

50<sup>th</sup> Anniversary Commemorative Edition

# sport health

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# Celebrating 50 YEARS of SMA



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## Happy Birthday SMA

**Both SMA and I happen to be celebrating our 50th birthday in 2013. For this I feel a great sense of symmetry which only adds to the privilege I feel being in a leadership role with such a wonderful organisation. As has been the case for me, a 50th anniversary offers the opportunity for reflection, celebration and the revision of goals.**

As is evident in the pages of this commemorative edition of Sport Health, SMA has achieved a great deal in its relatively short history. For this we owe a great deal to the forebears of the organisation and the founders of the Australian Sports Medicine Federation, now known as Sports Medicine Australia.

Sadly many of the key figures referred to throughout this issue, particularly in the early years, have passed on. Only in a small number of cases did I have the first-hand experience of meeting these pioneers who paved the way for future generations. Fortunately a number those figures such as Dr Ken Fitch and Professor John Bloomfield that were able to make a significant contribution in the formative years of SMA have been part of the immeasurable contributions by many to this issue.

It was decided some time ago that SMA needed to commemorate its 50th anniversary. As part of the commemoration of its 25th year, 'A Healthy Body' was commissioned. For those who are unaware, A Healthy Body, written by Wray Vamplew, is a 98 page, largely chronological description of the creation of the organisation we know today as Sports Medicine Australia. What is very evident in those early years is the political and parochial wrangling that took place and it highlights the enormous amount of time and effort which was contributed by so many.

Those efforts of the formative years again shine through with some re-visiting of the early history through personal accounts as well as a top up of some of the original history documented by Vamplew.

As was the case in Vamplew's, A Healthy Body, finding relevant historical information has again been a challenge. There has been enormous reliance on many contributors who were interviewed or provided some documentary evidence of events of years gone by. These accounts are still vivid in the minds of many who were instrumental in the shaping of SMA.

We hope this commemorative issue of Sport Health and the latest instalment of SMA history is a little more accessible than previous historical instalments. In addition to being distributed to all SMA members this issue will also be available online as

well as being distributed to numerous stakeholders that have contributed to the evolution of SMA.

We are very grateful to Emma Russell who has written and compiled much of this issue. Emma has painstakingly trawled through what relatively few records were available, combed through numerous websites, read countless copies of sport health and other SMA publications and interviewed over 30 people throughout the journey of preparing this issue.

In a further piece of symmetry SMA's 50th anniversary year has also seen a recent vote by members to again change the governance structure of SMA, from a federated to a unitary structure. Perhaps this is part of its reflection on the past and a revision of some of its goals. Those who have spent some time in association circles will realise that this is a monumental change in the context of sporting, medical and not-for-profit associations. This change sets a new foundation upon which the organisation will be continued to be built and hopefully thrive in years to come.

Happy birthday SMA, we wish you many more.

### Nello Marino

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## The best and worst of – a history of 20 years of Dr J



**Writing a “best of” 20 years of Dr J is not as easy as it looks. So many groups to take aim at and so few words in which to do it! Normally when I choose which group is deserving of more scrutiny in each issue, I get 1000 or so words to work my way into it before I have to succinctly twist the knife. Can the best of each of these be re-visited in a paragraph each as a proper commemorative of this column?**

As an overview, does this make Dr J simply a Robin Hood version of a shock jock? Whereas the shock jock will take aim at the likes of dole bludgers, asylum seekers, the Australian Taxation Office and climate scientists, for Dr J substitute orthopaedic surgeons, the AMA and Medicare and you have an outlet for a much more highbrow object of loathing. Have the best Dr J columns actually been the most outrageous that have ticked off 10% of readers and had 90% secretly squealing with delight? And is the gloss finish of Sport Health such that Dr J articles can't even be recycled as fish and chip paper? You be the judge.

There have been a few articles that have stood out as exceptionally objectionable to certain people and I am feeling brave enough to revisit these topics and examine where I went right and where I went wrong in creating such offence. On these occasions those higher up the food chain in SMA have been forced to contemplate sacking me as a contributor, with the column only saved by market research suggesting that Dr J columns were one of the more entertaining aspects of the publication. Saved every time.

On one recent occasion it got worse when my ACSP Fellowship was seriously questioned. The crime was to bag the AMA when the ACSP was in negotiations to get a better deal of recognition/support out of the AMA. Did my column adversely affect the outcome of these negotiations? Obviously I'll never know. It certainly had the potential to, but I would argue it may have had the potential to get the ACSP better recognition as well. It basically took the AMA and Medicare 20 years to recognise the ACSP training program. I doubt any other specialty of medicine has ever had to –

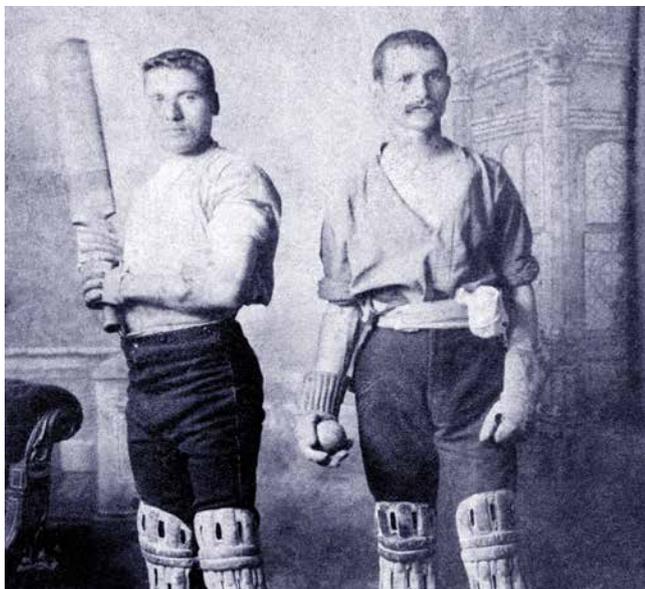
or ever will – wait as long for recognition. The negotiation strategy all the way was the “front door” approach of polite application and aiming to upset no one. After 20 years of polite rejection and – mainly – delaying tactics, Sport and Exercise medicine was finally recognised as a specialty. Could this have been achieved more rapidly if a Dr J-like agitation approach was used, or would we still be outcast by the remainder of the medical profession and refused entry into “the club”? On a personal level, I just call it as I see it. I resigned from the AMA in the year 2000 because I asked them, as my industry representative, “what they were going to do to help get my qualifications and training recognised?” Their reply was effectively that “they were the appropriate industry body for doctors like me who had no qualifications or training”. The assessment was finally made – a decade later – to adjudicate and determine that the ACSP indeed was a valid qualification. The AMA now belatedly recognise this. They haven’t apologised to me personally, nor have they made any formal gesture to the body of sports physicians to accept that they neglected a core value over that 20 year period – to fight for a fairer deal for doctors who weren’t getting one. The AMA view firmly seems to have been and still is that the ACSP had to fight its own fight and only if and when this battle was won could sports physicians be accepted as AMA club members. It is up to each sports physician to individually decide whether we want to be members of a club that would finally have us as members.

**“Have the best Dr J columns actually been the most outrageous that have ticked off 10% of readers and had 90% secretly squealing with delight?”**

But non-recognition wasn’t all bad news. Medicare rebates for sports physicians who practice in a consultant-like fashion (i.e. long appointments) are (compared to other specialist consultations) pathetic yet the work is actually still quite lucrative, as the patient market will generally meet out of pocket expenses. This is all down to the supply and demand curve of economics. For every year of non-recognition and non-funding of training, fewer potential sports physicians joined a training program and the supply deficit of sports medicine services became even larger. It is a simple rule of economics that if you are booked out you aren’t charging enough and if you have gaps in your booking sheet you are charging too much. Years of non-recognition have actually added zeroes to the gross fees that sports physicians can charge. The loser has only been those members of the public requiring sports medicine services without the capacity to



pay. Early in my sports medicine and Dr J writing career I managed to get sacked from the Sydney Swans (which was done in a fashion that happened to be in breach of my contract terms). I wrote a vitriolic column which jeopardised my own negotiations for any payout and meant that I stayed “on bad terms” for the next few years, although the passing of time has meant that I no longer hold a grudge and probably neither do any of the administrators at the Swans from the mid 1990s (since most of them have subsequently been sacked themselves). What are the take-home lessons for those who choose to work for elite sporting teams? Only one really – that professional sport is a cutthroat business where outcomes are often out of everyone’s control, yet you will all (still) potentially be held accountable. Health professionals who work with elite sport can be very thankful both for the



opportunity to do so and the equal opportunity to leave to an alternate income-generating activity once their time is up.

I don't have enough fingers and toes to count the number of other things I shouldn't have written, with the benefit of hindsight. However the most regrettable is probably an article I wrote which many female readers found offensive. I totally understand why but it also saddens me that the systemic discrimination against females in the medical world has only worsened in the 10+ years since I wrote that article. The logical thesis of this Dr J article was that if we followed scientific evidence, we should be building a career pathway for females that allows and encourages reproduction at a younger age. Instead we are turning undergraduate degrees into graduate degrees and increasing the youngest age at which anyone (male or female) can get the basic qualification in a profession. Like sporting proficiency, working in a profession probably follows the 10,000 hour rule to gain competency and you probably don't start getting the specialist hours until you are actually in the workforce, not attending lectures at university. Males can more easily afford to drag out the years it takes to become an expert in a profession and still not rule out the possibility of having a family. The female biological clock is not something that can be reversed with science. But because it is regarded by some as offensive to even discuss this issue, there is insufficient consideration of whether we are making qualifications in the health professions flexible enough to suit both sexes. Males "can't" say it, so perhaps specialist female doctors need to more often argue, for example, that it is not fair to make the minimum qualification standard in their field so lengthy that it puts their ability to have a family into jeopardy.

**“... none more so than advocating that indigenous Australians one day needed their own equivalent of the AIS. As fate would have it, a body such as this now exists ...”**

In the first year of Dr J – 1993 – I happened to make the call early in the career of Wayne Carey that he might become one of the all-time greats of the AFL. In terms of on-field ability this call was proven correct, although his image off-the-field didn't remain untarnished. In last year's Dr J I made the abysmal call that Oscar Pistorius should be considered one of the all-time greats of the Olympic movement. I have to admit it was unbelievably disillusioning to learn of the news that he had shot his girlfriend Reeva Steenkamp and in doing so joined the ranks of fallen heroes. Part of the disillusionment was because the circumstances were particularly tragic – that a human life had been taken. Another part was the personal feeling of gullibility. When we wake up to the news that Amy Winehouse had killed herself, we just consider this expected news in the drug-riddled world of musical entertainment. How did we get so surprised by a hero in the drug-riddled world of Track and Field? You get an even more hollow feeling in the pit of the stomach then watching the media spin doctors go to work along the now-familiar “innocent until proven guilty” pathway. By contrast, there have been some things I have been proud of writing and none more so than advocating that indigenous Australians one day needed their own equivalent of the AIS. As fate would have it, a body such as this now exists (the National Centre of Indigenous Excellence in Redfern) and after years of whinging about the lack of funding for sports medicine training, my clinic at Sydney University will perhaps have the opportunity to partially service the NCIE as part of the ACSP training program in 2014. It will be nice to play a small part in redressing this imbalance. It is sad that sports medicine is so well advanced in Australia if you have the cash to pay for it, but it is so inaccessible in the public system. Although for perspective it is worth remembering that we are one of the few “rich” countries in the world that can “afford” to have a specialist sports medicine sector at all. In countries about to default on government debt, there is certainly no momentum towards funding of sports medicine training as it is seen as a luxury good that the population can live without. The world will still take many more years to “get” that exercise for the population is essential and that sports medicine is an important part of maximising ability to stay active. Since the sports medicine world is still a somewhat unfair place and needs plenty more to change to make it better, hopefully there will be ongoing topics for Dr J to rant about in the future that could continue to lead to an even better sports medicine infrastructure in Australia and around the world.

## The Sports Medicine Marathon



### **Historian Emma Russell sets the scene for this special issue of *Sport Health*, celebrating 50 years of Sports Medicine Australia.**

Although this commemorative edition of *Sport Health* celebrates the fiftieth anniversary of Sports Medicine Australia, formerly known as the Australian Sports Medicine Federation (ASMF), this body was established because of an already entrenched discipline of sports medicine in Australia. Its history ought therefore begin many years earlier than 1963 to explore the evolution in its practice and scholarship, and the conditions that gave rise to this marriage of sport and exercise with medicine.

Sports medicine in Australia has been both diverse and agile of necessity. A relatively new and developing specialist area of medicine, it had to work hard to find its feet in the middle years of the last century. There was considerable jostling and elbow pushing before an acceptable framework was developed

that satisfactorily dealt with the questions of membership, professionalism, education, communication, purpose and vision.

Practitioners of sports medicine were untiring and ambitious (after all, they tended to be both medicos and sportspeople so had these characteristics in abundance) and the leaders amongst them soon set the pace for sports medicine in Australia through the auspices of the umbrella organisation of ASMF. A Journal was born and conferences organised, and within ten years of the Federation being established a World Congress was in the planning. Education and advocacy were an almost consistent focus of attention; with arguably the greatest achievement being the now thirty-year-old community based Safer Sport Program. Population health issues gained a hold on the consciences of health ministers, and Australia's performance in the sporting arenas of the world became a concern for sports ministers. These two foci of sports medicine

– prevention and performance – led to campaigns and health programs being rolled out across the nation, albeit limited, and the Australian Institute of Sport established in Canberra.

Non-medical practitioner members of ASMF became more numerous than the medical members. Buoyed by their numbers and their relevance to this developing specialty of sports medicine, and being as untiring and ambitious as their predecessors in the sports medicine family, practitioners from the allied health discipline groups began to make their move. One by one they gained accreditations, higher qualifications, and greater recognition, culminating in their own associations. Sometimes viewed as progressive, and good for sports medicine overall, and sometimes as belligerent, and therefore counterproductive, the professionalisation of the disciplines that make up sports medicine was nonetheless the move that shaped a marathon charge into the twenty-first century by this newest medical specialty on the block.

This is not a specialty that applies itself to a particular segment of the population – people with heart disease or a digestive disorder for example – nor is it one that can operate without the aid of other disciplines or specialties. Sports medicine is applicable to the healthy and active as well as the sick or injured, and requires the collaboration of a range of disciplines. In an earlier history of ASMF published to celebrate its 25th anniversary the author, Wray Vamplew, described sports medicine as ‘a perspective

[that] involves sport but is not limited to organised sport. It includes health but is not limited to medical supervision. It is the application of medicine, the health sciences and research to ... achieve excellence ... prevent and manage sports injuries ... increase the safety of participation ... [and] to ensure optimal benefit of exercise’. This is an inspirational call for anyone with an interest in medicine and sport. The marathon effort that sports medicine has made to get a respectable placing in the medical fraternity is still required. The challenges of obesity, diabetes and other chronic diseases presenting at a population level have been building for several decades and show little sign of diminishing. And at the elite sport level the pressure remains to assist athletes to go higher and faster and stronger, and to recover quicker (the pride of sporting fans and the nation is always at stake for these athletes even if of secondary concern to their sports medicine carers). Expert sports medicine is required to alleviate all these challenges. Nonetheless, while cancer and mental health specialists may hope for a day when their efforts are no longer so desperately required, sports medicine practitioners, with their focus on prevention as well as cure, will always have a future to look forward to.

