, the additional cost to Medicare would only be about $3 million.

The result is that SEM has been incorrectly categorised as a procedural specialty, meaning that patient rebates have actually *fallen* since SEM became a specialty. Prior to specialty recognition, Sports Physicians had special (timed) Medicare item numbers. These item numbers have now been replaced with the 'proceduralist', untimed, item numbers with lower rebates. Ironically, consultations with SEM patients have now increased in complexity as the vast majority have a referral, and require more in-depth consultations (i.e. only more complex patients unable to be sufficiently managed by a GP) and a letter back to their referring doctors.

Potential legal issues raised by the misclassification of SEM as a procedural specialty under Medicare

It appears that other bodies such as the Royal Australasian College of Physicians (RACP) and the Australian Medical Association (AMA) may also have some ability to influence which specialists are considered consultant physicians versus proceduralists.

For example, the AMA sets its own 'List of Medical Services and Fees' (AMA Fees). According to the AMA website, this list is 'provided to members for costing assistance and guidance only'.[3] The AMA Fees are largely based on the Medicare Benefits Schedule (MBS) but with some differences. Importantly, however, in NSW, the AMA Fees are more than just a recommendation for some patients. As WorkCover adopts the AMA Fees as a cap, these are the maximum fees that Sports Physicians can charge for seeing WorkCover patients, and there is no ability for a Sports Physician to charge a gap.[4] Theoretically, this could raise issues under competition legislation if it could be shown that the way the AMA made decisions about its AMA Fees involved an agreement between competitors that:

- Had the purpose or likely effect of fixing, controlling or maintaining price (or a component of price); or
- Had the purpose or likely effect of substantially lessening competition in a market; or
- Had the purpose of preventing, restricting or limiting the supply of services to particular persons or on particular conditions **(exclusionary provision)**.

This would depend on a range of factors, including the relevant market definition, the precise way the AMA made the decision (such which AMA entities and people were involved) and how it is implemented by WorkCover.

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Similar issues could arise if the RACP was able to decide which specialists/colleges were consultant physicians. In a personal communication to a Sports Physician in September 2010, the AMA President, Dr Andrew Pesce stated that the Federal Department of Health and Ageing 'relied on advice from the RACP' which resulted in Sports Physicians not being classified as consultant physicians.[5] At that time, the AMA was in process of requesting further details from the RACP to 'understand the basis of that advice'. While it is not known exactly what the RACP's role was, if it could be established that members of the RACP making such a decision were competitors of the specialists they were assessing, this would raise potential concerns as an exclusionary provision.

On the other hand, if the relevant decision in relation to consultant physician status was made unilaterally by the Federal Government, different issues arise. For instance, there would be theoretical grounds for challenging this decision based on administrative law and/or judicial review principles such as reasonableness and procedural fairness. Even more broadly, the *Discrimination Act 1991* (ACT) specifically prohibits unreasonable discrimination by a body empowered to confer qualification for the practice of a profession by failing to confer the qualification or imposing terms or conditions on the qualification.

Conclusion

As well as representing an incorrect view of the way Sports Physicians practice medicine, the misclassification under Medicare gives disincentives for bulk-billing and longer consultations, both of which are beneficial to patients. Incorrectly classifying a specialty that has been through a 14 year process to achieve recognition is not an appropriate way to save a small amount of money under Medicare. Rather, the AMC or the Commonwealth Department of Health and Ageing should determine the criteria for 'consultant physician' status and apply this consistently to all new specialties. Any other decisions aimed at reducing total Medicare expenditure should be made carefully and deliberately, with an aim of reforming the system broadly and fairly. Further, the role of any other bodies such as the AMA and the RACP in determining classification and/or fees for Sports Physicians must be very carefully considered in light of potential competition law issues.

Jessica Orchard, LLB*

* Jessica is a lawyer who currently works at Cancer Council NSW and has previously practised as a competition lawyer in top-tier Sydney firms.

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Will physical activity ever become a voting issue?

As long as Australian governments frame health behaviours as an individual responsibility, then physical activity will be effectively sidelined as a political issue. The language of 'personal responsibility' for health means that the focus for government becomes 'it's up to you to be more active' and 'what service or treatment is best (at cost) to help you change?'. It takes the focus away from the policies and programs that government could introduce that create a social and physical environment where it's easier, more enjoyable and desirable to be active.

Tony 'Iron Man' Abbott, as the former federal Minister of Health, embodied this individual responsibility philosophy. As a high level athlete himself, he had little empathy for others that didn't have 'what it takes' to train as hard as he did. Yet elite athletes are, by definition, small in number. The bulk of the population is not active even for the minimum 30 minutes a day of moderately intense activity. Most of these people, to some degree, genuinely believe that it's their fault they're not active enough, and many have not considered how the environment they live in directly influences their behavior. Some of these people would struggle to articulate how government policies have impacted on their activity levels, or choices to drive more instead of using public transport or walking or cycling.

I think the public would vote for political leaders that genuinely want to create a healthy, liveable and sustainable community. This requires a clear, consistent and well communicated vision, but also the allocation of funding. Increasingly, lack of investment in public transport is seen as a political failure. Over the past decades state governments have built a transport system designed for cars, making driving the most sensible decision when convenience, journey time and costs are considered. Sadly, the public investment in motorways was at the expense of investment in heavy rail or bicycle or walking paths, or safe access to schools. If public transport or cycling was as easy, quick and safe as driving, then people would chose to be more active because they recognise that it's to their advantage. Planning decisions clearly influence the travel choices people make. The choices may not be for health reasons, but health outcomes may result nonetheless.

In addition to vision, the public expects their government to be fair. Valuing fairness and equity does not sit well with values of individual responsibility. If increasing physical activity is an objective, when most people cannot afford gym membership or a personal trainer, other strategies are needed. Health in general is better and more equitably distributed when all people have access to the conditions and environments that support health and health enhancing behaviours.

Former Mayor of Bogota, Columbia, Enrique Peñalosa, argues that living in a democratic society involves a lot more than just voting at elections – in democratic societies all citizens should have equal right of access to public space for transportation and recreation. Improved social integration is achieved by adopting transport and road use policies that privilege public good over private interest by providing more equitable access to space and mobility. As Peñalosa has said: *"A bicycle path is a social statement that a person with a $40 bicycle is as important as anyone with a $40,000 car."* As documented comprehensively by Wilkinson and Pickett[1], fairer societies are healthier for many health outcomes. In Australia, a 'fair go' slogan is as in-depth a discussion of equity as we get.

There are signs that governments are recognising the important influence of the built environment on health and physical activity, and that this is what the public wants. The investment of $40million for cycle paths as part of the economic stimulus package, after negotiations with the Greens, was a popular initiative. This investment achieved wins for the economy, health and the environment, and the co-benefits of healthy urban infrastructure should be fully considered. In other sectors, this approach to co-benefits is sometimes referred to as a 'no-regrets approach' because, even in the absence of a need to stimulate the economy, there are already strong arguments for building bicycle paths.

New initiatives, such as the formation of Infrastructure Australia, the Major Cities Unit, the Building Australia Fund and the Australian Council of Local Governments, and new discussion documents from the Major Cities Unit such as *'Our Cities - building a productive, sustainable and liveable future'* signal possible new directions for the federal government. In his foreword to this document, Minister Albanese talks of the need to focus on better design and management of urban systems, and specifically *"…providing real alternatives in transport to reduce our dependence on private motor vehicles."*

When it comes down to what has to be done, there are already a raft of technical solutions. Creating disincentives to driving by restricting parking and removing tax incentives to drive such as fringe benefits for driving minimum distances as part of work-car remuneration packages are a start. Getting more people cycling – strategies to achieve this are well documented.[2] Increasing the incentives to use public transport or walk by providing better services and infrastructure are also obvious. It is political will that is the critical, and missing, ingredient.

Few politicians are true leaders, in the sense that they take the public with them in moving towards a new goal. Most respond to the public, and often just those most vocal. We need to move away from a simple individual responsibility paradigm to understand better how our collective decisions which shape our built environment can make us more, or less, active. Our politicians will likely respond if they learn that that's where the votes are.

Associate Professor Chris Rissel

Director, Health Promotion Service
Sydney South West Area Health Service

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The changing world of service delivery

An interview with Professor Lars Engebretsen, International Olympic Committee

How has sports medicine service delivery changed over the years?

Sports medicine is a relatively new specialty, or rather, many specialties now have an emphasis on sports medicine. Over the years, two distinct areas have emerged:

1. General sports medicine patient care (trauma, cardio, asthma, eating disorders).
2. The use of exercise to promote health.

Whereas the first has evolved slowly with many countries now having specialties or subspecialties on a high level, the second area is just starting to emerge. The International Olympic Committee (IOC), for example, has just signed an agreement with the World Health Organisation to use sports to promote health. New specialties in sports and exercise medicine are also emerging worldwide.

Why have these changes come about?

Patient related sports medicine is a result of the increasing importance of sports worldwide. High level athletes are expensive and require good care which is spilling over to the recreational athlete. Just look at Australian Rules football and the health service and how much it has developed over a few years. Exercise to promote health is a consequence of the western world's overweight problem and is enabled by people having more free time to be able to exercise.

Has government had an impact at all?

Yes, definitely. The specialties are as a result of a partnership between medical societies and government, as many governments see the only solution to the overweight problem as exercise and change of diet.

Do you think these are changes for the better?

Yes! The quality of care is improving with a stronger emphasis on research. In 2000 there were only 21 papers on prevention of injuries in sports; in 2010 there were more than 300. Research is improving the treatment of care and developing programs for using exercise in medicine.

On a world scale where do you think Australia fits in regards to their sports medicine service delivery?

From my knowledge, Australia is among the leaders in injury prevention programs, especially in regards to implementation, with Caroline Finch a world leader in this field. In sports traumatology, Paul McCrory is among the researchers who have changed the approach to head injuries. Your orthopaedists and trauma surgeons have also been hugely significant to sports trauma research. John Bartlett from Melbourne is one of the most influential orthopods in the world in this field.

What can Australia do to improve its delivery?

When I was visiting the Australian Institute of Sport and Sports Medicine Australia in October/November 2010, I witnessed high quality sports medicine at a level comparable or beyond the best I have seen. The research level was impressive. Perhaps though the structure for building research could be improved; as I noticed how difficult it is to obtain grants in sports medicine in Australia.

In your opinion, which country has the best method of sports medicine service delivery on a world scale?

This is a difficult question. The US obviously has a long history of good sports medicine, but their medical service has become extremely commercial and their research has perhaps not kept up their good work from the last century. When the IOC selected their sports medicine research centres (four centres worldwide), I noticed the reviewers gave the highest scores to groups from Australia, Canada, South Africa and Norway.

I was very impressed by the Canadian sports medicine in general and in particular in Vancouver during the Winter Olympic Games. Their level of sports medicine delivery is high, obviously in regards to the elite athletes, but also to the general public.

Why?

All these centres have good education in sports medicine, delivery services and research both on basic science, clinical services and implementation.

What do you think Australia can learn from this country?

Australia is pretty close to Canada in many ways. Australia is perhaps lagging behind in terms of research grants and centres of sports research. I would say in general though that the Canadian sports medicine structure is impressive.

Any other comments about the changes of sports medicine service delivery?

There is a need for further research on the implementation of injury prevention research – Australia is at the forefront and can teach others a lot in this area. These are exciting times for a sports medicine person like myself – so many countries are creating specialties and hopefully there will be economic resources to follow this. I would also like to highlight that many major organisations such as FIFA (the front runner), IAAF (International de Football Association), FIS (International Ski Federation), FINA (Federation Internationale de Natation), FIVB (Federation Internationale de Volleyball) etc are all doing great work in this field. The IOC is the newest player in this field, both on education, research and implementation of knowledge. The IOC President Jaques Rogge has made it an obligation for the IOC to put resources into the field of sports medicine and this will further strengthen this area.

Athlete's world of pain turns into golden dream

L–R: Sean Wroe, Joel Milburn, Kevin Moore and Brendan Cole celebrate their gold medals. (AAP Manan Vatsyayana)

Having the ability to be involved in a Commonwealth Games (CGs) in any capacity is an opportunity that I think should be treasured. I am lucky enough to have been involved in two CGs now as an athlete in the 400m hurdles and 4 x 400 relay, and I also had the privilege to work at the Melbourne CG as a soft tissue therapist with the Australian Netball Team in 2006 whilst I was competing; a challenging but truly amazing experience.

Back home, we all saw the numerous obstacles that the Delhi Commonwealth Games encounted in 2010, many with the Indian Organising Committee and their problems with being ready in time as well as issues of health and safety of athletes and officials. Closer to home in the village we had our own problems, from hygiene concerns to logistical issues and the one area which you will always find challenges – sports medicine.

I wasn't working at the 2010 Games, but I am a soft tissue therapist at the AIS in Canberra, and worked with many of the Canberra based athletes in the lead up to Delhi. This made me all the more aware of the specific issues that certain athletes faced at the games, and more appreciative of the amazing job that was done by the entire sport medicine network present. It was definitely different from Melbourne, where we notice that we're home and everything seems easier.

A great example of this was when the athletes I was staying with were concerned with the amount of post-construction dust in our room that hadn't been properly mopped. We had a bit of a working bee in our apartment to make it visitor friendly and habitable by our comparatively high western standards (not to mention the ridiculous living requirements for us high-maintenance track and field athletes!) I went in search of a mop and bucket, the former without problem, but trying to get a bucket from the very friendly but seemingly poor English speaking Indians assigned to our apartment block was a task that took no less than 14 different men and approximately 20 minutes of waiting on my behalf!

For those that aren't aware of the sports medicine system at Commonwealth and Olympic Games, there is a main headquarters with a number of doctors, physiotherapists and massage therapists who service the whole team. Some sports that are large enough (like swimming or athletics) will have their own providers and generally keep their athletes 'in house'. The smaller sports and those not able to bring their own practitioners use the headquarters and book in like any other clinic or practice. Over the years, athletics has put together a fairly consistent group that travels to most major championships and often will include a significant period of time before the major competition training and competing in Europe.

The conundrum that faces those involved in this system is as follows. There is very little money in these trips, with long periods of time away from their own practices back home, away from families and loved ones, and the hours worked are long and hard and often at times non preferable to those who like normality and routine. As 'enticing' as these conditions are, the crux of the problem is that we want the absolute best practitioners possible to look after these elite athletes. For those who have worked with track and field athletes, they will know and be able to tell you how high maintenance some of the athletes in my sport can be. We are a lovely and appreciative bunch, but we will expect nothing less than the absolute best from a physio/doctor/massage therapist.

Many practitioners would be scared off by these athletes and work conditions. However, the group that has worked with us for as long as I have been in the sport is absolutely outstanding. The consistency has meant that these support staff not only know the athletes well and personally, but also have developed an excellent knowledge of the sport, its typical injuries and physical demands, which has meant we truly have got the best treatment on tour – when it matters most.

My personal experience in Delhi was a great example of this knowledge and dedication, and an intense experience for me also. I came out of Delhi with a gold medal and a wealth of amazing moments on the track. I know it is said often when talking about the support staff of great achievements, but there is no possible way that I could have even competed if it weren't for those on the track looking after us high maintenance athletes, working when they should be eating or sleeping, and long after many of the other countries' staff had gone home...

As I mentioned, I was competing in the 400m hurdles (my best event) and was the reserve runner for the 4 x 400 relay. I made the final in the hurdles, coming 6th, which was very disappointing for me as I was hoping for a much faster time. I had had some issues with my 1st metatarsophalegeal joint on both feet leading up to the games due to a chronic hallux valgus (and probably running round in circles all day!) but they were both manageable before the final. Off the second hurdle in the final, I came down very awkwardly and jarred my left MTP joint which I didn't realise until I had finished the race. I suspect I forced it into a very high-force adduction with flexion, but needless to say it was sore and I was struggling to put much weight on the ball of my foot.

The heats of the relay were the next evening, and I knew that it was going to be in the best interests of the team to run me in the heat and rest one of the faster runners. After the hurdles I had my new best friend and trusted physio Dolph Francis (the magnificent) that I had been working with treat my foot and toe the best he could and very late into the evening. I also had the rare experience of two massage therapists working on me simultaneously post-race, again quite late and way past dinner. I spent the next 15 hours icing and trying to maintain mobility in the MTP joint and 1st ray, which proved difficult with the pain and swelling.