**“... the professionalisation of the disciplines that make up sports medicine was nonetheless the move that shaped a marathon charge into the twenty-first century by this newest medical specialty on the block.”**

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**“In an earlier history of ASMF published to celebrate its 25th anniversary the author, Wray Vamplew, described sports medicine as ‘a perspective [that] involves sport but is not limited to organised sport.’”**

This commemorative issue of *Sport Health* is an exploration of how sports medicine in Australia came to be what it is today. Although the first twenty-five years of ASMF’s history has been thoroughly documented in *A Healthy Body. The Australian Sports Medicine Federation, 1963–1988* by Wray Vamplew, some of that story will be covered here in order to make sense of the evolution and influences of European sports medicine on Australia, and the transition between the first generation of Australian sports medicine practitioners, those who volunteered their passion and interest in the decades leading up to the 1956 Melbourne Olympic Games, and who were then joined by the second generation who, also voluntarily, founded the ASMF, laid the groundwork and established the guidelines for sports medicine in Australia, and then the third generation who have built on these foundations to take sports medicine into the modern era. In the absence of an available Sports Medicine Australia Archive this history has benefited enormously from the input of many SMA members. Several members checked and corrected the ‘Discipline Histories’. Others provided copies of material from their own archives, and the “Barrie Towers Archives”, which Dr Towers

had donated to SMA, was a very welcome source of information on the 1950s to 1970s, as was the collection of papers on a later era lent by Peter Duras. Wray Vamplew’s 25th anniversary history, ‘A Healthy Body’, was a source of information for the 1963–1988 era. I would like to thank the Fellows who responded to a Survey Monkey questionnaire that was sent out in June. The responses to these twelve questions were my first indication of the passion that SMA members had for their work; over 40% of Fellows responded within the two weeks the questionnaire was online, many of them with very detailed and informative answers. I am particularly grateful for, and relied heavily on, oral history interviews with the following people: Barrie Markey, Bob Treffene, Peter Brukner, John Bloomfield, Tony Parker, Gary Moorhead, Michael Kenihan, Nello Marino, Peter Duras, Peter Larkins, Ken Fitch and Wendy Brown, several of whom were also generous with material and advice; and on discussions with, and counsel from, the Steering Committee of Peter Dorman, Peter Duras, Anita Green and Nello Marino.

**Emma Russell**

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## 5 minutes with ... The Referee

### A sports medicine journalist in the 1890s<sup>1</sup>

#### What is your profession?

I am a sports writer, a former amateur athlete and weightlifter, and in recent years I have trained dozens of aspiring young athletes.

#### How many years have you been involved in the pursuit of strength and athleticism?

A good many now, I would say about 30.

#### Where do you work?

When not writing for *The Referee* I used to relish the competition amongst men of my class in the gymnasiums and athletics tracks around the world. These days I have replaced my competitive efforts by imparting knowledge and instruction to a younger class of aspiring athletes.

**“Preliminary purgings, ascetic abstinence and the swinging of Indian clubs of enormous weights were a few of the things considered absolutely necessary.”**

#### What do you suggest a typical day consists of for an athlete?

For those wishing to compete at the highest levels, I would recommend a regular, strict and systematic course of training. Their muscles must be brought up to the necessary pitch by physical education and the science of how to use them to the greatest advantage. All athletes have to learn the proper methods of their endeavor, and a gradual increase of effort is essential. At the same time the internal organism requires to be studied. Should any severe strain be felt inwardly the athlete should desist and rest for a day or two.

The brain also needs systematic and ample exercise to develop its attainable powers. Fresh air is essential. It is generally a clouded brain that causes the athlete to fail, as many practice exercises without having obtained the knowledge of how to develop the muscles properly. Over development causes slowness. Strength may be gained by it, but quickness is lost. The first place for the

would-be strong man is the gymnasium where all kinds of apparatus are fitted up for developing the muscles. A favourite exercise with the Germans is the parallel bars. All exercises are strengthening, but constitution and the muscular framework being different, it is essential to select the kind of work suitable for each individual.

For those men and women wishing to develop their ‘veins of gold’ so they may possess well-developed, healthy and vigorous bodies and learn how to utilise their physical powers, they ought to muscularly exert themselves to a reasonable degree every day.

#### What dietary considerations should the aspiring athlete keep in mind?

In the heroic ages every man's energies were directed towards rendering his body as powerful as possible. At an ordinary meal Milo of Croton<sup>2</sup> is said to have consumed twenty pounds of meat, as much bread, and fifteen pints of wine. Later he adopted a vegetable diet, but would sometimes, to make amends for his abstinence, eat forty pounds of meat and drink an amphora of wine in one day.

We have learned much since those excessive days and today it is advisable to eat as little butter and fatty substances as possible or foods containing a large proportion of starch – such as potatoes and most vegetables. But you need not fear to eat meat, with as little fat as possible, nor eggs, in ordinary moderation, nor bread, which, though containing much starch is the least fattening of foods. Also, although I am aware I am treading on dangerous ground, I consider tobacco in any form to be injurious to one who would excel in feats of strength and athleticism – it is a distinct heart depressant.

#### What else have we learned about the pursuit of health and fitness in these more enlightened times?

It is amusing in the light of our present knowledge to read some of the books written on the subject of physical development some twenty or thirty-five years ago. Preliminary purgings, ascetic abstinence and the swinging of Indian clubs of enormous weights were a few of the things considered absolutely necessary. All such methods are now discarded by intelligent teachers.

We understand a great deal more regarding the science of physical exercise. For example, when muscles are used the tissue of which they are composed breaks down faster than if they were not exerted, and carries off effete matter more rapidly and thoroughly. The muscle then immediately begins to absorb material from the blood to build up and replace what has been discarded; the digestive organs respond at once to this call for nutritive blood by providing more digested matter, and the appetite is correspondingly increased. A system free of effete matter and bountifully supplied with healthy blood busy building up muscle is the immediate reward of those who exercise intelligently.

We also now understand that physical strength depends upon the power to contract muscles, hence the objection to the use of Indian clubs, the swinging of which severely stretches the muscles. Elasticity of muscle refers to the power of contraction not the possibility of extension. Under the microscope a muscle is seen to consist of a number of fine cords or fibres bunched together, much as telephone wires are massed into one rope. Each of these has its separate power of contraction and it is a simple arithmetical proposition that the greater the number of these cords a muscle contains, the greater must be its contractile power as a whole.

**“However athletes, like highly-strung animals such as thoroughbred horses, have their days on and their days off and we must allow them these fluctuations.”**

#### **What are the primary requisites for a professional athlete?**

The primary requisites are that he should have head as well as heart; that he should possess the fortitude of a Spartan, pluck to endure punishment, endless patience, extraordinary endurance and unbending will power. The ideal athlete is he who instead of making a specialty of any one branch of athletics, aims rather at an even and harmonious development of all his bodily powers, and keeps his physical standard at least sufficiently high to have a lasting and beneficial effect on his life. However athletes,



like highly-strung animals such as thoroughbred horses, have their days on and their days off and we must allow them these fluctuations.

#### **What's the best piece of advice you could give someone?**

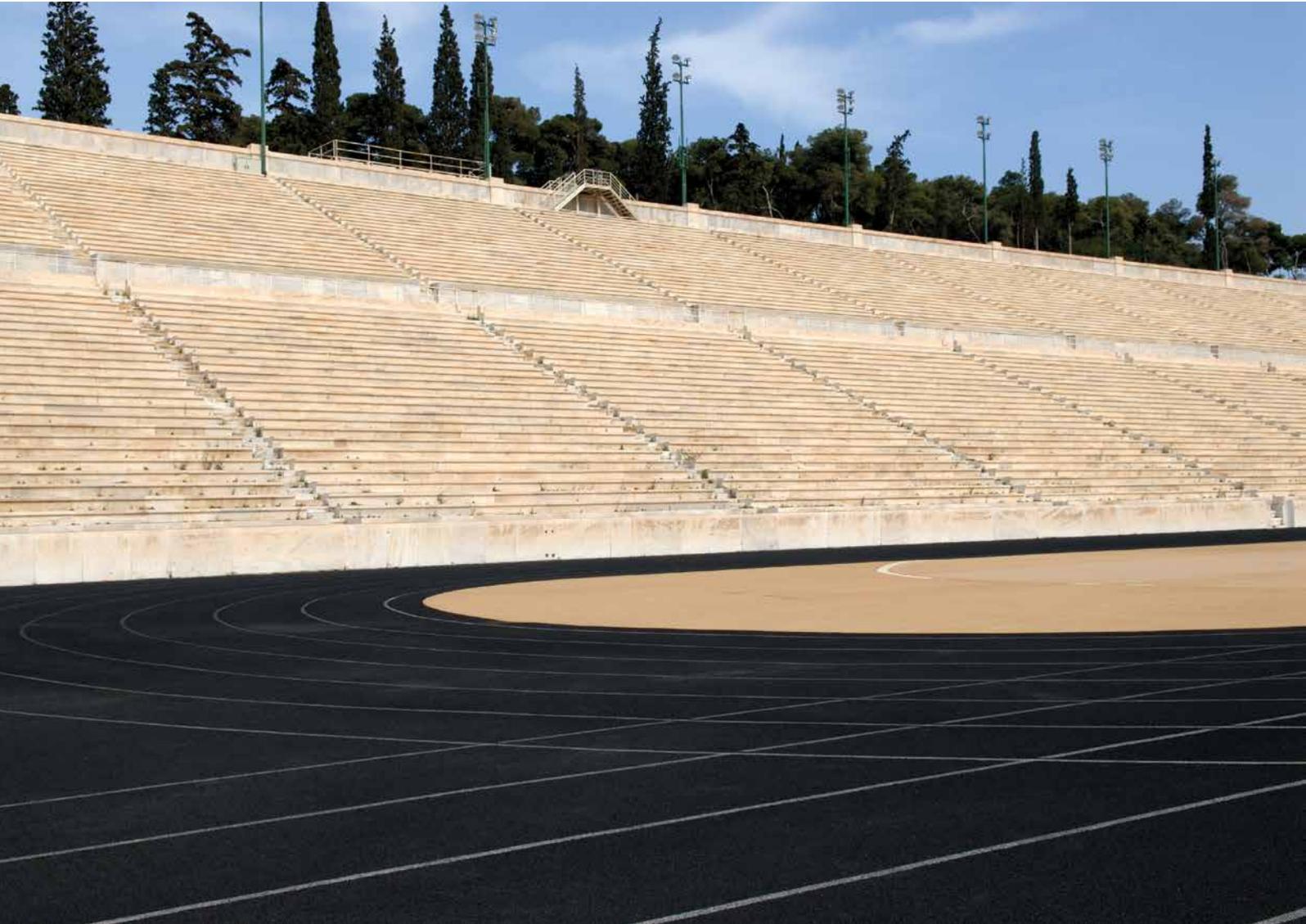
Exert yourself every day that you can. The general relationship existing between health and exercise is universally admitted. In the first place a reserve of vital force would be stored up against that evil day when sickness comes; and secondly, their bodies would be freed of the impurities that are cast off by active exercise, and afford a less likely hatching place for the germs of disease, which thrive and propagate on corruption.

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

Sampson, Professor William Millar, "Father Bill" Curtis and Mr John Doyle. They are all great athletes and strong men, respectively from Europe, Australia, America and New Zealand, who have proven that a life devoted to physical culture makes one healthy and vigorous into their latter years.

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

## The Evolution of Sports Medicine



### **From a late start to world leader, sports medicine in Australia has come along way.**

*The Referee* journalist, although talking over a century ago, speaks of many things that are familiar to us today. Our recognition that daily exercise is beneficial is not new, neither is the advantage of a low fat diet, although we are definitely more informed about the 'injurious' nature of tobacco as being more than just a 'heart depressant'! The journalist refers to the great athlete Milo of Croton from the 6th century BC and the historical and archaeological record shows that playing, exercising and competing in sport have been a part of human history forever. So, aside from the fun of it, is there a reason why sport is so entrenched in human culture all over the world?

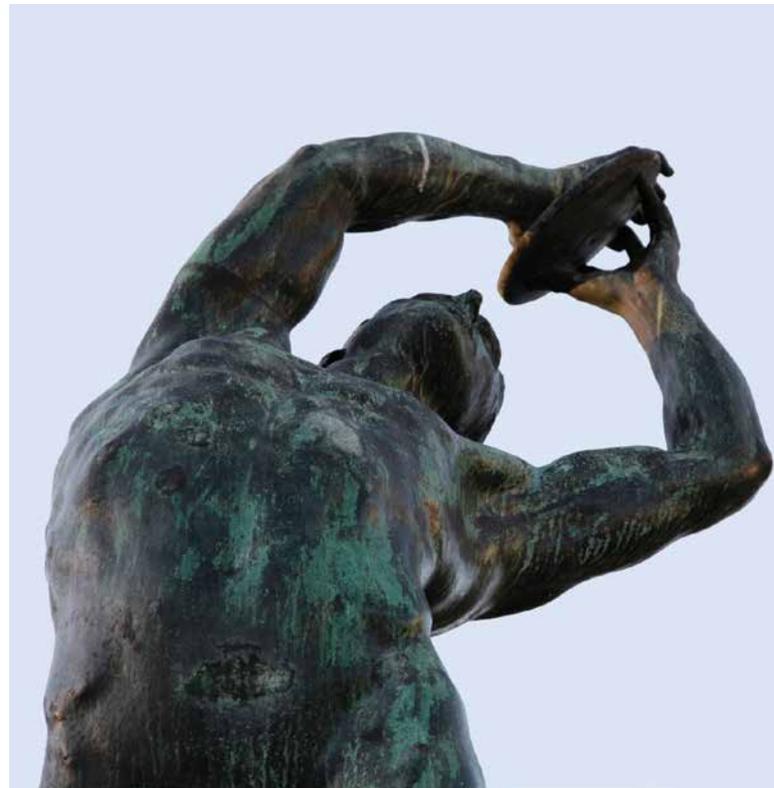
Initially of course, running was essential to chase or escape from animals, depending on whether we viewed them as food or foe. Sometimes we had to tackle as well. These activities sprung from an urge to survive. By the time of the first recorded Greek Olympic Games in 776 BC they had been integrated into our culture. The Games were dedicated to the Gods, particularly Zeus who had the unenviable job of being the God of fertility, meteorology, the harvest, and the protector of the family, but they were in fact secular in nature and their purpose was twofold: to showcase human physical evolution and triumphs, and to encourage good relations between the far flung citizens of the Greek islands.<sup>1</sup> The Greeks understood the value of fitness and agility and friendly competition so the

Games lasted for twelve centuries before the Christian Emperor Theodosius banned them in 393 CE as a pagan cult. Physical education also dates to the ancient Greeks or even further. In fact it is even considered to be a 'first systematic attempt at instruction in the history of man' and 'so inextricably interwoven with the progress of civilisation that it can be assumed that one never existed without the other'<sup>2</sup>. Exercise as treatment has also been recorded as far back as ancient times in the Hindu Arharva-Veda and the Chinese book of Kung Fu.<sup>3</sup>

**“While Australia chose nineteen athletes for these Games in 1928 they had no sports medicine people to send.”**

Between survival, hunting, performing, and improving international relations and the progress of civilisation it is not surprising that sport and exercise is at the core of our cultural evolution. In the eighteenth and nineteenth centuries a physical culture began slowly to gain a foothold in Northern Europe, Germany and Austria, with gymnasiums and gymnastic societies teaching the craft of an active, wholesome life in the open air, 'training together in harmony [and] kindling a public spirit of service to the nation' and a patriotism in unity.<sup>4</sup> While sport and exercise had been developing as a physical culture across Europe and in the UK it was also introduced into schools, particularly in the form of drills, exercises and games in the private school system in England and in the high schools and colleges of the United States.<sup>5</sup> Sport for competition was revived fifteen hundred years after the ancient Olympic Games and reintroduced into the modern era with the formation of the International Olympic Committee in 1894 and the first Games, held in Athens in 1896. Germany had long been at the forefront of the physical culture movement by this time and it paid off – the top three medalists were all German gymnasts.<sup>6</sup>

So by the early years of the twentieth century sport and physical activity had taken on significance as a patriotic exercise in wholesomeness, a military and educational component aimed at fitness and discipline, and a display of athleticism, skill and endurance on the world stage. As sporting federations and institutions developed across Europe to attend to the demands of both the sporting public and the elite, the attention also turned to the inevitable consequence of injury and requirements for focused medical care. One by one medical associations for sport or physical education were established in France, Germany, the Netherlands, Switzerland and other countries. The First World War was an interruption to progress but shortly after the proposal for an International Association of Sports



Medicine was put forward. This was eventually established in 1928 as Association Internationale Medico-Sportive (AIMS) and six years later renamed as the Federation Internationale de Medicine Sportive (FIMS), the name it is known by today. Its first International Congress was held only a few months following AIMS' establishment, at the 9th Olympic Summer Games in Amsterdam. Over 280 sports physicians attended from twenty countries to share information and knowledge amongst themselves, provide medical care to the athletes, and collect anthropometric, cardiovascular, physiological and metabolic data for future sports science research.<sup>7</sup>

While Australia chose nineteen athletes for these Games in 1928 they had no sports medicine people to send. This would not happen for nearly thirty years. However sport and exercise had been of interest to Australians for a long time, for its pure fun and enjoyment (often associated with betting and drinking<sup>8</sup>), for physical and mental well-being, for discipline and fitness, as well as for the future health of the nation. By 1900 there were clubs at both a community and an amateur level in several sports, inter-colonial teams, individuals and national teams able to compete with great success internationally, and plenty of weekend and community sport.<sup>9</sup> The 1890 'interview' earlier in this issue indicates a high degree of interest amongst the



community for information on the health benefits of exercise and sport; this journalist's articles ran fortnightly for several months. Despite this interest, one which is often claimed to be ingrained in the Australian psyche, the population was small and widely dispersed compared to European nations and a sophisticated engagement with the science and medicine of sport took a lot longer to develop.