The next day the pain level certainly improved and I thought I should be fine in the heats that evening to run my last race of the games (probably), hopefully get the rest of the boys into the final and serve my country well. Some more treatment from Dolph and a look-see from the Team Doctor Adam Castricum saw me with a suspected joint inflammation or synovitis in the MTP, but mild enough to run that night without too much intervention.

Back in our apartment the 4 x 400 team were getting ready for battle in the heat, an experience I have had the privilege of before, but not at this level. We knew we were in with a chance to medal or even win, but being up against the 400m powerhouses of Bahamas, England, Jamaica and Kenya, it was not going to be easy and everyone had to bring their A-game. This atmosphere was as intense as it gets and although I was feeling good after two consecutive days of hurdling, some small doubt remained as to whether my toe would be 100%. Many team sportspersons may laugh at the severity of these injuries, claiming to have 'played a whole footy game with a broken toe' or a similar heroic story, but I challenge these sceptics to try doing so running at approximately 36km/h around a corner on a near concrete surface with about 4mm between you and the track. The harsh reality of athletics is that if you are not at 100% fitness and health, it is going to have a big impact on that time at the finish line. This being the case, I most certainly did not want to be the one adding seconds to our team's result.

As I started to warm up I was pleasantly surprised at how much my toe had seemed to settle and was confident about really having a go and making a difference in this qualifying round. Dolph was happy with the swelling around the joint and I knocked back treatment in the warm up thinking it would be fine to run. However, as soon as I put my spikes on and started running on the bend, the pain in my toe sky-rocketed (to about a 7–8 out of 10 for you epistemologists out there). My heart sank to the ground as the call room time was less than 20 minutes away and the pain was getting worse as I ran. I told Joel Milburn who was supposed to rest the qualifiers to start getting ready as I desperately called Dolph over with my tail between my legs and a limp in my step.

Australia's Kevin Moore (left) receives the baton from Brendan Cole (right) during the 4 x 400m final. (AAP Dave Hunt)

This is where the Athletics Australia sports medicine staff started to earn their modest pay. Dolph called over Dr Castricum and head physio Brent Kirkbride who spent the next 10 crucial minutes assessing and treating my foot and toe in a semi round-table discussion. This included an immense stabilising taping effort on the foot, some painkillers, foot and ankle mobilisation and surrounding soft tissue treatment that I can only liken to the pit-stop of a formula one car mid race. I meanwhile had the relay coach, my coach, and the high performance manager asking me some of the biggest questions of my life and working out whether to go into damage control for the team or to give me the inspirational speech that would get me going and out on the track.

I decided to rely on the adrenaline of running in a major championship and the age-old pain killing properties of desperately chasing after other people with a baton in my hand, hoping that these factors would get me through the race and us into the final. Knowing how much sorer it was getting with each run through, I didn't dare do anything more in my warm-up other than put my tracksuit on and walk through the long tunnel with my teammates. The next 40 minutes before the race I basically got a lot more scared, or fired-up (sometimes I can't tell the difference), but when we entered the stadium I knew it was going to take a lot to stop me from running well.

I got the baton in 4th position and I am happy now to admit that my foot hurt like hell on the first bend as I got going. Running in a straight line was fine and by the time I came to the 2nd bend, I felt no pain and all I could think about was getting past the Bahamas runner in 1st place. I finished much stronger than my hurdles race on the previous night and came over the top of the leader, giving the baton off to our last runner in 1st place and securing a spot in the final.

I expected that I was finished for the championships, but the sports medicine team ensured I was treated as though I would run in the final, again working into the night and offering treatment and possible solutions for my much-worse-than-before toe and foot. Assessments, icing, soft tissue work again and chats with the Doctor about some more severe pain-killing options followed, and early the next morning I was informed that I would be running in the final of the 4 x 400m relay at the Commonwealth Games – the final and arguably most prestigious team event on the athletics program.

Constant contact with Dolph during the day, as well as some trial injections with the Doc into my MTP joint, lead to a solid treatment plan for the final to be held later that night. I had never been injected with a local anaesthetic before, and was still worried about the high level of pain during the day, but I was reassured that I would be on the track in the final. In my nervousness before the final I managed to do the unforgivable task of leaving my accreditation at the village. This left me stranded out the front of the warm-up track at the main stadium without the ability to go in, or go back to the village for about 30 minutes. Kept company the whole time by yet another member of the amazing support staff, I finally got back into the track.

The injection and treatment I received meant I could hardly feel that part of the foot at all, but I certainly didn't have any pain. It was a very odd sensation to be running without the feeling in the toe I am used to, but I managed to warm-up without any issues and made it out to the stadium with three of my best mates to try and win gold.

A fairytale ending followed, us winning the gold, and me having a large part in the win. Words can't describe the feeling of achieving that win, and we certainly celebrated accordingly. There is simply no-way on earth that I could have run without the dedication, passion and commitment from the support staff with us in Delhi. It would have been very acceptable for the staff to do the job they went to Delhi to do without working the hours they did, or caring to the level they cared which allowed me to run in that heat and final of the relay.

I would love this article to act as not only a thank you to the efforts of these staff (particularly Dolph Francis and Dr Adam Castricum), but also as an inspiration for anyone who can be involved in team travel at an elite, or sub-elite level. The money sucks, the working conditions can be rough, and the expectations are very high, but just sometimes you get the chance to be part of someone's dream.

Brendan Cole

Commonwealth Gold Medallist 4 x 400m athletics relay
AIS soft tissue therapist

ACSMS 2010 recap

ACSMS 2010 Conference highlights

The 2010 Asics Conference of Science and Medicine in Sport was held in Port Douglas in November 2010 and was again a highlight of the year. A total of 478 delegates attended including 46 from overseas. For the first time registrations were closed due to reaching full capacity.

SMA owes thanks to the Co-Chairs; Professor Wendy Brown, Associate Professor Jill Cook and Dr Anita Green. SMA would also like to thank Mark Doherty and Asics Oceania for sponsoring a third boutique conference in yet again another fantastic location. Further acknowledgement also needs to be extended to the two new Australian Sports Medicine Federation Fellows, Professor Gregory Kolt and Associate Professor Robin Daly.

All Conference abstracts will be published online as a supplement to the December 2010 edition of the *Journal of Science and Medicine in Sport* (JSAMS). More details about JSAMS, including subscription information can be found at **www.jsams.org/**

This year's SMA National Conference 'ACSMS 2011' will be held at the Esplanade Hotel in Fremantle from October 19-22, 2011. Speakers confirmed include Refshauge Lecturer Professor Ken Fitch, Dr Richard Bouché and Mark Fenton.

The organisers invite the submission of abstracts for ACSMS 2011 that address the conference theme **'Optimising Health and Fitness – Participation, Prevention and Performance'**. The 2011 Conference will again be offering The Australian Sports Medicine Federation Fellows Awards. All papers submitted by the March 31, 2011 deadline may be eligible for an award.

One for the diary: In 2012, SMA will host the paramount sports medicine, sports science, sports injury prevention and physical activity promotion conference event in Australia.

The Conference will incorporate the:

- 4th International Congress on Physical Activity and Public Health (ICPAPH)
- Australian Conference of Science and Medicine in Sport (ACSMS)
- Australian Physical Activity Conference (NPAC)
- Australian Sports Injury Prevention Conference (NSIPC)

under the banner of "be active 2012".

be active 2012 will be held at the Sydney Convention and Exhibition Centre, New South Wales, Australia from October 31 – November 3, 2012.

Congratulations to the following

2010 Australian Sports Medicine Federation Fellows Award winners:

L–R: Leo Pinczewski, Louise Naylor, David Lubans, Dara Twomey, Mark Doherty (Asics) and Chris Handley.

Asics Medal – Best Paper Overall ($5,000 prize including Best Paper award)

Louise Naylor, The University of Western Australia
Impact of shear stress on vascular function in humans: Explaining the direct impact of exercise on vascular health
Co-Authors: H. Carter, T. Cable, D. Thijssen & D. Green

Asics Best Paper – Lower Limb ($2,000)

Chris Handley, School of Human Biosciences, La Trobe University; Musculoskeletal Research Centre, La Trobe University
Overuse tendinopathy is characterised by changes in the metabolism of proteoglycans present in the extracellular matrix of tendons
Co-Authors: J. Parkinson, T. Samiric, M. Ilic, J. Cook & J. Feller

Asics Best Paper – Clinical Sports Medicine ($2,000)

Leo Pinczewski, North Sydney Orthopaedic and Sports Medicine Centre
Long term survival of high Tibial Osteotomy for medial Osteoarthritis of the knee – 8 to 19 year follow-up in a series of 455 patients
Co-Authors: C. Hui, L. Salmon, A. Kok, H. Williams, W. van der Tempel & R. Chana

Asics Best Paper – Exercise and Sports Science ($2,000)

Louise Naylor, The University of Western Australia
Impact of shear stress on vascular function in humans: Explaining the direct impact of exercise on vascular health
Co-Authors: H. Carter, T. Cable, D. Thijssen & D. Green

Asics Best Paper – Injury Prevention ($2,000)

Dara Twomey, University of Ballarat
Accuracy of the field-based injury and exposure data collection methods in a large scale injury prevention randomised controlled trial
Co-Authors: C. Finch, T. Doyle, D. Lloyd & B. Elliot

Asics Best Paper – Physical Activity and Health Promotion ($2,000)

David Lubans, The University of Newcastle
Randomised controlled trial of the Physical Activity Leaders (PALs) program for low-active adolescent boys from disadvantaged secondary schools
Co-Authors: P. Morgan, E. Aguiar & R. Callister

Asics Award for Best New Investigator – Lower Limb (Presentation package at ACSM)

Ross Clark, ASICS Sports Medicine Research Fellow; The Centre for Health, Exercise and Sports Medicine, The University of Melbourne
Can the adductor longus transmit force across the pubic symphysis? Implications for the pathophysiology of athletic groin pain
Co-Authors: K. Norton-Old, A. Schache, P. Priscilla, T. Dettmann, S. Harrison & C. Briggs

Ken Maguire Award for Best New Investigator – Clinical Sports Medicine ($2,000)

Clare Ardern, Musculoskeletal Research Centre, La Trobe University
Return to sport following ACL reconstruction surgery: Are our expectations for recovery too high?
Co-Authors: K. Webster, N. Taylor & J. Fellar

John Sutton Award for Best New Investigator – Exercise and Sports Science ($2,000)

Jamie Stanley, The School of Human Movement Studies, The University of Queensland; Centre of Excellence Sports Science Research, Queensland Academy of Sport.
The effect of hydrotherapy on cardiac parasympathetic recovery and exercise performance
Co-Authors: J. Peake & M. Buchheit

NSW Sporting Injuries Committee Award for Best New Investigator – Injury Prevention ($2,000)

Juliana Usman, School of Risk and Safety Sciences, The University of New South Wales
The investigation of shoulder forces in Rugby Union
Co-Authors: A. McIntosh & B. Frechede

Asics Award for Best New Investigator – Physical Activity and Health Promotion (Presentation package at ACSM)

Mitch Duncan, Institute for Health and Social Science Research, CQUniversity
Population trends in adults' physical activity, sedentary behaviour and overweight and obesity
Co-Authors: C. Vandelanotte, C. Hanley, C. Caperchione & K. Mummery

Wendy Ey Women in Sport Award ($500)

Angela Fearon, ANU Medical School, College of Medicine, Biology and the Environment, Australian National University; Trauma and Orthopaedic Research Unit, Surgery, Canberra Hospital
Greater Trochanteric pain syndrome is not a benign condition to be ignored
Co-Authors: J. Cook, J. Scarvell, W. Cormick & P. Smith

Asics Best Poster – Clinical Sports Medicine ($500)

Narelle Wyndow, Centre for Health, Exercise and Sports Medicine, Melbourne Physiotherapy School, The University of Melbourne
Neuromotor control of the triceps surae during gait in people with and without Achilles Tendinopathy
Co-Authors: S. Cowan, K. Crossley & T. Wrigley

Asics Best Poster – Exercise and Sports Science ($500)

Jason Bonacci, The University of Queensland and The Australian Institute of Sport
Is plyometric training effective for correcting altered running neuromotor control post cycling in triathletes?
Co-Authors: D. Green, P. Saunders, M. Franettovich, A. Chapman, P. Blanch & B. Vicenzino

Asics Best Poster – Injury Prevention ($500)

Evert Verhagen, EMGO Institute/VU University Medical Center, The Netherlands
The impact of compliance on sports injury prevention effect estimates in randomised controlled trials
Co-Authors: M. Hupperets, C. Finch & W. van Mechelen

***Journal of Science and Medicine in Sport* Award for Best Poster – Physical Activity and Health Promotion** ($500)

Juliette Choong, University of Ballarat
Pole-walking and the older adult: A thematic analysis
Co-Author: W. Payne

Where are they now?

A snapshot look at the recipients of the Australian Sports Medicine Federation Fellow Awards

The 2010 Asics Conference of Science and Medicine (ACSMS) in Sport held in Port Douglas may have come and gone, however, it will be hard to forget the fantastic research highlighted throughout those three fun-filled days in the warm sun and with the beautiful backdrop of 4 Mile Beach. I think all in attendance can agree there was some very innovative research showcased, and we now look forward to more great work in 2011.

For those who were awarded Australian Sports Medicine Federation (ASMF) Fellow Awards at the conference, congratulations, your hard work and dedication has definitely paid off! In particular, *Sport Health* would like to acknowledge this year's winner of the Asics Medal – Best Paper Overall and the Asics Best Paper – Exercise and Sports Science, Louise Naylor, for her paper entitled *'Impact of shear stress on vascular function in humans: Explaining the direct impact of exercise on vascular health'.*

These honours are not new to Louise however, as she received the Ken Maguire Award for Best Young Investigator in the clinical section and the Asics Medal for Best Overall Paper in 2003.

Given these recent and past successes, *Sport Health* is honoured to have Louise provide a personal narrative of what she has been up to since first becoming a researcher, her thoughts about her 2003 and 2010 ASMF Fellow Awards, and what she has planned for the future.

Dr Louise Naylor

I completed my undergraduate degree, with a taste of research during my Honours year at The University of Western Australia in 2000. After a short break during which, amongst many other things, I got married, I decided to return to research and enrolled in a PhD at the University of Western Australia in early 2002.

Barely a year into my PhD, I had the oppportunity to present my work on cardiovascular adaptations in elite athletes at a podium presentation at the SMA conference in Canberra. This was the first conference I had attended, and a great experience in every way. I remember listening to the presenters and feeling in awe of them and their work. It was on my return to Perth that I checked my message bank and heard the news from my supervisor that I had won the Ken Maguire Award for Best Young Investigator in the clinical section! What an honour! To make things even better I also won the Asics Best Paper prize! The prize consisted of an opportunity to present my work at the American College of Sports Medicine Meeting to be held in Indianapolis the following year. Woo hoo! I am forever grateful to SMA for this opportunity. At this conference, I was blown away by the number of researchers and physicians interested in sports science, and the calibre of work presented. It was a great place to network and learn more. This conference enabled me to establish new collaborations with other exercise physiologists, and boosted my work.

But then it was back to reality, and back to the PhD. At this stage, I had completed the first series of studies, and was about to embark on part two. Along with my supervisors, I decided the next step should be to apply my previous work in elite athletes to optimise clinical outcomes for 'at risk' populations. We chose obese children to be that population.

In late 2005 I submitted my thesis, and begun a post-doc research appointment at Royal Perth Hospital, working on a National Heart Foundation grant that was looking at different modalities of exercise in advanced heart failure patients, and also became involved in clinical trials running at the hospital.

In September 2006, I finally graduated, and was awarded a PhD with a High Distinction. I attended my graduation ceremony four months pregnant with our second daughter. When she was born, I took a year off to stay at home with my young family.

My return to my research career came in early 2008, when my PhD supervisor, Dr Danny Green, returned to Perth from Liverpool, and needed some help to re-establish his research lab in WA. This also enabled me to delve into some basic

science research to add further mechanistic insights into mechanical and neural regulation of the cardiovascular system. During my honours year, we had come across a fascinating observation that blood flow is biphasic (i.e. it runs forwards and backwards in our arteries) during exercise. Exploring this further, our reseach group started to piece together that in humans, blood flow, or more particularly the shear stress imparted on the vessel wall, was an important determinant of vascular health. Studies have shown that regular exercise can reduce the risk of cardiovascular disease by 30-40%, and it was commonly believed that this was because of the impact of exercise on cardiovascular risk factors, like hypertension and hypercholesteroleamia. However, in the early 2000s, a study was published stating that modification of these traditional risk factors could only account for about half of the benefit of exercise.