Physical education was of greater interest, in the British vein of fitness and discipline. In response to an apparent lack of fitness amongst Australian men enlisting for WWII, the Menzies government established the National Fitness Council in 1941 to encourage physical activity amongst the population.<sup>10</sup>

A few years earlier in an odd confluence of participants the National Council of Women, keen to ensure that teachers in health related fields were qualified and registered, inspired Professor Browne of the University of Melbourne Education Faculty to advocate for a Diploma of Physical Education at the University. Browne corresponded with the Australian Council of Educational Research about the lack of qualified teachers (they had to go overseas for suitable qualifications), the prevalence and danger of unqualified teachers in Melbourne (of which there were many given the lack of qualifications and of legislation to control the field), and the need for quality physical education given its importance and 'the full programme of health work to be carried out in the schools'. At the same time academic bodies in several countries were seeking safe havens for German exiles, one of whom was Dr Fritz Duras, Director of the University of Freiburg Institute of Sport Medicine and whose father was Jewish, thereby making him subject to the Aryan Law which prohibited professionals with Jewish ancestry to work. So in 1937 Dr Duras arrived in Melbourne and established the University's, and Australia's first, Diploma of Physical Education. He went on to play many important roles in physical education and eventually in sports medicine including as one of two inaugural vice-presidents of the newly formed Victorian Sports Medicine Association in 1955.<sup>11</sup>

While there was no physical education available at other universities in Australia there were many medical practitioners with a strong interest in sport, and sports medicine around Australia was built on the work of volunteer medicos providing care for school, state and national teams of all sports.

Over time these doctors, physiotherapists, orthopods and others with an interest were champing at the bit to research, write and publish their work and their research findings at least during the 1950s and probably even earlier. In the archives of Dr Barrie Towers are transcripts for talks given during the 1950s from alumni such as Forbes Carlisle, Dr Thurlow and

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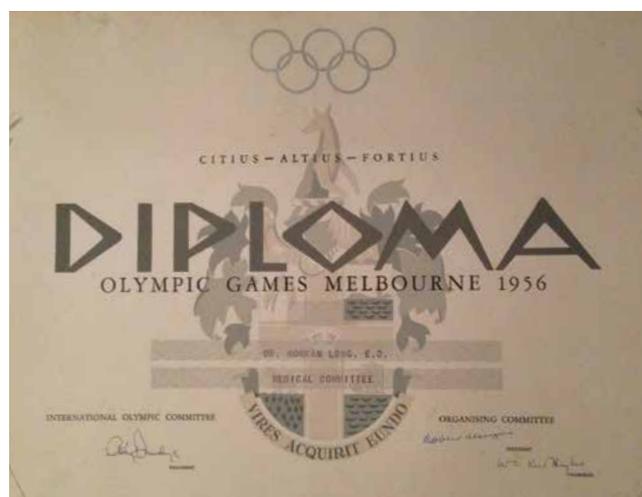
Dr D Rowe on subjects such as 'Modern Concepts of Football Training', 'Effect of Preliminary Passive Warming on Swimming Performance', 'Knee Injuries in Sport', and 'Relationships between physical fitness and sports' performance' amongst others. In 1958, Dr Towers, the ASMA NSW branch's secretary, published the first edition of *The Australian Sports Medicine Bulletin*:

This Journal has been published in an attempt to inform you of the latest developments in Sports Medicine here and overseas, as well as to make you familiar with the work done by the Sports Medicine Associations in Australia. This year has seen a great upsurge of interest in the scientific approach to sporting activities ...

**“Basically in Australia we'd only really considered the treatment of injuries as sports medicine, whereas the Europeans were looking at a lot of other aspects of sport performance.”**

The Bulletin underwent a name change to 'The Australian Journal of Sports Medicine' and Vol. 1, No. 1, produced in May 1961, kicked off with 'Introducing Sports Medicine. A new era in sport' by Les Cotton, who was then Vice President of the NSW SMA and a Technical Consultant to the NSW Amateur Athletics Association. His concern, nearly twenty-five years after Dr Duras established the first Diploma of Physical Education, was with a lack of quality physical education in schools and amongst adults. He called for 'trained leaders and coaches in different spheres of sport and recreation ... as more properly trained people take charge of the children of tomorrow, so will the many problems, such as delinquency and poor health tend to vanish, and a strong, healthier race develop.' His concerns regarding the population's long-term health still remain, and both the title of his paper and his comments reveal Australia's late start compared to Europe and the United States in embracing the concept of sport and exercise as medicine.

In comparison, members could also read about longitudinal studies around the globe such as the 'Physiological functions of men and women re-examined after an interval of twenty-five years' from Copenhagen researchers who were studying the influence of age on physiological working capacity. A footnote explains that the Danish author, Dr Erling Asmussen, was a supervisor at the University of Copenhagen's Laboratory of Theoretical Gymnastics, first instituted in 1909 and attached to the Danish State College of Physical Education.



Norman Long's 1956 Olympics Medical Committee certificate.

Another article, 'A statistical study of sports trauma cases encountered at our clinic for the last 25 years and some cases of lumbago due to sports trauma' was from K. Mizutani, the Assistant Professor of Orthopedic Surgery at Nippon Medical School in Tokyo. Mizutani refers to the first systematic study of sports trauma in Japan based on an observation of 4,000 sports trauma cases, and conducted nearly thirty years previously by the orthopedic clinics of Nippon Medical School and Tokyo University, and the Medical Information Office of the Education Department. In 1961, when Vol. 1 No.1 of the Journal was produced, Australia was still a long way from the sports medicine and sports science capacity required for studies such as these.

Sports scientist John Bloomfield, having had the opportunity during the late 1950s and early 1960s to work and study overseas, 'noticed that sports medicine was much more complex than in Australia. Basically in Australia we'd only really considered the treatment of injuries as sports medicine, whereas the Europeans were looking at a lot of other aspects of sport performance. For example, the physiology of exercise, applied anatomy, biomechanics and even some sports psychology, they had this all integrated with sports medicine. It was very much in front of what we were doing in Australia.'<sup>12</sup> Despite this, the passion, drive and voluntary efforts going into building the ASMF and the field of sports medicine, was palpable at the time. For Australian sports medicine enthusiasts there was a lot at stake.

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

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**BROOKS**

## The Jostle at the Starting Line



**Like many great organisations SMA grew out of humble beginnings with meetings held around kitchen tables. Here historian Emma Russell paints a picture of those beginnings.**

Clinical sports medicine had long been practiced on an ad hoc basis across Australia, driven by the enthusiasm of sports mad practitioners prepared to work in an honorary capacity for clubs, or who saw sporting injuries amongst their regular patients. However, there was no formal organisation of sports medicine until the 1950s when Melbourne's hosting of the 1956 Olympic Games loomed. The Honorary Secretary of the Australian Olympic Federation (AOF), Mr Edgar Tanner asked Dr Norman Long, a radiologist in Melbourne, to survey the possibility of forming a medical body interested in sport and that could be affiliated with the AOF. A meeting at the Amateur Sports Club in Little Collins Street, Melbourne on 8 January 1954 resulted in a provisional executive of Tanner, representing the AOF, Dr J.L. 'Spudda' Thwaites as President and someone else with a longstanding association with the AOF, and Long as Secretary-Chairman.<sup>1</sup>

Within fourteen months they had communicated their intentions to the administration of FIMS (Federation Internationale de Medecine du Sport) and the British Medical Association (Victorian branch), to all amateur sporting associations across Australia asking for the names of any doctors associated with them, and then to these doctors directly. Thirty-five doctors replied showing an interest in this new 'movement' to coordinate sports medicine in Australia, and several offered

suggestions and assistance with particular aspects such as neuro-muscular research (Prof Donald Fraser in Sydney), cardio vascular research (Prof Frank Cotton in Sydney) and Sport Medicine knowledge (Prof Fritz Duras in Melbourne).<sup>2</sup>

Again at the Amateur Sports Club in Melbourne a meeting was held in March 1955 to take the next step. Fifteen people were present, and five apologies, and the main outcomes of this meeting were 'that this body be formed into a medical unit to be known as the Australian Sport Medicine Association'; that everyone present would constitute the provisional council; and that branches would be formed in all states. This happened almost immediately in Victoria and Western Australia (1955), then in NSW (1956), Tasmania (1959), South Australia (1961), ACT (1963) and Queensland (1970).

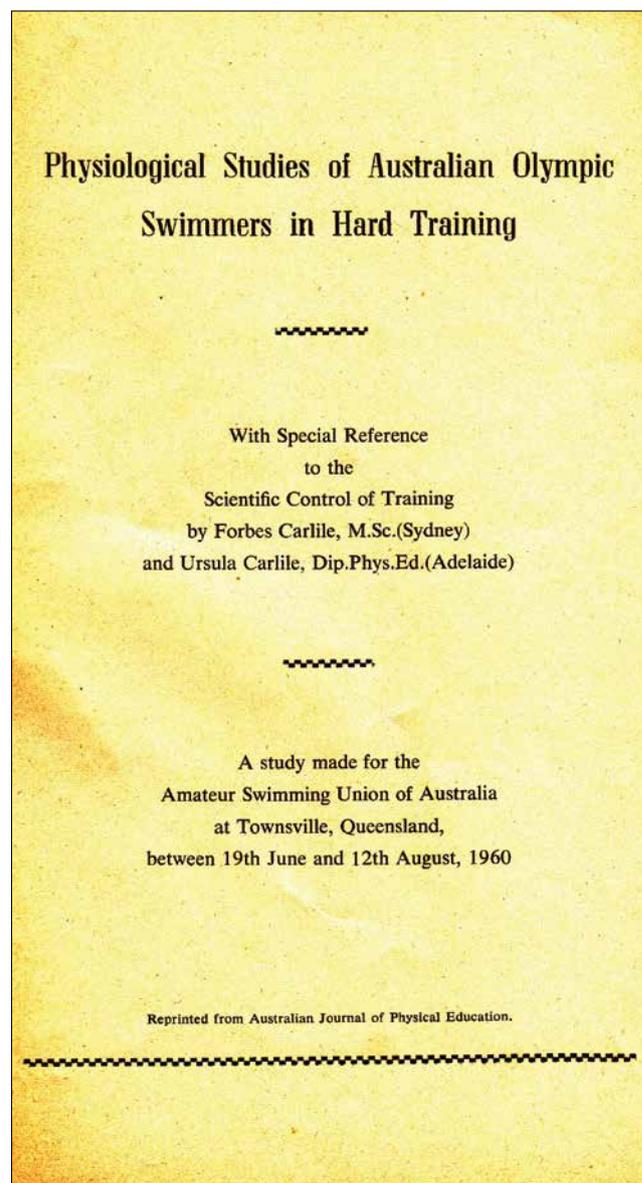
***"Peter Duras, Fritz Duras' son, remembers 'as a youngster in the mid-50s, some of the figures from sports medicine coming to our house in Canterbury ..."***

Of these beginnings Victoria's was vibrant and eager; Peter Duras, Fritz Duras' son, remembers 'as a youngster in the mid-50s, some of the figures from sports medicine coming to our house in Canterbury, people like Dr John Diggle and Dr Israel Zimmerman, coming and having meetings at our place about the formation of sports medicine'. NSW needed considerable urging by Long and was eventually pulled together by Dr Dunn in Sydney but then languished within a year and a half, only to be reignited by Dr Barrie Towers with

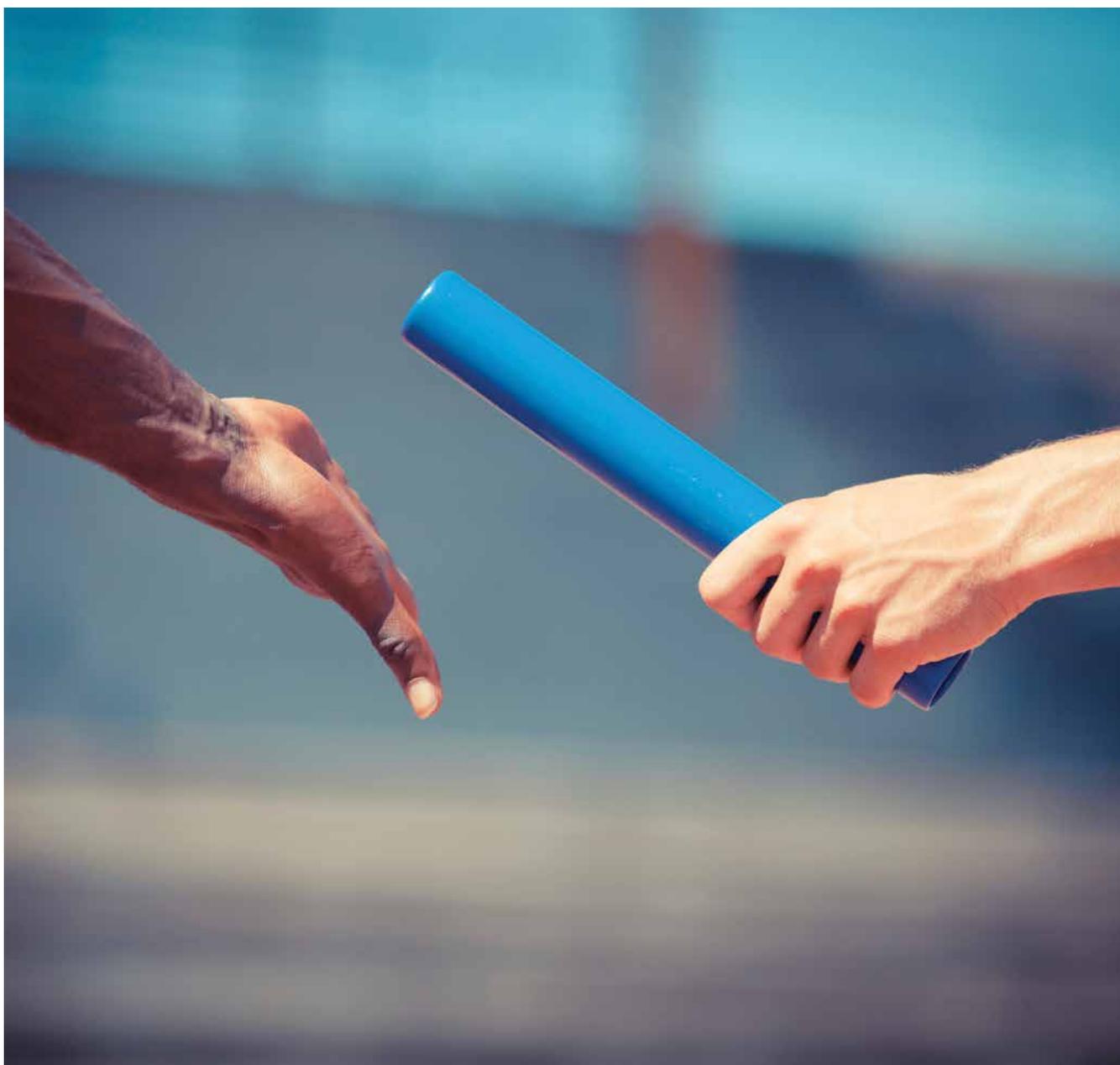
the help of Drs Forbes Carlisle and Les Cotton. WA had a dedicated committee of Dr Jim Pannell, Sir Thomas Meagher and Dr Lindsay Gray who tried hard but made little progress. Maybe the problem was they were involving the wrong people – Ken Fitch returned from medical school in Adelaide and got involved as a local football club doctor in 1956, as had Peter Tunbridge at Claremont football club a couple of years earlier, but ‘we were never invited [to get involved in WA SMA] by these old doctors and I think this probably held up progress a bit’.<sup>3</sup> As with the impetus provided by the Olympic Games in Victoria, the British Empire and Commonwealth Games in Perth in 1958 was the catalyst for rejuvenating the WA SMA, with Jim Pannell as President. Tasmania always suffered a numbers problem and floundered completely after about three years with only Drs Joe Cannon and William Law, while South Australia, although taking a little longer to get started, did so under Bert Apps, Sandford Skinner, Howard Mutton and Albert Simpson.<sup>4</sup>

**“When Ken Fitch and Barrie Towers were the secretaries for the WA SMA and the AFSM in NSW in the early 1960s they ‘used to send tapes to each other, because that’s all you could do back then.’”**

Queensland had begun a state branch in 1965 led by academic Dr Barry Smithurst, which folded after a year. However Queensland was the success story with a later attempt in 1970 by physiotherapist Peter Dornan and Dr Kevin Hobbs. Dornan had joined the NSW ASMF and been inspired by a visit to Sydney in 1968 when he attended the third AGM of the ASMF and visited the new Lewisham Sports Medicine Centre. On his return to Queensland he and Dr Hobbs arranged a meeting at which about fifty people turned up. Maybe the later start for Queensland enabled the participants to be inspired by activities in the other ASMF branches around Australia, but there is no doubt that the multi-disciplinary nature of sports medicine was captured in Queensland’s first meeting and inaugural committee, which included doctors, rheumatologists, physiotherapists, a physical educator, and a pathologist as well as an accountant and businessman. Public lectures and meetings in country areas, newsletters and the first acquisition of a grant from the Rothman’s Sporting Association encouraged considerable interest and within a year Queensland had more members than any other ASMF branch.<sup>5</sup>



Difficulties began arising between the states very early on, caused largely by the perennial problems that come with state bodies attempting to create a national cohesion. For many years phrases such as ‘protecting their patch’, ‘shoring up power’, ‘lobbying’, ‘outside interference’, ‘jealously guarding’, ‘facetiousness’ ... were thrown from one state to another in correspondence and across tables at national ASMA meetings.<sup>6</sup> However, what the protagonists in each state were really doing was contributing untold voluntary hours,



along with the odd personal expense, to establish a group from amongst their local network that could function and contribute to the development of sports medicine both locally and nationally. It was not an easy task and therefore often frustrating and vulnerable to upsets. When Ken Fitch and Barrie Towers were the secretaries for the WA SMA and the AFSM in NSW in the early 1960s they 'used to send tapes

to each other, because that's all you could do back then ... and we would do that every six or eight weeks.'<sup>17</sup> Although not as immediate as a face to face conversation, the inflection and rhythm of their speech had the advantage of being more personal and expressive than a letter.

When NSW broke away from the ASMA in 1961 to form the Australian Federation of Sports Medicine (AFSM) it was

out of frustration at the perceived dominance and lack of consultation coming from the Victorian group in particular, and their inability to instigate a rotating national committee. A comparison of the Victorian SMA Constitution and the AFSM Constitution reveals no differences in their aims that would justify a split. Both listed

‘the maintenance and improvement of the physical and mental health of the nation by muscular activities and more particularly by physical education [and] gymnastic sports; the scientific study of the effects of such activities both normal and pathological; to act in an advisory capacity to the Australian Olympic Federation in medical matters; and to undertake all such other acts or matters as may be incidental to the foregoing objects’.<sup>8</sup>

The only difference between the two was that Victoria wished ‘to affiliate with the Victorian Olympic Council and the Australian Sports Medicine Association’, while the AFSM aimed ‘to co-operate with national and international bodies having kindred objects and in particular with the Federation International Medicine Sportives’.

**“These two very, very reasonable, nice blokes, I remember them getting up and saying “look, we’ve got this impasse, we’ve got to get a national body, we just can’t go on like this.”**

For a few years there was considerable disquiet amongst the Victorian, SA, WA and NSW branches, and while the blame was often put on their Victorian colleagues for creating many of the problems it was in fact the Victorian leaders who paved the way for reconciliation. Norman Long, who had worked so hard to instigate the ASMA and served as Secretary from 1954–58 and then President from 1958–62, appears to have been astute enough to realise he’d invested too much of himself and was unable to let go of the reins easily. He wrote to Dr Purflett, the President of the breakaway AFSM in NSW, to say he was stepping aside to give the two groups a chance to amalgamate seamlessly. It was the only way that sports medicine as a profession could evolve in a country that had so few practitioners, and a successful merger was on the minds of most of the sports medicine leaders of that era. With the Commonwealth Games in Perth in 1962 Jim Pannell, the WA SMA President, was chosen to succeed Long as President of the national body, and Fritz Duras of Victoria suggested

the event be used to facilitate a Council meeting and an amalgamation of the ASMA and the NSW-based AFSM.<sup>9</sup> Fitch remembers it this way:

Of course we had the situation whereby Melbourne couldn’t even get on with the national body ... and of course Sydney and Melbourne always fight so this was one time when they didn’t. So they sent Fritz Duras ... and Sydney sent Les Cotton ... These two very, very reasonable, nice blokes, I remember them getting up and saying “look, we’ve got this impasse, we’ve got to get a national body, we just can’t go on like this”. They were so amenable and so accepting of the fact that “Here you West Australians, take it over, give us a national constitution and we’ll go from there” and that’s exactly what happened.

The merger was in fact unanimous, as was the name change, which honoured the derivation from both organisations without preferencing either of them. The newly amalgamated Australian Sports Medicine Federation (ASMF) had as its aims the medical supervision and care [of those] promoting and conducting physical activities in a sporting and recreational form ... to safeguard and improve [their] physical and mental health; the arrangement and support of the scientific study of the effects ... of physical activities on the human organism; to provide information to sporting bodies throughout Australia by way of the state branches; to cooperate between kindred national and international bodies such as FIMS; to liaise with the Australian Olympic and Commonwealth Games Federations and advice on medical matters; to act as co-ordinating body for all state bodies; and to promote policy and undertake responsibilities and tasks in relation to the aims of the Federation.<sup>10</sup>

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

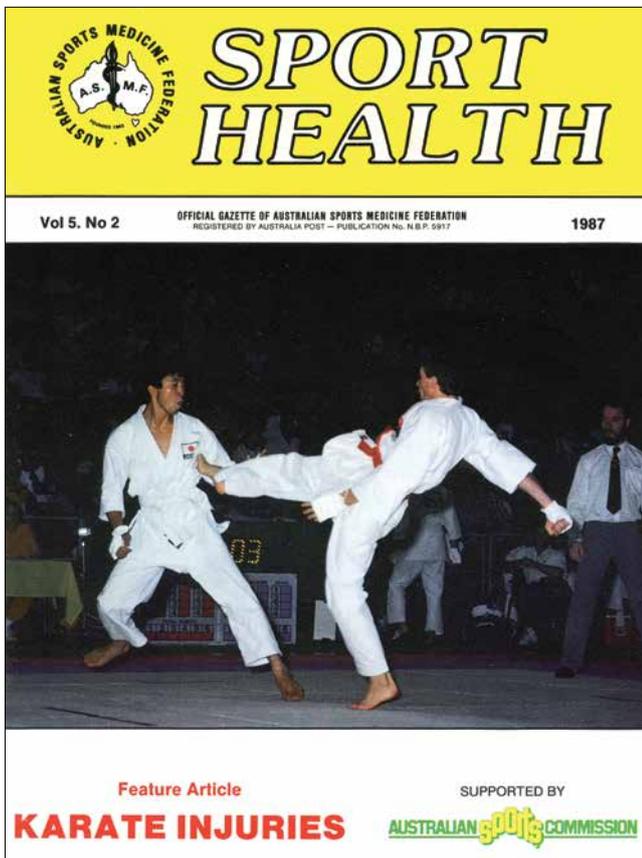
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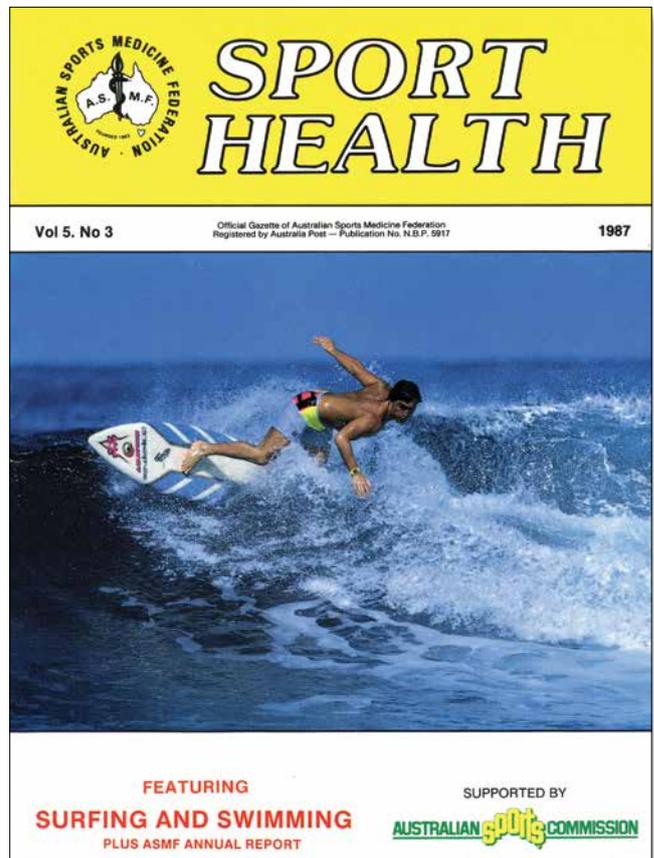
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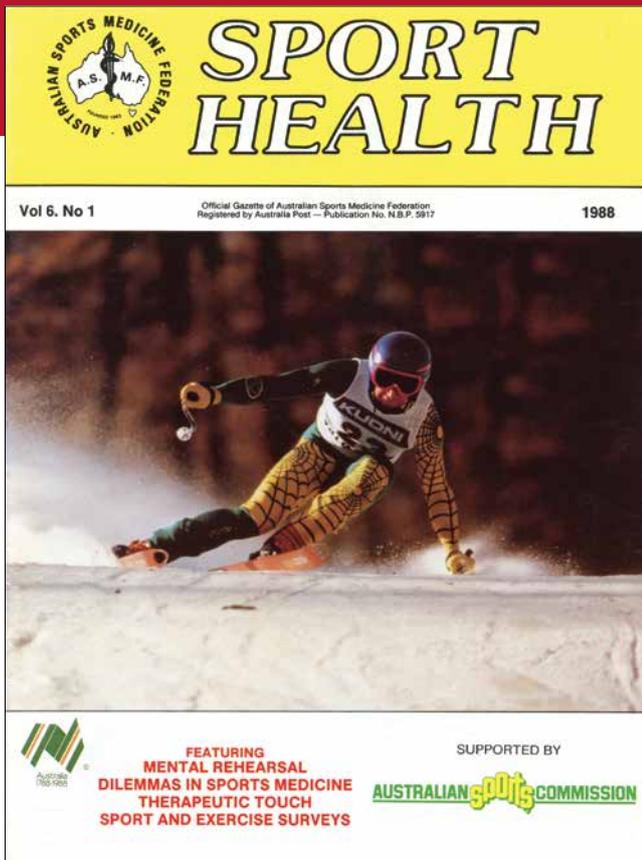


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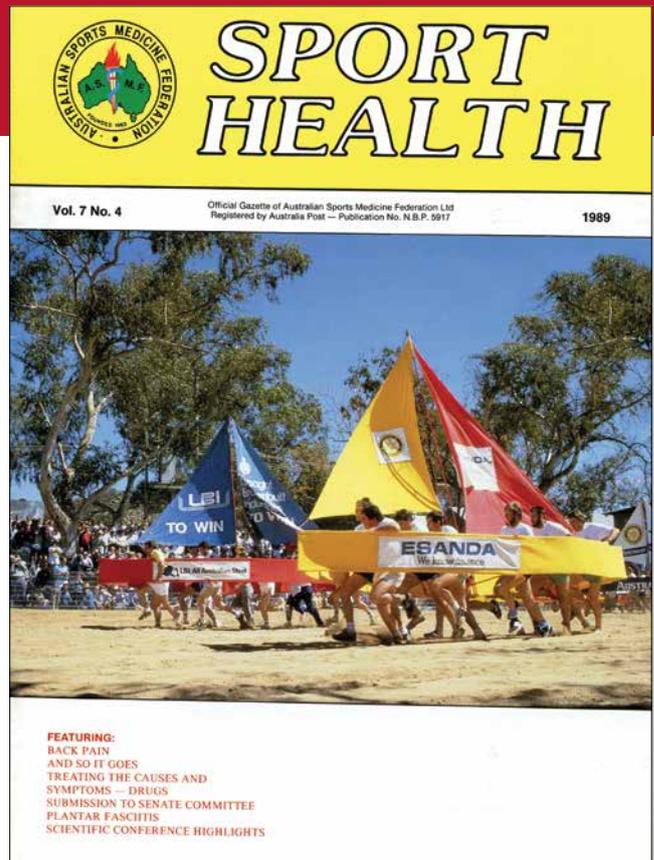