After many studies (and years), our research group had come to believe that the missing link could be a direct effect of exercise on the blood vessels. This direct effect can be explained by the biphasic nature of blood flow through the arteries. We have already established that different types of exercise cause different patterns of shear stress, and that these different patterns have differing effects on vascular health. This led us to the study we presented this year at ACSMS.

In this study we tested whether manipulating shear stress, independent of exercise could improve vascular health. To do this, we used healthy young men, and 'trained' their vasculature by placing their forearms in a hot (42 degree) water bath for 30 minutes, three times a week for eight weeks. During each training session, we used a blood pressure cuff inflated around one arm to clamp the increased shear stress, hence creating a one arm training model. By assessing their vascular function before, during and after the 'training' period, we observed that manipulating shear stress, can improve vascular health, even without exercise. In the other arm, that was clamped by placing the cuff around one arm, we stopped any vascular adaptations across the training period. This study reveals that manipulating shear stress, independent of exercise, can impart vascular benefits in humans. Keep an eye out for further advances in this area, as we continue our research, which is supported by the Australian Research Council.

Of course, my work with the obese children has continued, and now we have the opportunity for my research to expand to include children and adolescents with Type 2 diabetes. I have recently received a BrightSpark Foundation Fellowship to expand my work in this area.

Louise Naylor with Arata Ikeda from Asics receiving her award.

Finally, I would like to take the opportunity to congratulate the other winners at last year's ACSMS, and to offer my wholehearted thanks to SMA, Asics, the SMA conference organisers and scientific committee for the opportunity to present my work, and for the honour of being awarded the Asics Medal. I look forward to seeing you later this year on the West Coast, for the SMA Conference in Fremantle! Please look me up **louise.naylor@uwa.edu.au**

Cristina Caperchione

Senior Post-Doctoral Research Fellow
Institute for Health and Social Science Research
CQ University

australian conference of SCIENCE & MEDICINE IN SPORT

Fremantle, 19 - 22 October 2011

We are headed west!

"Optimising Health and Fitness – Participation, Prevention and Performance"

sports medicine

sports science

physical activity and health promotion

sports injury prevention

Call for Papers

The organisers invite the submission of abstracts that address the conference theme.

Abstracts from all aspects of sports medicine, including sports science, sports medicine, physical activity promotion and injury prevention are invited.

We encourage all researchers, practitioners, policy makers and students who wish to present their work to submit abstracts for presentation at the conference.

The 2011 Conference will again be offering The Australian Sports Medicine Federation Fellows Awards. All abstracts must be submitted online and must be received by **31 March 2011**. All papers submitted by the March 31 deadline may be eligible for an award.

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Get your mind in the game: A look at the sport and exercise psychology profession

Often it can be difficult or awkward to refer someone to a sport and exercise psychologist. Sometimes it is hard to even bring up the subject. Some of us may not even be clear on what they do and how they can help. On behalf of the Australian Psychological Society (APS), psychologists Tracey Veivers and Gene Moyle help to fill us in.

Who are sport and exercise psychologists?

Sport and exercise psychologists are specialists who have completed a minimum of six years full-time university training, including two years of approved postgraduate studies in sport and exercise psychology and further supervised practical experience.

All psychologists are legally required to be registered with the Psychology Board of Australia, to ensure they meet specified standards of ongoing competence and ethical practice. Furthermore, 'Sport and Exercise Psychologist' is a legally protected title that can only be used by individuals who have completed accredited training and demonstrate competence in this area.

In addition, psychologists follow strict guidelines for professional conduct that cover client privacy and confidentiality. Ethical codes are set and monitored by the APS and have been developed to safeguard the welfare of recipients of psychological services and the integrity of the psychology profession at large.

Who uses sport and exercise psychology services?

In addition to recreational, elite, and professional athletes, a range of people use sport and exercise psychology services:

- Coaches, managers, and administrators.
- Trainers, physiotherapists, physicians, dietitians, and other sports scientists.
- Umpires, referees, and officials.
- Performing artists (e.g. musicians, dancers, actors).
- Non-athletic or sporting individuals (i.e. exercise, health, weight management).
- Business personnel (interested in leadership, conflict resolution, team building, and optimal performance).

Why do people see sport and exercise psychologists?

The areas in which sport and exercise psychologists can typically provide assistance include: performance enhancement and the development of mental skills such as goal setting, concentration, resilience training, confidence, and imagery; creating the 'zone' or ideal performance state; personal development skills such as exercise and health behaviour changes (e.g. weight management); time-management skills (e.g. balancing sport, study, employment, or family life); career transitions; communication; and travel skills.

Additionally, issues related to the consequences of sport involvement can also be addressed, such as recovery from heavy training loads, staleness, overtraining and burnout, dealing with the media, drug and alcohol issues, and rehabilitation from injury.

Referring someone to a sport and exercise psychologist

Some people feel that seeing a psychologist is admitting that one is mentally disturbed. Mental illness is only an issue in a minority of clients who see a sport and exercise psychologist. Clients can be referred for a number of reasons including:

- Assisting with adjustment issues (e.g. joining a new team, relocation, relationship issues, work/study/school issues).
- Developing a holistic approach to case management.
- Improving compliance.
- Improving outcomes.
- Aiding understanding through further insight into the individual.
- Dealing with a performance slump.
- Having a gut reaction that it could be useful (i.e. professional intuition).
- Freeing up your time from informal 'counselling' so that you can do your job.

We recognise that it can be difficult or awkward to refer someone to a sport and exercise psychologist. Possible barriers to referral include not knowing when or to whom to refer, the stigma of seeing a psychologist, finances, availability and time, and your own possible apprehension around referring to a psychologist. Here are some informal 'lead-in lines' that may help you find it easier to discuss the option of consulting a sport and exercise psychologist:

- *"It is very common now to work on your mental game as well as your physical game. Have you ever thought about working with a sport and exercise psychologist to develop your mental game?"*
- *"You seem to be finding things challenging. Would you want to make it easier for yourself? Sport and exercise psychologists are trained specifically to help you personally and with your sporting goals."*
- *"I know a number of my colleagues work as a team with other service providers such as physios, conditioning coaches, dietitians, and sport psychologists. You seem to have all other service areas covered except for the psychology. Would you be interested in ensuring you are fully prepared for…"*

Where to find a sport and exercise psychologist

Sport psychologists can be contacted through the APS website (www.psychology.org.au) and APS College of Sport and Exercise Psychologists website (www.groups.psychology.org.au/csep/). Another point of contact can be through respective State or Territory Institutes and Academies of Sport.

Final note: Rebates for sessions with sport and exercise psychologists often can be claimed either through private health funds or through the Medicare Better Access Scheme via a referral from a GP.

Tracey Veivers and Gene Moyle

APS Psychologists

Case study

Jason, 23 years old, plays for the local premiership side in rugby union and has been seeing a physiotherapist during rehabilitation post ACL reconstruction. Part way through a consultation, the physiotherapist becomes aware that Jason is exhibiting some psychological consequences of his injury:

Jason: *"...it's the set-up you know, you train away from the boys when you're injured...and so all it does is make me focus on the injury even more...and I just don't feel a part of the team..."*

Physio: *"Most clubs have that set-up where injured players do their training separately, but I think that's more because the type of rehab exercises perhaps require you to spend more time in the gym rather than on the field. Regardless, have you spoken to any of your teammates or coaches about how you are feeling?"*

Jason: *"Nah. I don't wanna whinge..."*

Physio: *"I don't think you are whinging, but fair enough. Would you consider speaking with a sport and exercise psych about how you are feeling? You might even find that he or she can help you with some strategies with your pain."*

Jason: *"Dunno, hadn't thought of it. But I do know that some of the boys have mentioned seeing one at some time or another. We don't have one at the club so..."*

Physio: *"Well, I can recommend a couple to you. And if you are up for it, maybe the psych and I can work together on helping you return to your game - fit, strong, and confident both mentally and physically."*

Jason: *"Ok. Don't see why not."*

Physio: *"Great. I'll get you some numbers before you leave."*

REPAIR, RECOVER & REFUEL.