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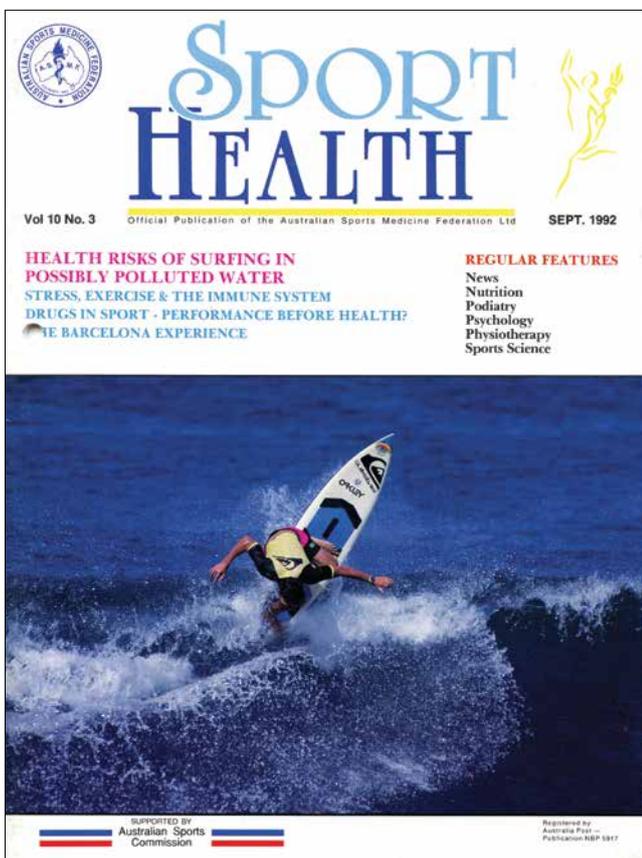
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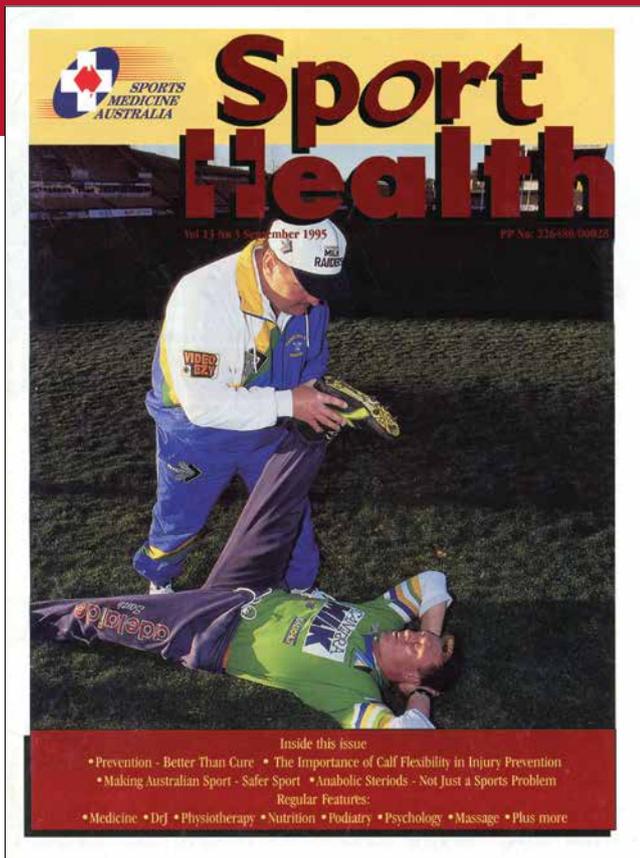


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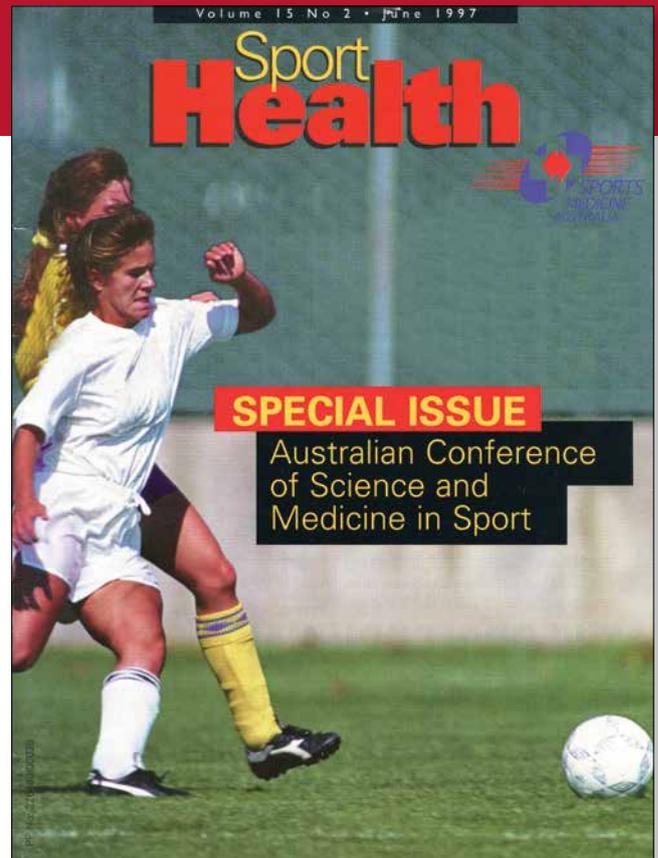


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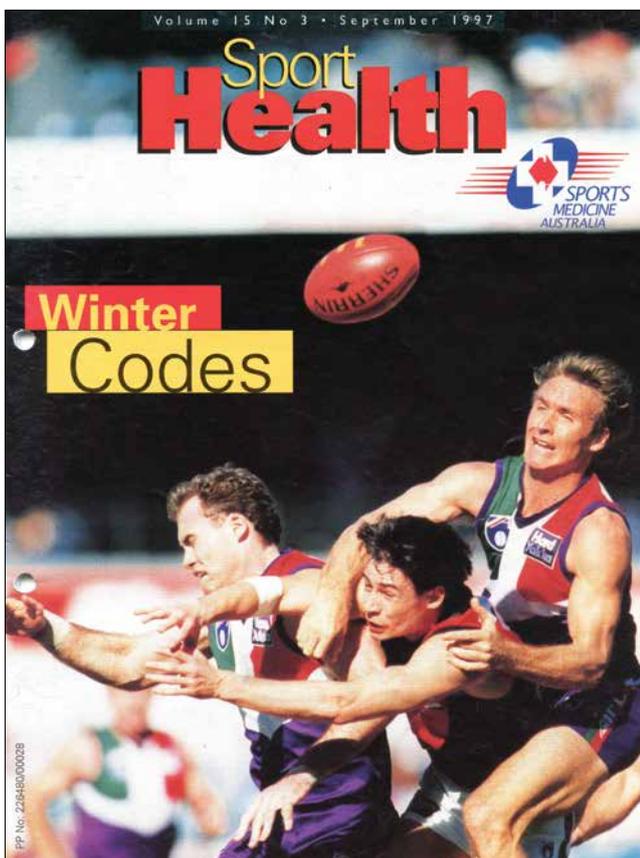
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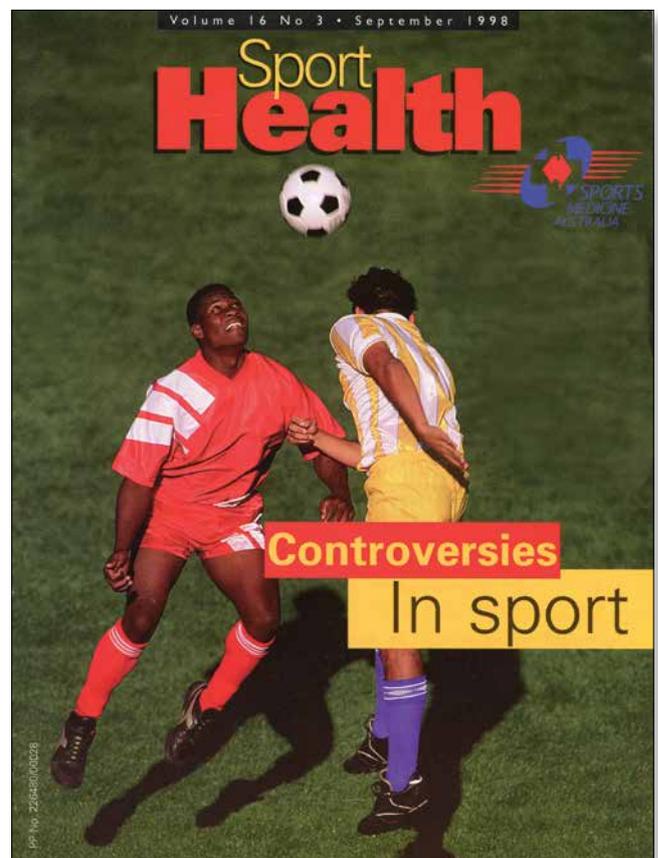
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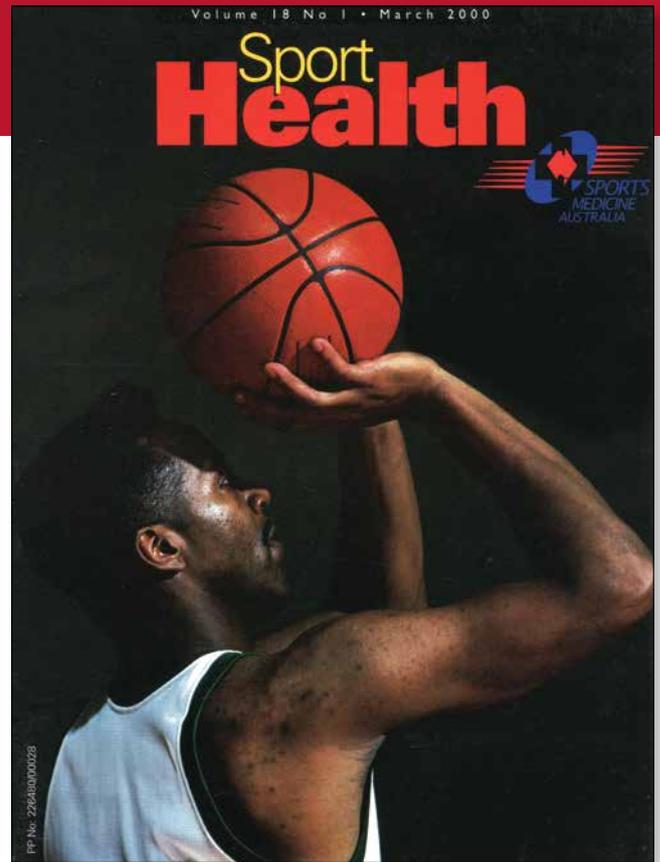


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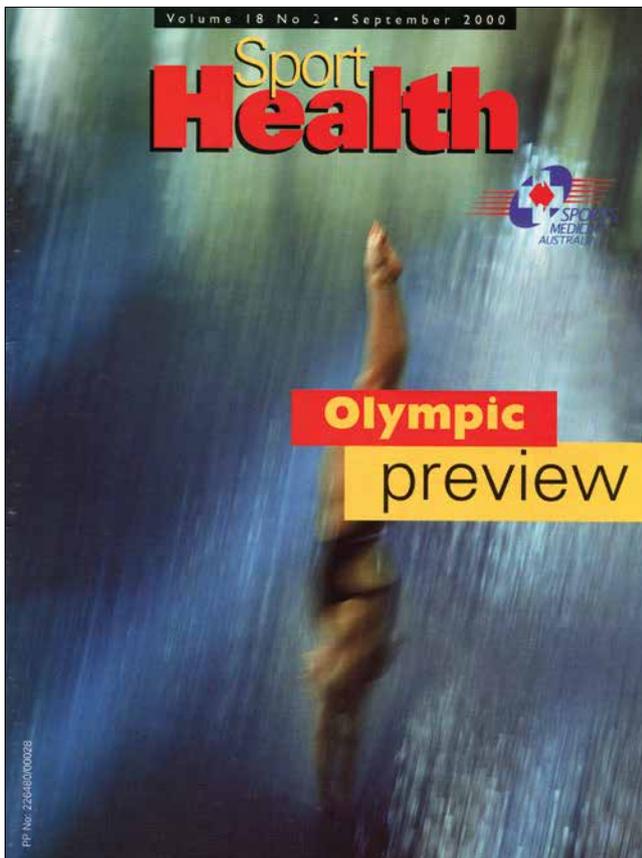
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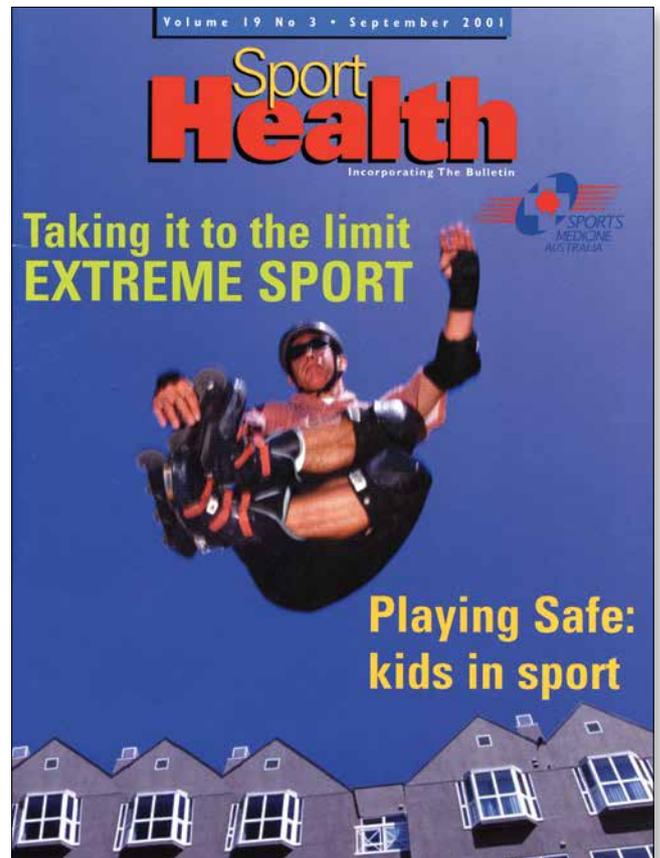
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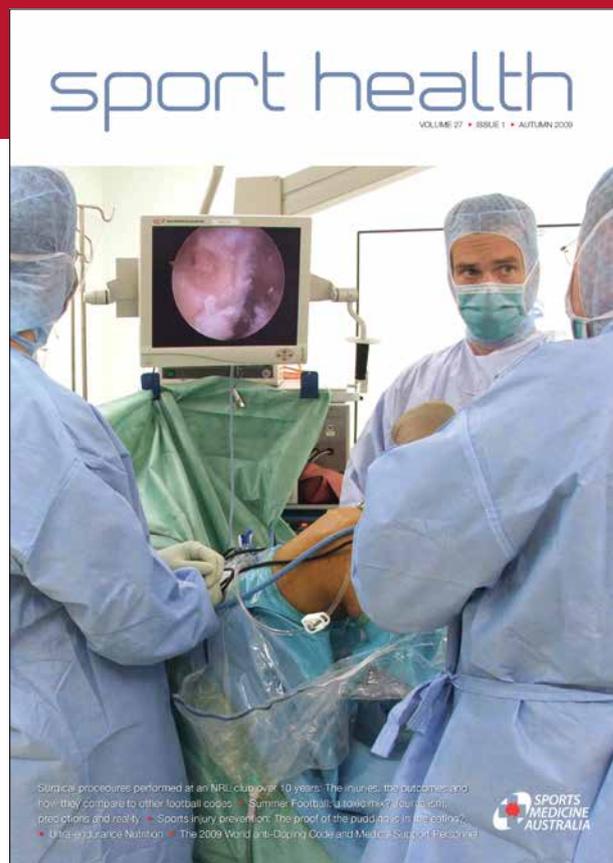


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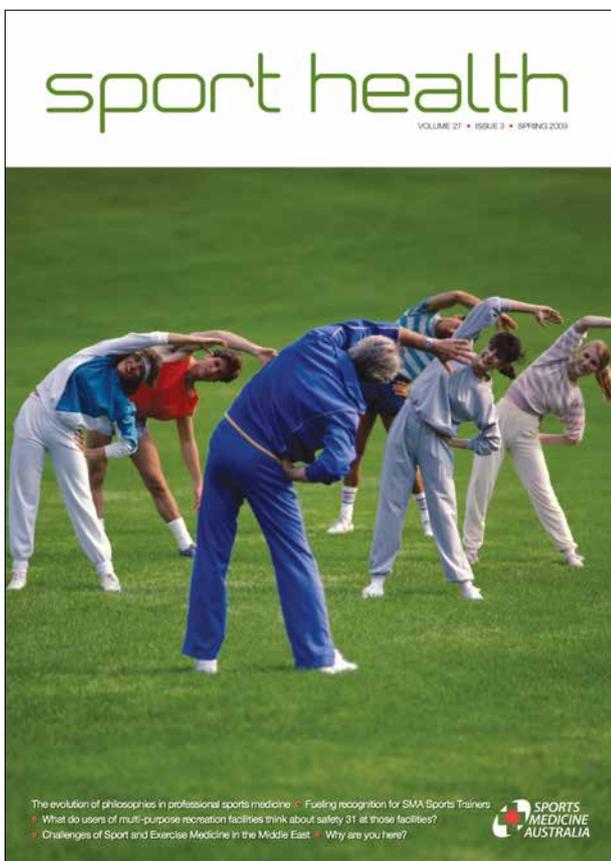
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## Setting The Pace



In 1963 there was a new beginning with a new set of aims and objectives that effectively supported all those initially intended by the sports medicine founders of Australia but also hinting at a broader focus on the wider sporting community. The doctors, physiotherapists and others working in sports medicine were no longer 'medicos with an interest', they had their own professional organisations with plans for the future.

### Establishing a workplace

Sports medicine clinics are a common sight across much of Australia today, but these commercial enterprises were preceded by part time clinics established in public hospitals or on university campuses. Prior to these, sports medicine care was provided in the course of general practice, or by doctors who, through their own personal involvement in

sport, provided honorary medical services to sporting clubs. Professional football clubs became the earliest employers of paid sports medical and paramedical staff. Community clinics started to appear during the early to mid 1960s, just as sports medicine associations were also establishing themselves. The university clinics were developed initially at the University of Adelaide and then Monash University and within a few years at both La Trobe University and the University of Melbourne. In Victoria particularly there was a considerable effort made to take sports medicine into the community albeit in a limited fashion. State branches of ASMF actively recruited volunteers to provide sports medicine coverage at the University clinics and at a large number of sporting events. In the hospitals the first clinic appears to have been at the Sydney Hospital and run for a few months in 1964 by Dick Tooth, who was an orthopaedic surgeon. Vamplew, in 'A Healthy Body', explains that the difficulty for this clinic was that Tooth saw patients referred to him by casualty staff, but it was quite likely they would not recognise an injury that should be treated by someone with specialist knowledge of sports medicine.

Two or three years later, at the Royal Perth Rehabilitation Hospital, Ken Fitch was discovering the same problem of limited, or complete lack of, knowledge about sports related injuries. He became 'fed up with seeing multiple patients who'd

been to casualty [and given] a diagnosis of "no bones broken"', so spoke to the influential head of both the orthopaedics unit and the spinal unit, Sir George Bedbrook, and received his support for a study. After studying the records from the Royal Perth Hospital Fitch managed to demonstrate the need for a proper sports clinic that was able to look beyond the orthopaedic diagnosis of fractures and breaks to consider soft tissue injuries. The clinic was established in 1969 and Ken 'went there four days a week, got no pay, for seven years and then suddenly ... I was made a physician to orthopaedics, remunerated and stayed there until 2001. That clinic went for 32 years as a public hospital sports clinic', and also played a role in training physiotherapy and orthopaedic students.

**"... Fitch managed to demonstrate the need for a proper sports clinic that was able to look beyond the orthopaedic diagnosis of fractures and breaks to consider soft tissue injuries."**

In 1966 the Lewisham Sports Medicine Clinic opened in Sydney 'for the treatment of all forms of athletic injuries'; the same one that inspired Peter Dorman to establish sports medicine as a profession in Queensland. This Clinic was different from all the others because it was independent from



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a hospital or university, although it was situated within the Lewisham Hospital in Sydney's west. It was a self-funded private enterprise, run by Dr Tony Millar, a physician with a great deal of sports medicine experience with elite rugby league players, and staffed by others with a strong interest in sports medicine. It was for anyone who had injured themselves playing sport or exercising and wanted to, not just heal the injury, but be able to train or play again at the same level as soon as possible. Treatment could afford to be more aggressive or demanding, and it was more effective when the circumstances of the injury were understood, not just the consequences. This was an important understanding that the Lewisham Clinic staff were able to provide, whether their patients were elite athletes or weekend runners.<sup>1</sup>

**“Up until then football clubs had had a doctor from here and a doctor from there and a physio from here and a physio from there and so on, all on a part-time basis because football was part time in those days.”**

ASMF state branches clinics were also established in Adelaide (1977) or being planned in Victoria with state government assistance. ASMF (Vic) established a joint venture with the Carlton Football Club, which lasted for at least three years. Their move to the City Baths in 1983 was driven by Dr Fred Better, the recent past President of ASMF (Vic). Peter Brukner remembers that Better ‘wasn’t very happy that other places weren’t doing a very good job of setting up sports medicine clinics, so he thought this was the way to do it’. Like Lewisham, it would be open full time and staffed by physiotherapists and doctors experienced in dealing with sports related injuries. The staff were all ASMF members and rostered to the City Baths just once or twice a week as they had their own practices to which they were more committed. The other problem for the City Baths was that ‘it was not in the right position. Well, no passing traffic if you think about it ... It was a great little centre, it was good, but it was in the wrong position.’<sup>2</sup> Eventually the City Baths Sports Clinic began ‘losing money and it was a real drain on ASMF finances. We had to ask the government to bail us out and Fred organised all that. He had amazing contacts in government.’<sup>3</sup>

In Victoria there were a few other clinics establishing themselves on a commercial basis with a part or full time sports medicine focus, then in 1986 the Olympic Park Trust put out a call for tenders to establish a sports medicine clinic as part of the overall sporting precinct. Peter Brukner, who had

been doing some shifts at the City Baths and who shared a general practice in McKinnon with a growing focus on sports medicine ‘said to Fred [Better] “Why don’t we privatise the City Baths Sports Medicine Centre and move it to Olympic Park?” ASMF could retain a share in it and it would solve the issue of losing money for ASMF’. So with Peter Harcourt, Brukner and Better ‘put this tender together which, to everyone’s surprise other than ourselves we won ... and that opened in 1987.’

Not long afterwards Brukner was engaged by the Melbourne Football Club to look after their players. He negotiated it ‘as a clinic thing. Up until then football clubs had had a doctor from here and a doctor from there and a physio from here and a physio from there and so on, all on a part-time basis because football was part time in those days. I thought it would be a good idea to have a clinic contract so the same people who worked at the football club would be working together at the clinic ... so Olympic Park got the contract with Melbourne Football Club and then subsequently we got contracts with Richmond and Collingwood and Hawthorn over the years. So that’s how Olympic Park started.’

This put a stamp on the sports medicine clinic movement. Twenty-six years later a quick search of today’s online White Pages brings up 49 businesses in New South Wales with the words ‘sports medicine’ in their name, 32 in Victoria, 22 in Queensland, 20 in South Australia, 16 in Western Australia, and single digit numbers in the Northern Territory, Tasmania and the Australian Capital Territory. There would be many more practices with sports medicine expertise but that don’t include those words in their names, while countless practitioners throughout Australia claim some expertise in the treatment of sports injuries or other aspects of sports medicine.

**“It was doctor, doctor, doctor, doctor and everybody else was a nothing. It was a lack of understanding that sports medicine is a team discipline.”<sup>4</sup> Ken Fitch remembers one meeting ‘when Bert Apps who organised it wasn’t even allowed to vote because he wasn’t a doctor.’ There was a strict rule that non-medical membership could not exceed 10%.”**

## Who should we let in?

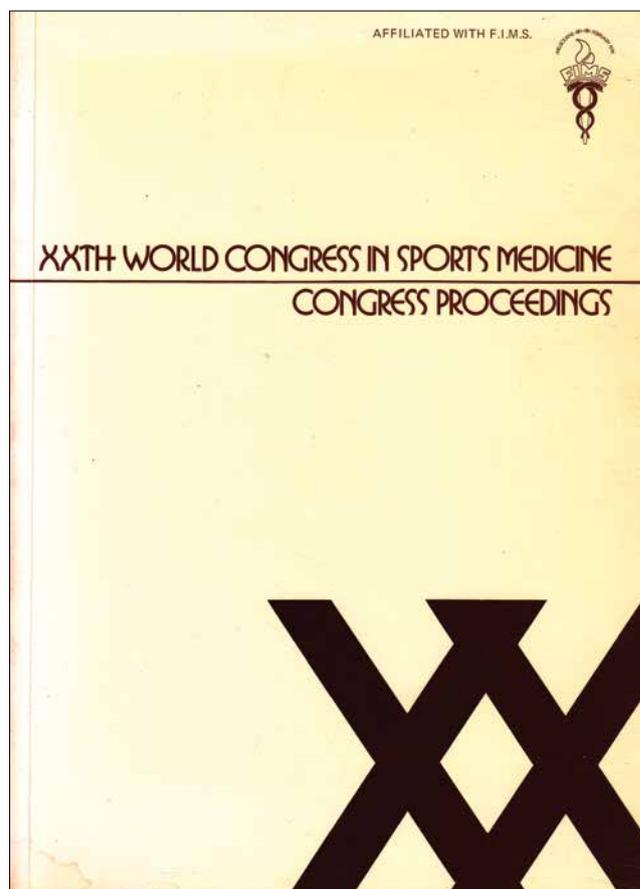
Within ten years of ASMF being established the Federation had a President who was not practicing as a doctor and was not even medically trained so that ‘when I came back [from studying

overseas] in 1968 I was just an associate member because I wasn't a medical doctor'; Professor John Bloomfield was a sports scientist with a research background in the anatomy and physiology of Olympic swimmers. Today this background would seem perfectly reasonable and not worth commenting on, but the long memories of those involved with ASMF in the early 1960's, and the record provided by Vamplew's 'A Healthy Body', would indicate a completely different way of thinking fifty years ago.

'It was doctor, doctor, doctor, doctor and everybody else was a nothing. It was a lack of understanding that sports medicine is a team discipline.'<sup>4</sup> Ken Fitch remembers one meeting 'when Bert Apps who organised it wasn't even allowed to vote because he wasn't a doctor.' There was a strict rule that non-medical membership could not exceed 10%. This was crucial in the minds of some of the senior ASMF members who felt that sports medicine's integrity could only be ensured by affiliation with the Australian Medical Association (AMA). Jim Pannell, President in 1965, believed that sports medicine's future lay with convincing the medical profession that sport and exercise was required for health and disease prevention, and a close affiliation with the leading medical body in Australia would provide them with the influence they needed. Others, particularly Howard Toyne and Leigh Wedlick in Victoria, agreed.<sup>5</sup> But there were also senior members such as Brian Corrigan and Barrie Towers in NSW, Bert Apps in SA, and Ken Fitch and Brian Blanksby in WA that felt just as strongly sports medicine could only flourish if it was true to its disciplinary mix, which had to mean accepting disciplines in equal numbers, and allowing that same mix to vote and hold positions of authority alongside the doctors.

The debates amongst themselves, and the negotiations with the AMA, went on for several years with very little ground given by both sides of the argument. Eventually an offer by the AMA to accept a non-medical membership of 20% was turned down in a motion by Ken Fitch and Geoffrey Vanderfield at a 1969 Council meeting; 20% was unacceptable to them because it was not 100%. Their motion was passed, indicating the tide was changing, and the next year it was agreed that any registered medical practitioner and 'graduates from an accredited tertiary institution in a discipline relevant to sports medicine' could be a member of ASMF.<sup>6</sup>

No one in 1965 would have predicted a sports scientist could soon be President but the election of Bloomfield in 1971 is an indication of the tenacity that the younger members had



and the convictions they held for the future of their profession. Jim Pannell's urging that a mixed membership would be 'detrimental to sports medicine' has proved to be wrong and the second generation of practitioners who were setting the pace in the 1960s opened the way for other membership changes in the 1980s and 1990s that could not possibly have been envisaged by the first generation of medical doctors.

## 1974 Congress

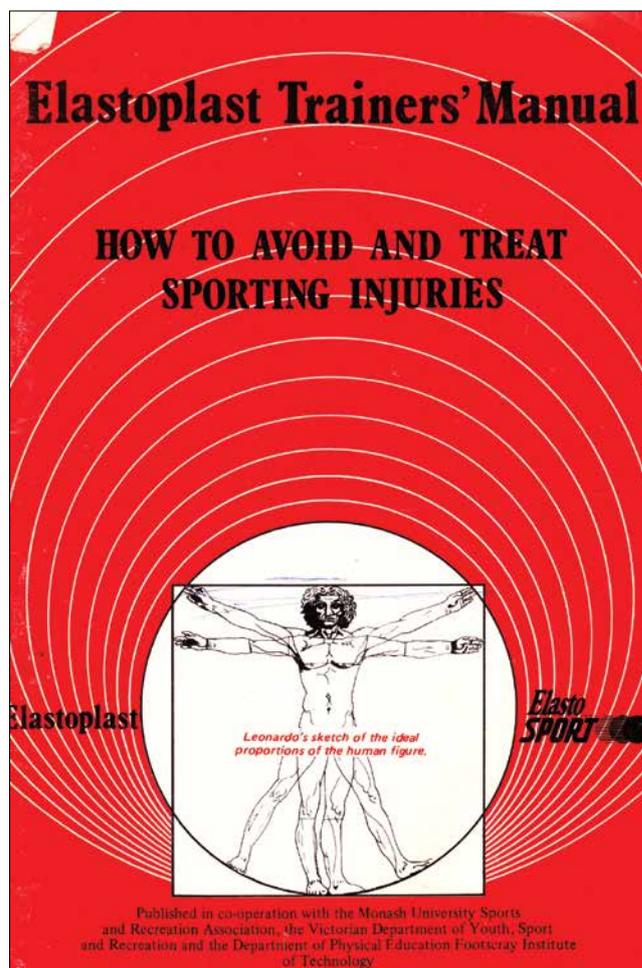
In all fields of medicine and science one of the most important events in a clinician's or researcher's calendar is the scientific meeting or conference. It is here that opportunities are provided for talking about your own and others' work, for networking and arranging collaborations, and for learning what others are doing in related fields of endeavor. The 1960s was the pre-digital era, almost without television, and communications were a great deal more time-consuming and less immediate unless you could meet fact to face, making them maybe even more important than they are now. ASMF began holding

meetings in 1965 with the first in Adelaide and the 1966 one in Perth, although they were mainly Council meetings rather than scientific ones. Ken Fitch remembers that the 'Adelaide meeting was a nothing meeting and so was the Perth meeting ... there was hardly anybody here and both of those meetings really didn't do much. The first decent meeting was ... due to the Victorians. We had a [scientific] meeting in Melbourne in 1966 ... and it was a good meeting and those that followed were similar.'

**“Many believe this Congress ‘is undervalued as to how much it really did to put sports medicine in this country on the map and how much it helped SMA to grow as a body.’”**

There was a meeting every year in a different city – in 1967 they were back in Adelaide, then Sydney, Perth, Melbourne, Surfers Paradise, Adelaide, Hobart, and in 1974 the meeting was held from February 4–9 in Melbourne again. This was a particularly special meeting as it was also the Federation Internationale de Medicine Sportive's XXth World Congress in Sports Medicine. This Congress had only moved outside Europe three times since FIMS was established in 1928, to Santiago do Chile in 1962, Tokyo in 1964, and Mexico-City in 1968. Howard Toyne, President of ASMF at the time and Secretary-General of the Congress, is mentioned every time someone speaks of this Congress yet it was a huge undertaking requiring the work of many people. Toyne himself says as much when he writes in the Congress proceedings that they 'represent the culmination of over six years of activity by members of the Organising Committee who were subject to many anxieties and elations during its gestation: their reward was in acting as hosts for Australia during that memorable week of scientific and social activities.' The Congress Supporting Committee, the Congress Executive Committee and the six sub-committees were almost entirely made up of ASMF members from around Australia.