The Melbourne Vixens netball team represent their home city in the elite Australia and NZ Championship competition. The Melbourne Vixens includes Australia's best female athletes and a new generation of netball stars, with seven Australian squad members in the team, including recent World Champions Julie Prendergast, Bianca Chatfield and two-time Commonwealth Games gold medallist Sharelle McMahon.

Sports Dietitian Kerry Leech speaks with Sharelle McMahon, captain of the Melbourne Vixens Netball team.

Q. What is your favourite food?
I'm a little partial to chocolate but my favourite meal is chicken and vegetable risotto.

Q. Cereal or toast for breakfast?
Definitely a cereal girl, eating muesli, yogurt and milk helps me to keep going through the morning.

Q. Sharelle, you are working with Netball Victoria as well as playing and training with the Vixens - how do you fit it all in?
I'm very busy. I manage it with a very up to date diary!

Q. So how do you manage healthy meals on the run?
I need to be organised and pack food each morning. It makes drinks like Sustagen important as I can have them in the car on the way to or after training.

Q. What flavour Sustagen is your favourite?
That's easy, Chocolate - I told you I am a chocolate girl!

Q. How do you feel Sustagen helps your recovery?
Netball is a hard game, I tend to come out of each game with a few bumps and bruises. Sustagen after each game helps to get the recovery process started and provides a great source of protein and carbohydrate.

Q. So what now for Sharelle McMahon?
The Vixens are finished for the season but the Australian team has international matches over the next few months against New Zealand and England. So plenty of training camps, travel and tough matches. No slowing down for me!

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VIXENS MELBOURNE

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Building SMA's position statement on drugs in sport

As a peak medical body, SMA has a central role in the policy debate around managing drugs in sport. To contribute to this debate, SMA needs to establish a position consistent with its Mission and Vision of achieving health through and within sport. This article outlines why Australia has the drugs in sport management policy it has with the aim of stimulating discussion about what position SMA should take on drugs in sport.

Most people's view on drugs in sport is clear cut – it is bad and drug users should be punished. Documentaries like *Such is Life* (Ben Cousins documentary) demonstrate that drugs can destroy lives, whether alcohol, amphetamines or steroids. To this extent, I think that Australia does need a policy on drugs; we need to manage their role in sport and society so that people can 'dodge the drug's bullet'.

Australian governments argue there is a significant health and social burden associated with drug use, and work hard to mitigate the use of drugs. The policy approach of choice is zero tolerance and the 'War on Drugs', like the 'Just Say No' campaign. This stance is promoted by the United Nations (UN), and an obliged position by signatories to the relevant drug treaties.

The zero tolerance policy has its roots in the criminalising of the drug trade in the 1800s for economic and political reasons (the Opium Wars[1] and controlling drug related tax revenues[2,3]). While the rationale has evolved over time to include moral (the temperance movement) and public health arguments[3], it essentially retains its 1800s prohibitionist nature. The consequence is a highly legalistic approach to drug control using the main administrative tool of that approach – punishment.

A potted history of drug control in sport

The birth of modern sport in the late 1800s coincided with the revolution in natural science and the rapidly evolving pharmacopeia[4]. The use of pharmaceutical aids was a normal part of sport, with Olympians using strychnine in the marathon. Concerns about drug use emerged in the 1930s with discussion around 'pep pills' and the like.

The antidoping policy banning drug use in sport was introduced in 1928, and included hypnosis[5]. The policy remained on the shelf until pressure to respond more aggressively evolved during the Cold War. The superpowers used Olympic sport to test the legitimacy of their ideologies[5], with Communist countries such as East Germany gaining ascendancy due to their superior 'doping machine'[6].

The initial Western response was to dope as well – it was alleged 25% of the 1984 Australian track and field team were doping[7]. By 1988 Western doping caught up with Communist doping, and then Canada was caught by the apparatus installed to limit the Communist doping machine. Pressure grew on an IOC keen to reap the revenues of the US broadcast market from nations used to using sport for political agendas, leading to a policy managing drugs in sport based on the mechanisms that had evolved to control drug supply – prohibition.

Doping came to a head when the French government (rather than the UCI or IOC) showed how ineffective drug control in sport was using the 1998 Tour de France. The formation of the World AntiDoping Agency and its World AntiDoping Code soon followed, with 50% control by the IOC and 50% control by governments[8]. The policy and its administrative apparatus used the UN's legalistic prohibitionist approach, relying on punishment to deter drug use in sport.

Managing drugs in sport in Australia

As a signatory to UN drug conventions and treaties, Australia is obliged to take on the 'zero tolerance' approach to drugs in society and, by corollary, drugs in sport. When we talk about 'drugs in sport' the first thing that jumps to mind is performance enhancing drug use, or doping. As such, when we talk about managing drugs in sport it means the antidoping policy. Importantly, the antidoping policy also covers many illicit drugs.

The antidoping policy seeks to deter drug use by detection and sanction of athletes found to have contravened this policy[9]. Doping is a strict liability offence; the mere presence of the substance in the athlete's test sample means they are guilty. For example, elite swimmer Ryan Napoleon was initially sanctioned because his pharmacist handed over the wrong medication – it was the athlete's fault for relying on the pharmacist.

The antidoping policy also includes ways to sanction either an athlete or a support person (e.g. an SMA member) that focus on protecting the integrity of the antidoping policy[10]. For example, if a sports physician finds out an athlete has been using marijuana while they are treating an unrelated condition (necessary when prescribing medication), the sports physician can be sanctioned (banned) under Australia's antidoping policy if they fail to report the marijuana use. The effect of this is that athletes may deny themselves the treatment and support they need for fear of punishment. Drug using athletes need to feel they can approach SMA members to discuss their drug use without the threat of sanction. Equally, as a practicing psychologist, I want clients to feel they can talk to me confidentially about drug use without either of us risking a ban and my potential deregistration. I hope other sports professions, both medical and allied health, feel the same.

Another method used to protect the antidoping policy is the Athlete Whereabouts system, where athletes have to report, in advance, one hour of every day, a place they will be available for drug testing. Athletes who fail to report or fail to be present can be sanctioned as if they had tested positive. This sort of reporting is usually reserved for convicted criminals, especially paedophiles or terrorists[9].

Australia's *National Illicit Drugs in Sport Policy* borrows heavily from antidoping, making the two largely interchangeable. For example, the illicit drugs policy calls for a range of punishments (suspensions and fines) to be handed out to athletes who test positive to certain drugs. The key distinction between the two policies is that the illicit drugs policy includes a statement about counselling and rehabilitating athletes found to have used illicit drugs.

At a Federal level, licit drugs (e.g. alcohol, tobacco, and prescription drugs) have no specific sport related policy attached to them. Instead, the policies that govern drug use in sport are the same that govern drug use in the rest of society. The contrast with doping and illicit drugs policies is that there is a tolerance policy – people can use these drugs only in certain ways and can be punished for transgressing those boundaries of use (e.g. drink driving, smoking indoors, using without a prescription).

SMA Mission and Vision

With this context, how does SMA view the management of drugs in sport? Should we support the dominant zero tolerance approach with its punishment basis? Is there an alternative? An appropriate starting point for answering this question is the Vision and Mission for SMA.

As members know, SMA's passionate and unwavering focus is on promoting health both through and within sport. When SMA talks about health, it refers to the idea that people maintain a certain level of physical integrity that prevents illness or injury, or that we work hard to get people back to their sport after illness or injury.

Given health is the concept core to SMA's being, it should be the lens through which we interpret management policies. That is, the critical test is how the policy promotes health through and within sport, either as prevention or rehabilitation.

Health and the AntiDoping Policy

At first pass the antidoping policy has a strong health rationale; stopping people from using drugs means averting a potential harm to their health. The problem is whether it actually deters athletes from using drugs or contributes to their abusing drugs. For example, the therapeutic use of anabolic androgenic steroids (AAS) carries with it little in the way of side effects if monitored and managed by an appropriately qualified physician[11]. We know this because AAS have been used this way for some decades[12]. Equally, we know that when athletes use AAS without medical supervision, it can quickly become abuse and terrible things can happen.

If an athlete has been found to have doped (recalling that it is a strict liability offence), the policy response is to cut them off from sport completely. For example, an Academy or Institute athlete immediately loses their scholarship and is ejected from the program. Isolating athletes from the emotional, social and economic support seems to fall well short of best practice for treatment of drug use. Indeed, this response may lead the athlete to self medicate with illicit substances or alcohol to cope with the catastrophic change in their circumstances. In this context, we should remember that, in Australia, most athletes sanctioned for doping are second or third tier athletes. Professional athletes may have teams of lawyers working towards reinstatement; lesser athletes are simply cut off.

Critics argue that antidoping prioritises the preservation of the integrity of sport above that of individual athletes[15]. The Code treats athletes as the object of antidoping rather than the subject[14]. That is, antidoping is done 'to' athletes rather than 'for' athletes. For example, there are a range of things an athlete has to do to in order to comply with the antidoping policy, such as Athlete Whereabouts. This onerous system is fundamentally unfair as athletes are unable to access the same civil rights and enjoy the same freedoms as other Australian citizens[13]. Prioritising the sporting system above that of an individual is a clear and present danger to athlete health and wellbeing.

Health and the Illicit Drugs Policy

The illicit drugs policy appears to take a slightly different approach to health. The sanctions are complemented by treatment in the forms of counselling and rehabilitation. In some professional sports in the US, athletes found to have used are offered treatment before sanction. These sorts of policies could be applied in Australia to suit our context (such as when governing bodies tell clubs about illicit drug use problems), using the general principle of treatment aimed at helping the athlete become drug free. That is, returning to a state of health.

In this context, a suspension (rather than a ban) is implemented because the athlete is medically unfit to participate in sport. Suspension gives the athlete time away from sport to sort out whatever is driving their illicit drug use, whether self medicating with ecstasy for depression, 'partying hard' with cocaine, or crystal meth to keep up with younger athletes. Keeping the athlete within their sport means accessing all the support systems that sport brings with it, such as sports trainers willing to lend a hand or an ear as required. The athlete can then return to competing when they have the capacity to include it in their life again.

Interestingly, sport seems to have a protective effect against illicit drug use[16]. It is ironic that the policy that most preserves and protects athlete health is reserved for the substances athletes are least likely to use.

Health and Licit Drugs

Licit drugs extract a more significant cost to the health of athletes through and within sport than doping and illicit drug use combined. Where sport protects against illicit drug use, sport makes athletes more vulnerable to alcohol abuse[17]. The consequences of alcohol abuse are extensively documented and yet we seem impotent to do anything.

In this context, alcohol sponsorship represents a significant factor. We know that alcohol sponsorship of a team can lead to increased consumption, even at the local level[18]. For example, if the local football team (whichever version) is sponsored by the local club or pub, players may feel obliged to demonstrate their support by consuming the product. The consequences of meeting this obligation have been keenly felt by the Manly Sea Eagles.

Concerns are mounting about caffeine consumption among adolescents, popularised by 'high energy' and 'high energy sports drinks'. These drinks contain high levels of sugar which, given the way athletes consume them, have significant implications for dental health[19]. Further, some drinks contain 3–6 times more caffeine than a standard cup of coffee; at these levels the threat of caffeine toxicity related anxiety, tremors, tachycardia or, in rare cases, death becomes very real[20]. This danger is magnified by the combination of these drinks with alcohol, and the possibility it becomes a gateway to other drug use[21]. Caffeine may be innocuous, but its potential to do serious damage is clear.

Focusing on health – harm minimisation

The previous information outlines the problems that arise from translating the zero tolerance policy into sport. All it does is make drug management in sport vulnerable to the same criticisms levelled at the zero tolerance policy in general[22]. Importantly, the zero tolerance policy contradicts the SMA focus on health through and within sport.

The main alternative to zero tolerance is harm minimisation. This approach prioritises athlete health and welfare over any other concern, making the athlete the subject rather than the object of the policy. In practice, this means that athletes found to be using drugs in ways that threaten their health are treated according to best practice principles. For example, an athlete displaying dangerous levels of alcohol consumption might be suspended until their alcohol consumption can be controlled; the Sydney Roosters support treating Todd Carney's alcohol abuse is, perhaps, a good model. Further, because the aim is treatment, athletes are free to seek treatment and support without fear of punishment, and their support personnel are free to provide best practice treatment and support without risking sanction or deregistration.

These arguments are nothing new, especially for sport. For example, the British Medical Association[23] released a 165 page discussion on the role of drugs in sport that argues this approach. The policy discussion in Australia has been championed by prominent sports policy academics Bob Stewart & Aaron Smith, who point out that focusing on athlete health eliminates a swathe of other problems that emerge from the legalistic, prohibition based antidoping policy[24,25]. If SMA is an organisation that focuses on health through and within sport, it makes sense for SMA to advocate and lobby for a health based harm minimisation approach to managing drugs in sport.

Where to from here?

Following SMA's Vision and Mission, I propose the following as the basis for a discussion on SMA's position on drug in sport.

1. The protection and preservation of individual athlete health and welfare is paramount.
2. Athlete health and welfare should be prioritised above other concerns.
3. SMA supports policies aimed at primary prevention.
4. SMA supports policies that promotes treatment of drug using athletes.
5. SMA supports policies that enables support personnel to treat drug using athletes without fear of sanctions to the athletes or themselves.

Where policies contradict this focus on athlete health, it is incumbent upon SMA as a peak body to lobby on behalf of the interests of its members. To be clear, I am suggesting that SMA needs to lobby government to change the way it manages drugs in sport, especially with regards to doping.

There is a risk in adopting this position. There are powerful political interests that have invested heavily in the current system, including the political and financial capital invested by the Australian Government. SMA needs to weigh into such fights to preserve that which we hold most dear; protecting, maintaining and promoting health through and within sport.

Dr Jason Mazanov, MAPS

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Have your say

What is your view on the position SMA should take on drugs in sport?

Email comments to *Sport Health* Editor, Amanda Boshier on amanda.boshier@sma.org.au.

Please note: All efforts will be made to publish comments in an upcoming issue of *Sport Health.*

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Discipline group news and events

Australian Academy of Podiatric Sports Medicine (AAPSM)

News:

- The AAPSM has continued to be active in ongoing education pursuits for its members nationally. AAPSM members were out in force at the recent Asics Conference of Science and Medicine in Sport in Port Douglas, which certainly lived up to the expectations now anticipated from this great SMA event.
- The Academy Board of Trustees is currently reviewing Fellowship requirements for the future with some exciting possibilities in the making. Watch this space.

Upcoming events:

- Plans for another Road Show covering three states is under discussion with negotiations taking place with an international keynote speaker.
- AAPSM will once again have a significant presence at the Australasian Podiatry Council National Conference in Melbourne from April 26–29, 2011.

For more information visit www.aapsm.org.au

Australasian College of Sports Physicians (ACSP)

News:

- Specialist accreditation of ACSP was finalised in October 2010 with the addition of Sport and Exercise Medicine (SEM) to Schedule 4 of the Health Insurance Act. ACSP joins 11 other colleges in being recognised as the only professional body in Australia and New Zealand to offer specialist qualifications in SEM. The recognised qualification for this group of specialists is Fellowship of the Australasian College of Sports Physicians (FACSP).

Upcoming events:

- ACSP Clinical Sports Medicine: The Knee
  March 6, 2011
  Sydney
- ACSP Annual Scientific Conference
  November 13–16, 2011
  Hyatt Coolum

For more information visit www.acsp.org.au

Sports Dietitians Australia (SDA)

News:

- SDA will kick off 2011 with a new strategic plan, vision and wide range of activities focused on promoting the benefits of sports nutrition and the services of our members. Under our new President, Kellie Hogan, SDA continues to support our growing membership with high quality education, useful resources and up to date sports nutrition information, so our members are sought after as leaders and influencers in sports nutrition practice.
- Internationally, SDA is delighted to again be presenting our Sports Nutrition Course in Canada (May), along with two courses here in Australia. For the broader community, SDA offers our popular Nutrition for Exercise and Sport Course, as well as a range of practical sports nutrition related resources that can be downloaded from the SDA website.