The Congress was backed financially by both State and Federal Governments, sponsored by many businesses, attended by 396 full registrations and 101 student and day registrations, held press conferences after every morning and afternoon session resulting in a wide coverage, accommodated overseas visitors at Newman College in the University of Melbourne and nearby hotels, and had a social agenda that included a welcome cocktail party at Newman College, an opening ceremony at Dallas Brooks



Hall, a Lord Mayor's reception at the Melbourne Town Hall for overseas delegates, a reception for all delegates hosted by Premier Rupert Hamer at Parliament House, an afternoon tour of Healesville Sanctuary, a general Assembly of F.I.M.S. for all delegates, and a Congress banquet on the final night! They also somehow managed to fit in a scientific program that included 114 papers by speakers from Australia, England, Canada, Turkey, Belgium, U.S.A., Japan, New Zealand, Denmark, Italy, Malaysia, Sweden, Switzerland, Czechoslovakia, German Democratic Republic, Bulgaria, Brazil, India, Philippines, Yugoslavia, South Africa and Finland.

In about 1972, as the Congress began to loom, ASMF decided to employ the services of International Convention Management Services (ICMS) to assist them. Barrie Markey was the Director and, as a former radiologist and keen sportsman himself, he had a good feel for what was needed to make this Congress work. In his foreword Toyne also thanks



Markey, saying 'I would be confronted with what would seem an insurmountable problem, only to find that it did not exist. It had been anticipated and planned for'. But even Markey did not anticipate everything. He was completely taken aback when three taxis pulled up at the College and a dozen Brazilians announced their arrival. They had not registered or had any accommodation planned but were eager to take part and had two papers to give. Markey likes to tell the story of when he "invited them home one night because they were at a bit of a loss and I took some of the staff that were with me ... They brought some coffee so I made coffee for us all after

dinner. The next morning the staff said to me "did you sleep last night?"" Melbourne's coffee culture was still a thing of the future and the Brazilian coffee had an unsettling effect on Australians used to tea or instant coffee.

Many believe this Congress 'is undervalued as to how much it really did to put sports medicine in this country on the map and how much it helped SMA to grow as a body.'<sup>17</sup> The 54 Australians that presented 40 papers played a very large role in this. The Congress also inspired many young Australian medical students, one of whom was Peter Larkins who had his 'first ever meeting with Howard Toyne at the FIMS World

Congress. I just thought that was the best thing I'd ever been to. I met these guys from Russia and Poland and realised that it was all happening over there, overseas and that's where I had to get to. I couldn't wait to finish my medical degree to go away because there was nowhere in Australia.' The success of the Congress organisers in attracting State and Federal Government support, and their engagement of ICMS to oversee the administration of the Congress, provided the framework for it and were two significant turning points that helped set the pace for the future development of ASMF.

## Professionalising the ASMF

Members had conducted everything in the world of sports medicine in this country in their spare time, and often at their own personal cost. This included the seven or eight years spent building interest and support and negotiating amongst each other before ASMF was formally established, the negotiations over membership numbers, establishing a journal, an annual scientific congress and the bid for and lead up to the FIMS World Congress, and a great deal else besides. The bulk of the workload fell on the Secretaries of the Federation, to date only Barrie Towers (1963-'65) and Ken Fitch from 1965-'73 who ran ASMF 'with my own staff, with my own money, for seven and a half years. Jack [Refshauge, the incoming Secretary] didn't have the time or the patience to do that, and quite rightly, it was getting bigger and bigger.' So in 1974 Refshauge applied for and received a government administration grant after arguing that 'the Federation's impact on the Australian community should be immense, but, due to lack of administrative services, it cannot be developed to anywhere near its true value.'<sup>8</sup>

The government provided a grant of \$5,000 in the 1974-75 year and ASMF used it to continue the engagement of Barrie Markey and ICMS, this time as an Association administrator rather than a Congress administrator, and on a part-time basis. It was supposedly enough to cover eight hours of secretarial assistance provided by ICMS staff and some executive work from Markey, who remembers their role as being 'the glue that kept running it as the secretariat. I ran it as the quasi-executive director, which was really honorary, in a sense. It didn't make any money, it cost us money to run.'

ASMF continued to receive small grants over the next few years to continue with this arrangement and, combined with the sponsorship money that was beginning to come in from companies like Beiersdorf, Markey used it to arrange 'meetings and get educational stuff out. This was about dedicated

voluntary workers trying to get the sports message across and get it going ... we used to have national meetings around the country, a lot of them were at airports, fly in, fly out ... they talked about national issues and tried to put out national recommendations in terms of what should happen with sporting injuries and things like that ... We were the throughput rather than the instigator, just providing admin for that work ... I think government awareness of sports medicine was the key factor [for them] in those days.' Markey also managed the business of the Journal and the quarterly magazine, compiled a membership directory, computerised data from a national survey and did much else besides.<sup>9</sup> These were tasks that the membership, no matter how dedicated, would never have been able to follow through and still maintain their own practices or employment. This marked the beginning of ASMF moving from a state-based organisation to a national one and, more importantly, one that was able to take on and carry through projects that supported the development of sports medicine.



Past president Dr Ken Fitch.



Peter Dorman and Carl Smith (Fastest man in the world) Mid 1970's.

In 1977 the Federal Government established a Sport Development Program and ASMF applied for and received a two-year grant of \$37,000 to establish a permanent secretariat. Still part time, the resources nonetheless made Markey's and ICMS's work a great deal more productive. So much so that at a Council meeting in 1982 it was decided to apply for a larger grant and establish a full-time secretariat. Markey was invited to fill this role but declined, preferring to focus on his already established and successful conference management business.

**“In fact John Bloomfield remembers returning to Australia in 1968, after eight years at the University of Oregon and then travelling for ten months around Europe in both the Eastern and the Western Bloc, and feeling ‘appalled at what wasn’t being done’ in this country.”**

Robert Quimby was employed as the first full-time Executive Director, followed by Terry Saunders in 1986, and during these years the ASMF office, having begun ‘on the kitchen table or someone’s study’<sup>10</sup> then incorporated into the office of ICMS, finally established it’s own home in Canberra in 1984. This had the advantage of bringing ASMF closer to government, an important move at a time when lobbying ministers and the public service was ‘determining the direction to be taken by Australian sport via its legislation and funding operations.’<sup>11</sup>

Markey believes that ‘probably the timing was right, for it to set up its own office and do things. You need that momentum to get over the next level ... associations ... do a certain amount then they generate funds and generate more and they want their own employees to do it. That’s a natural progression.’

## Developing an influence

The first political administration to seriously consider sport as a national responsibility to come under the purview of government was the Whitlam administration in 1972. There had been next to no interest in sport as it relates to recreation, health or elite competition prior to this. What interest there had been came intermittently from local or state governments, or was a token funding arrangement for the Olympic and Empire Games on condition that the AOC provide most of the money, or was funding for the 1941 United Australia Party’s Council for National Fitness program. This program was established in response to the reported low level of fitness in Australian enlistees during the war and it continued until the 1970s. One other area in which federal governments provided limited funding was lifesaving because this was acknowledged as a community service, not because it promoted physical activity, fitness or sport.<sup>12</sup>

During the 1960s various liaisons and negotiations between state branches of ASMF and state or federal governments were successful. They resulted in funding for branch headquarters and two conferences (Queensland), the 1974 F.I.M.S. conference (Victoria), a community sports medicine clinic (South Australia), and continuation of a physical activity program in schools (NSW).<sup>13</sup> These were piecemeal and either for one-off events or with no guarantee of a long-term future. Australia was behind Europe and the United States in its approach to both elite and community sport, to competition and to participation. In fact John Bloomfield remembers returning to Australia in 1968, after eight years at the University of Oregon and then travelling for ten months around Europe in both the Eastern and the Western Bloc, and feeling ‘appalled at what wasn’t being done’ in this country.

**“It took a national disaster at the 1976 Montreal Olympics, when Australia only won one silver medal and four bronze medals, to get some interest – ‘that created a big panic.’”**

The ASMF began to lobby the government, though at first to no avail. Bloomfield ‘tried with the Liberal Party ... they just wouldn’t have a bar of this, I kept getting knock-backs all the way through. They had no Minister for Sport as that had never been thought of’. Then, in the lead up to the December 1972 federal election he wrote to Labor parliamentarian Barry Cohen who had shown some interest in the idea of a national sport and recreation system and received a positive response.

'Of course, I was sweating on [Labor] getting in, and they did.' Gough Whitlam established a Department of Tourism and Recreation under Minister Frank Stewart who, at the urging of Barry Cohen, commissioned a report from Bloomfield on the status of sport and recreation in this country with recommendations for the future. Whitlam viewed 'sport as a means for improving the overall welfare of the nation ... [and therefore] a legitimate focus for public policy'.<sup>14</sup> This boded well for Bloomfield who in his recommendations targeted participation through good physical education programs in schools and encouraging medicos to have an influence on preventative medicine, and competition through 'improving the sports system so we get many more people to play at the recreational level, in order to have some possible national heroes.' He also recommended a national institute of sport and overall professionalisation of the Australian sports system.

**"But there were also senior members such as Brian Corrigan and Barrie Towers in NSW, Bert Apps in SA, and Ken Fitch and Brian Blanksby in WA that felt just as strongly sports medicine could only flourish if it was true to its disciplinary mix, which had to mean accepting disciplines in equal numbers, and allowing that same mix to vote and hold positions of authority alongside the doctors."**



The Labor government embraced the notion of a vastly improved system at both elite and community level, but of course did not last long enough to implement all the recommendations. When the Liberal-National coalition returned to power in 1975 under Malcolm Fraser one by one the Labor initiatives were disbanded or scaled back. It took a national disaster at the 1976 Montreal Olympics, when Australia only won one silver medal and four bronze medals, to get some interest – 'that created a big panic, of course, in the Fraser government'<sup>15</sup> and resulted in the establishment of the Australian Institute of Sport in 1981. Other lasting initiatives were set in place by the Fraser government, despite Barry Cohen's opinion that their approach to sport 'reflected a time when "sport was primarily the domain of affluent gentlemen"'. These included the Sports Development Program established in 1977 (enabling ASMF to establish its first permanent secretariat); a program for disabled people; and an award scheme to financially assist elite athletes.<sup>16</sup> In 1983 the Labor government was back in power under Bob Hawke with John Brown as the Minister for Sport, but this time with a supposedly greater balance between elite or competitive sport and grassroots or participation programs, as opposed to Gough Whitlam's heavy focus on recreational activities for the nation's welfare.<sup>17</sup>

**"Robert Quimby was employed as the first full-time Executive Director, followed by Terry Saunders in 1986, and during these years the ASMF office, having begun 'on the kitchen table or someone's study' then incorporated into the office of ICMS, finally established it's own home in Canberra in 1984."**

Throughout all of this the ASMF Council and Executive were developing their lobbying and advocacy skills, fine-tuning their relationships with government, and building a collection of Position Statements aimed at influencing government policy in areas relating to health and sport. Their membership had grown and the 10% non-medical members was well and truly a thing of the past; the number of medically trained members in 1980 was 441, far short of the over 700 non-medicos who made up the rest of the membership. Prevention and participation were the prevalent philosophies of the sports medicine organisation, and the discipline groups that had emerged after the 10% rule was disbanded began to make their move and influence the direction this sports medicine movement would go over the next thirty years.

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

## Making The Move



SMA President Michael Kenihan cast his vote in favour of OneSMA.

**The modern era of sports medicine begins, and the professional nature brings about changes in the discipline groups, and SMA.**

### **Making their own moves – the disciplines**

With the battle for non-medical members fought and won long ago, and their numbers increasing at a greater rate than doctors during the 1980s, ASMF found itself with a new internal challenge on its hands, albeit one that had been building for a while. It had weathered the battle of the states, 'which came down to personalities. They were fundamentally personality based in some cases',<sup>1</sup> but the battle of the

disciplines was about to begin in earnest. Gary Moorhead joined SMA as their Chief Executive Officer in 1999, not long after a major review of the organisation had occurred. Several recommendations had been made, largely regarding the constitution and the structure and aimed at reducing the difficulties that kept cropping up between the state branches. 'The irony of events was that while those tensions with the states were certainly true and came and went at different times with different sets of circumstances, the real issues of the organisation were actually coming from a different direction, which the review hadn't even acknowledged ... the emerging concern was the growth of the disciplines as a separate entity within sports medicine.'



Dr Peter Dornan and Dr Kevin Hobbs 1986 on Hobbs retiring from SMA.

**“... the disciplines have all contributed a great deal to Sports Medicine Australia and vice versa ... I think the frictions were minor and the tensions were necessary.”**

The seven discipline groups within SMA (sports physicians, exercise and sport scientists, sports physiotherapists, sports dietitians, sports doctors, sports psychologists and sports podiatrists) have all had their own associations or groups for over ten years, some for nearly thirty. These groups are professional bodies with some educational and information activities directed towards the public but which are mostly interested in any issue or activity of a professional nature that relates to the status, welfare, management, training and continuing education of their members. Sports Medicine Australia has always been an umbrella body interested in any issue or activity of a medical or scientific nature that relates to the health and well being of people who are active and people who are riskily inactive. Therein lies the problem because membership of SMA is of great importance to members of all discipline groups but cannot help them with accreditation, professional development, and the myriad collegiate benefits that come with associating oneself with others who have the same professional understandings, qualifications, experiences and aspirations.

Each discipline group found their own ways of solving these problems and Moorhead remembers that things ‘waxed and waned with different disciplines as different issues arose. Some disciplines saw an alignment with SMA as the smartest thing they could do to grow their own discipline and probably the best example of that was the sports podiatrists. They were strongly committed to SMA from day one and just worked in step with us. So did the sports doctors ... the sports physicians, who were specialists, ... had a special issue with getting formal recognition through the Australian Medical Council ... a number of them formed a view that they weren’t getting that recognition because their association with Sports Medicine Australia made people think they weren’t that special ... it was very difficult and frustrating for the sports physicians ... the sports physios were a different group again ... their issues were with the APA and defining the relationship with the APA .. and they also had recognition issues distinguishing themselves from regular physios ... any physio can put up a sign that says “treats sports injuries”. So that used to irritate them as well.’<sup>2</sup>

There are few, if any, SMA members of any longevity who would dismiss the importance of, or the disturbance created by the different discipline groups over the years. Physiotherapist Peter Duras, a contributing member for over forty years to both the APA and SMA and one of a few who were deeply involved in forging a separate path for sports physiotherapists, reflects that ‘other than when there was a direct clash of disciplines, and I’m talking about things like physios versus chiropractic ... the disciplines have all contributed a great deal to Sports Medicine Australia and vice versa ... I think the frictions were minor and the tensions were necessary. If you’re going to get something done then political correctness really holds you back. The sort of personalities you get in sports medicine are very strong personalities anyhow, capable of arguing pretty vociferously, but once the argument has been settled, it’s back to the bar.’<sup>3</sup> In fact, Duras is convinced that if all those disciplines operated in isolation they would not have been as productive. Equally, former SMA president Anita Green considers SMA an organisation that nurtured sports medicine and science disciplines and ‘allowed them to start off amongst the team and then gradually they developed their own PD and accreditations, then branching off and cutting the umbilical cords before coming back in a more mature form.’ Given this history of SMA’s discipline groups, a potted history of the evolution of each is relevant to this issue.

## Australasian College of Sports Physicians<sup>4</sup>

### Founded

At a meeting in October 1985 at Cumberland College, Sydney.

### Inaugural President

Vince Higgins.

### Fellowships and Trainees

The first Fellowship exam was held in 1991, at which 42 passed. The first trainees were in 1992 (Michael Dixon, Sydney; Andrew Webster, Perth; John Orchard, Melbourne). Positions were for the 1st year of a 3 year post graduate Training Program for the FACSP.

### Specialty

A submission was first made in 1994 to the National Specialist Qualifications Advisory Committee. It was achieved in New Zealand in 1999 but not in Australia.

From 2001 the approving organisation for specialist medical qualifications was to be the Australian Medical Council. This body estimated the cost of seeking specialty status was likely to be \$50–\$100,000. The College voted to levy all Fellows \$1000 to fund the submission and this was regarded as the final hurdle to specialisation.

In 2003 the ACSP was informed they were one of nine prospective new Colleges short listed by the AMC for specialty recognition.