Upcoming events:

- **Nutrition for Exercise and Sport Course**
  One day professional development course tailored to meet the needs of fitness and health care professionals interested in nutrition for the active person. Accredited with Fitness Australia, Kinect and ESSA.
  Course dates:
  Victoria – February 19 & May 21, 2011
  New South Wales – February 26, 2011
  Western Australia – March 12, 2011
  South Australia – March 19, 2011
  Queensland – March 26, 2011

For more information visit www.sportsdietitians.com.au

Exercise & Sports Science Australia (ESSA)

News:

- **ESSA celebrates its 20th anniversary**
  At the National Sports Medicine Conference in October 1990 at Alice Springs, a small group of exercise and sports scientists, led by Professor Tony Parker and Tom Penrose, met to discuss the formation of a new professional body for exercise and sports scientists. In October 1991, Professor Parker was elected as Foundation President of the newly formed Australian Association for Exercise and Sports Science (AAESS).

  The past 20 years have seen AAESS rapidly develop into a strong independent professional association, dedicated to promoting the profession of exercise and sports science, within the fields of exercise and preventative health, clinical exercise physiology and the enhancement of exercise and sports performance.

  AAESS changed its name to ESSA in 2010 and now has over 2,500 exercise scientist members and approximately 1,400 accredited exercise physiologist members.

  ESSA will celebrate its 20th anniversary on May 28 in Melbourne at its Business Forum.

Upcoming events:

- **ESSA Business Forum**
  May 28 and 29, 2011
  Topics to include:
  * Financial planning, legal and tax advice.
  * Marketing and brand development.
  * Business development.
  * Risk management procedures.

For more information visit www.essa.org.au

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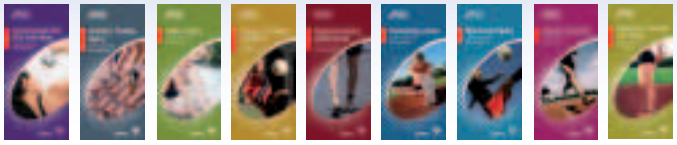

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Top 10 hottest articles of the *Journal of Science and Medicine in Sport*

July to September 2010

The *Journal of Science and Medicine in Sport,* published by Sports Medicine Australia (SMA), is the major refereed research publication on sport science and medicine in Australia. The Journal provides high quality, original research papers to keep members and subscribers informed of developments in sports science and medicine. Produced for SMA six times a year by Elsevier Australia, it reflects SMA's commitment to encouraging world-class research within the industry, and its commitment to the continuing education of its members. Journal articles can be found at jsams.org.

The following highlights the most popular article downloads at jsams.org over recent months.

1. Does warming up prevent injury in sport?
   Vol. 9, Iss. 3, June 2006, pgs. 214-220
   Fradkin, A.J.; Gabbe, B.J.; Cameron, P.A.
2. Does plyometric training improve strength performance? A meta-analysis
   Vol. 13, Iss. 5, September 2010, pgs. 513-522
   Saez-Saez de Villarreal, E.; Requena, B.; Newton, R.U.
3. Heart rate and blood lactate correlates of perceived exertion during small-sided soccer games
   Vol. 12, Iss. 1, January 2009, pgs. 79-84
   Coutts, A.J.; Rampinini, E.; Marcora, S.M.; Castagna, C.; Impellizzeri, F.M.
4. Vertical jump in female and male basketball players? A review of observational and experimental studies
   Vol. 13, Iss. 3, May 2010, pgs. 332-339
   Ziv, G.; Lidor, R.
5. Maximising performance in triathlon: Applied physiological and nutritional aspects of elite and non-elite competitions
   Vol. 11, Iss. 4, July 2008, pgs. 407-416
   Bentley, D.J; Cox, G.R.; Green, D.; Laursen, P.B.
6. Effect of water immersion methods on post-exercise recovery from simulated team sport exercise
   Vol. 12, Iss. 3, May 2009, pgs. 417-421
   Ingram, J.; Dawson, B.; Goodman, C.; Wallman, K.; Beilby, J.
7. Negative effect of static stretching restored when combined with a sport specific warm-up component
   Vol. 12, Iss. 6, November 2009, Pages 657-661
   Taylor, K.L.; Sheppard, J.M.; Lee, H.; Plummer, N.
8. A new framework for research leading to sports injury prevention
   Vol. 9, Iss. 1-2, May 2006, Pages 3-9
   Finch, C.
9. A systematic review on the effectiveness of external ankle supports in the prevention of inversion ankle sprains among elite and recreational players
   Vol. 13, Issue 3, May 2010, Pages 309-317
   Dizon, J.M.R.; Reyes, J.J.B.
10. Fundamental movement skills among Australian preschool children
    Vol. 13, Iss. 5, September 2010, Pages 503-508
    Hardy, L.L.; King, L.; Farrell, L.; Macniven, R.; Howlett, S.

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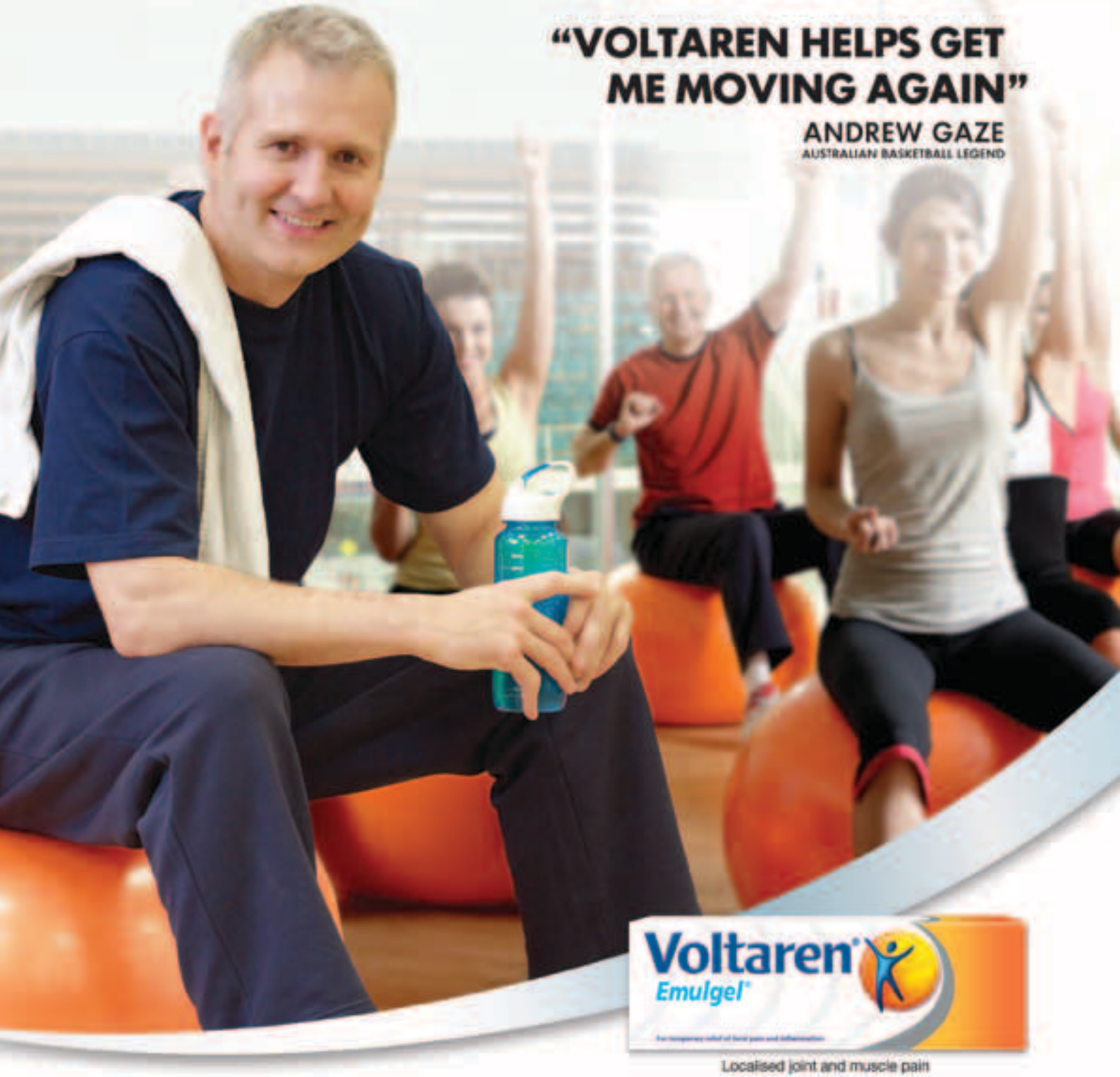

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