In 2004 the College was the first to go through the first of the AMC two-part process. Part one is to prove that sports medicine is a distinct and viable specialty in its own right. Part two is to demonstrate the ACSP can provide the necessary training and accreditation to Fellowship standard.

In 2007 the Minister for Health and Ageing Tony Abbott decided that a case had been made for recognition of sport and exercise medicine as a medical specialty. Part one was finally completed after 13 years. That same year New Zealand was reaccredited for the third time by the ACSP for another 3 years.

In 2009 the Australian Medical Council finally declared that sport and exercise medicine was a medical specialty.

### History

Peter Brukner remembers 'it took us 20 years really to get there and a huge amount of work and an incredible number

of meetings in Canberra and meetings with government and meetings with all the other colleges because all the other colleges have to support you. So we'd go around to a lot of their meetings and so on. So it was very, very difficult but we eventually got there and ASMF, to their credit, were very supportive of that and helped us with lobbying Canberra and so on. By that stage they had realised that we were on the same side and were very helpful.'

### ASMF

When the College was formed they held their first Conference in Melbourne in 1986, which included a meeting with ASMF.

Later on there was 'heated discussion on whether to hold stand alone conferences or in parallel with ASMF/SMA'. In 2000 they formally decided to alternate from 2002. Ultimately the College had to happen somehow, whether through ASMF or through a 'breakaway group', in order to provide an opportunity for sports medicine practitioners to study and specialise in the field. One of the original members, Peter Larkins, is frustrated still today, 'we're sitting in 2013 and they [RACGP] still don't grasp it. I mean, if it wasn't for the ACSP there'd be no career pathway for a doctor in Australia graduating now as an alternative.'



Dr Brian Sando and Dr Peter Brukner with a representative from Syntex.

## Exercise & Sports Science Australia

### Founded

ESSA was originally called the Australian Association for Exercise and Sports Science and was formally launched in 1992 at the ASMF Conference in Perth.



### Inaugural President

Tony Parker.

### Origins

It had its origins in the late 1980s with a lot of discussion within ASMF concerning representation and recognition of different professional groups within the organisation. The medical practitioner members had already decided to form a specialist group of sports physicians, which was founded in 1985.

At the time exercise and sports scientists in ASMF were included within a broader range of professionals, so within the community there was a lack of recognition of the difference between people in the field with a 25-hour course and those with a degree. Degree graduates needed appropriate recognition and community members needed to be able to identify the appropriate people to consult.

### History

At the 1988 Bicentennial Conference of ASMF, a meeting was organised by Tony Parker to discuss the potential of a new organisation. This meeting garnered support from exercise and sport scientists and from ASMF but required numerous meetings over a 4-year period before the development of a Constitution and a formal launch in 1992 was achieved.

Its purpose was to increase the status of the profession; promote quality assurance methods and practices; promote and progress improvement in education and communication in the profession and all levels of the community, promote and advance the standard of tertiary educational offerings in E&SS and formulating, implementing and managing procedures for the recognition and registration of personnel within the area of E&SS.

Exercise and sport science has always had a strong research background but prior to formation of ESSA, a weaker and less integrated professional background. Now ESSA has accredited most university courses in Australia training Exercise Scientists, Exercise Physiologists and Sports Scientists. They are all 3 or 4 year courses. Exercise physiologists accredited by ESSA are recognised as allied health professionals and are eligible to register with Medicare and be recognised by health insurers.

In the early period of development, they sometimes found the physiotherapists were not very supportive of exercise and sport scientists in the clinical situation as they were potential challenges for positions in hospitals and other clinical situations. This was soon resolved with clarity in relation to role definitions.

### Membership

In 2012 ESSA had over 6000 members.

## APA – Sports Physiotherapy Australia

### Origins

A number of physiotherapists working to represent the interests of the profession throughout the '60s and '70s did so as volunteers and office bearers within the ASMF.

In mid 1970s, recognising the need to service the increasingly specialist needs of physiotherapists in the field, most states formed Sports Medicine Special Interest Groups within the A.P.A.

Sports Physiotherapy Australia, then known as the APA National Sports Medicine Group, was officially formed at the Australian Physiotherapy Association Conference in Melbourne in 1980. It was a sub group of the APA, which has existed since 1906.

### Foundation Chairman

Peter Duras.

### Development

In its first year a specialisation committee was formed. In 1981 the title was changed to the A.P.A. Sports Physiotherapy Group. National standards were established in continuing education and for selection of touring physiotherapists. During the 1980s the SPA became involved in national and international conferences, established the Level 3 S.P. course in Canberra and encouraged growth in research, publication, injury prevention, post-graduate education, P.R. and advocacy. The Sports Physiotherapy Title was finally implemented in 1996, whilst a number of sports physiotherapists emerged with Doctorates and international reputations for research and knowledge. In 1995 a major text *Sports Physiotherapy, Applied Science and Practice* was published in Australia.

### ASMF/SMA

Physiotherapists had always played a role in ASMF, including helping to establish it. Over the years strong links were established between the SPA and the SMA, joint membership encouraged, and in the mid 1990s the Vice-President Physiotherapy position was created on the SMA Board. The current National SMA President is a physiotherapist.

### Membership

Today there are 2,214 SPA members; 565 SPA Titled Sports Physiotherapists.



## Australian Psychological Society – College of Sport and Exercise Psychology

### Founded

The CoSEP had its origins in the Board of Sport Psychologists, whose first national executive was elected in Melbourne in November 1991. The Board then became the College of Sport Psychologists, and then the College of Sport and Exercise Psychologists.

### Purpose

A professional association for those interested in how participation in sport, exercise and physical activity may enhance personal development and wellbeing throughout the life span.

The study of psychological factors that influence or are influenced by participation, and the application of this knowledge to everyday settings.

The College develops standards of practice; sets quality of service; advises and recommends re education and training; and deals with the general public.

### History

The World Congress of Sport Psychology was hosted by Australia in 2005 with around 600 delegates from +50 countries.

### Membership

In 2013 there are 221 members.

### Accreditation

Full membership requires 6yrs university training, 2yrs of supervised practice experience in sport and exercise psychology and continuing professional development.

Two universities are currently offering accredited sport and exercise psychology – University of Queensland and Victoria University.



## Sports Dietitians Australia

### Founded

October 1996.

### Origins

The Sports Nutrition Interest Group (SNIG) of SMA was the first of the special interest groups to form within SMA.

In 1996 it was reborn as the Sports Dietitians Australia, a name chosen 'to reflect our professional group status as one of the new discipline groups of SMA'.

### Purpose

Its purpose was to promote excellence; provide continuing professional and community education; encourage recognition of sports Dietitians as experts; and provide support and a network for members.

### Membership

Accredited Sports Dietitians must have Accredited Practising Dietitian status (APD) with Dietitians Association of Australia; post graduate sports nutrition qualifications, two years practical experience and have completed SDA's 4 day Sports Nutrition Course.

Associate membership is open to APDs, while student membership is open to anyone enrolled in full time study, irrespective of discipline.

A Fellowship was introduced in 2005 and Honorary Life Members welcomed in 2011.

Within a year of establishing there were 140 members, and SDA now has 472 members.

### History

A Sports Nutrition course for Dietitians was developed as SNIG's first project in 1991. This four-day continuing education course became the first professional education course in sports nutrition for Australian dietitians. The first course was held at the Australian Institute of Sport in 1992 and by 1996 there had been 9 courses with 244 Dietitians attending. Since 2006, the course has been run fifteen times, both within Australia (10) and overseas (5), including Singapore, Malaysia, New Zealand and Canada. The course celebrated its 21st anniversary in 2013.

The course notes were worked into a *Clinical Sports Nutrition* textbook by Vicki Deakin and Louise Burke, launched in 2000.

In 2011 SDA celebrated its 15th anniversary and SDA's inaugural conference.

## Australasian Academy of Podiatric Sports Medicine

### Founded

1978.

### Inaugural President

Keith Pollock.

### Membership

In the 2013 financial year there are 257 full members, thirty-four of whom are Fellows of AAPSM, and thirty-nine student members.

The AAPSM Fellowship program began in 1979.

### Purpose

The national organization of Sports Podiatrists in Australia and New Zealand aims to supervise specialist qualifications, provide professional development, and encourage clinical and research excellence.

### SMA

AAPSM was associated with SMA from its beginning. This association has provided AAPSM members with career opportunities, participation and training, often towards selection for Olympic and Commonwealth Games international medical teams. In 2008 the AAPSM Board decided to set up a virtual office in association with SMA's considerably larger resources to enable them to manage their growing membership.

### History

The AAPSM was established to provide podiatrists with opportunities to further their specialist skills and interests in sports podiatry and to have them recognized and acknowledged by the profession. This was initially achieved through submission of a paper and completion, available by correspondence, of a course at the Lincoln Institute of Health Sciences.

In 1994 'the amount of information currently available in Sports Medicine now makes the possibility of a programme of self education an achievable goal.' A curriculum and syllabus was developed that could be achieved through self-education and that would be examined by a Panel appointed by the Board of Trustees of the Academy. This Panel consisted of 4 Podiatrists, 1 Sports Physician and 1 Physiotherapist and a Fellowship of the AAPSM was awarded to successful candidates.

Recently, a biannual interstate travelling roadshow has been instituted. This includes international speakers and is considered a great success as far as proving members with ongoing professional education specifically in sports podiatry.

## Sports Doctors Australia

### Founded

June 1999.

### Inaugural President

David Garlick.

### History

The large number of medical graduates undertaking the Graduate Diploma and Masters of Sports Medicine at the University of New South Wales prompted them to write to SMA and the ACSP with a proposal to form a society for doctors with postgraduate qualifications in sports medicine. After close discussions with both bodies, who were supportive of the idea, it was agreed that the new society would accept as members any doctors who were also a member of SMA. Two years later the Sports Doctors Association was ready to be launched by the Federal Minister for Sports, the Honourable Jackie Kelly, with a constitution in place and a registered name.

The SDrA's role is to provide a professional society for doctors who gain and incorporate sports medicine skills into their practices, whether that be family, emergency, rehabilitation or any other field of medicine.

The first major project of the SDrA was to coordinate the medical stream of the scientific program at the pre-Olympic Congress in September 2000.

Requirement for Fellowship of SDrA requires a higher degree in sports medicine, a substantial component of clinical practice to be in sports medicine, contribution to the sports medicine literature or research, and involvement in the teaching of sports medicine.

### SMA

The purpose was always to form an SMA group that was also an independent professional society for doctors doing postgraduate training in sports medicine but who were not recognised specialists in sports medicine. The Constitution enabled all medical practitioners in Australia who had an interest in sports medicine to become a member, and membership fees included a subscription for SMA membership. The executive committee includes an ex officio position for an SMA representative, and one for a representative from the ACSP.



The ASMF/SMA national conference is always a highlight, be active 07 in Adelaide, was no different.

For most groups accreditation and professional development were the critical issues. Peter Larkins joined the Australian College of Sports Physicians, for example, along with a number of doctors 'who felt that ASMF wasn't being dynamic enough in medical education ... there was still no career path for someone who wanted to be a specialist in sports medicine. Those that had been around doing it literally since the '70s [were asking] "where do we continue to expand other than just experience on the job" ... I guess that's why they felt that ASMF, because of the sort of federation it was at the time, wasn't really providing enough continuing education for doctors ... it was trying to be all things to everyone, to the podiatrist, to the physiotherapist ... there was too much repetition occurring at the annual conference so you weren't learning every year.' Larkins considered this to be 'a really sad breakaway' because it was so controversial at the time and thought to be driven by a NSW branch desire to establish their own sports medicine organisation (state rivalries were never completely solved) and 'it could easily have been done, I think, through ASMF at the time ... that would have meant more focus on medicine [but] they're a multidisciplinary organisation. It's their strength and it's their weakness.'

The disciplinary path has been rocky for some of them since the 1980s, but just as ASMF found its way during the 1970s and '80s, the discipline groups have also established a presence and sureness in terms of their professional

goals. Michael Kenihan, SMA's current President, believes 'over probably the last 10 years there's been a recognition that uni disciplinary – so just physio or just doctor – those groups can't represent their members to a broader church. So there's been sort of a movement back towards SMA as being the representative body, because they had to see that SMA weren't trying to take them over or control them but wanted them to be part of the bigger arena ... So a good example is recently Nello Marino [the current CEO] was involved in the senate hearings about the sports scientists, which has been very popular in the media, and we went with ESSA to that senate committee. So it was a joint thing – ESSA/SMA – rather than them standing on their own, which is a demonstration that the groups are more closely aligned.'

**"Today, and for quite a long time now, Australia has been highly regarded in sports medicine and this has been largely 'driven by sport itself, and the international success and reputation of Australia in sport has been supported by the AIS and other institutes, SMA, and sports medicine and sports science professionals."**

The annual ASMF/SMA conference, an unbroken tradition since 1966, is another reflection of the variation in discipline groups' engagement and the attempts by SMA to find a

solution. Gary Moorhead, who joined SMA in 1999, struggled with the problem of thinking 'about how the organisation fitted into the new world we operated in along with these new discipline groups who were also servicing our same members ... SMA's biggest event is its national conference and [this] was run with all the disciplines as a partner. As they grew in status themselves they decided, "we need to have national conferences as well"'. The conferences became a competition for sponsorship, for delegates, for key speakers and even for times and venues. 'It was very difficult and we tried all kinds of strategies to overcome it.' These included sharing timetables and having alternate years, which was an eventual strategy with the ACSP after considerable negotiation between both organisations as to who would have which year. Conference organisation, negotiation and experimentation has always taken up a huge amount of effort on the part of the SMA executive and eventually the alternate year solution seemed to work for sponsors as well. Since then SMA has run its own big conferences every second year in a similar fashion to the traditional ones, while running a boutique one in partnership with major sponsor Asics in exotic locations. This would be called the Asics Conference of Science and Medicine in Sport 'which just happened to have the same acronym as our conference, the Australian Conference of Science and Medicine in Sport. We didn't have to change any logos or anything. Ironically enough that conference, because of its boutique flavor, became bigger than the other conference.'

The next complication was finding partners for the Australian conferences. Upon Moorhead's appointment as CEO in 1999 he had been directed to take the organisation into the public health domain as much as possible, which would have been aided by his background in federal government. 'We joined ... with a national physical activity conference which had been run by the Heart Foundation [then] we found another partner that was a national sports injury prevention conference ... [this made] our other year even bigger ... attracted lots of sponsors, both government and private ... we got the occasional international event to join us too' such as the International Conference on Physical Activity and Public Health.

Wendy Brown sees the conferences over the last ten years as allowing SMA to 'go a long way to providing an avenue for this kind of inter-disciplinary thinking. Everybody comes together and there certainly seems to be great engagement and exchange of ideas ... This is an academic talking of course, I can't talk about the practitioner side of things.' However many practitioners would agree the conferences are important. Peter Larkins believes that 'if you want to practice

sports medicine in this country ... you have got to go to an SMA meeting and you've got to understand how all that works.' The problem with all the discipline groups running their own conferences is that 'you could spend your time [going to them] because each of them have got some specific high powered things that are relevant.'

There always will be differing views on how much SMA can do or should be doing for the disciplines that identify with sports medicine. Twenty five years ago, on the cusp of these developments, Wray Vamplew wrote in the 25th anniversary history 'There is no single profession to be defined for Sports Medicine ... Sports Medicine draws from the various professions but does not absorb them. A mutual understanding and respect among these professions, therefore, is necessary for the promotion of the ideals of Sports Medicine ... Sports Medicine has a responsibility to share, respect and synthesise the inter-professional implications of its contributors.'<sup>5</sup>

## Moving as a group – SMA

After the first twenty-five years the organisation was hardly recognisable to those who established it, and today it is barely the same as when Vamplew was writing. There were times when the disharmonious disciplines found it difficult to 'share, respect and synthesise' with each other or with SMA, but the umbrella body for sports medicine has since taken up the responsibility and developed a capacity to work with the times.

Consideration had been paid to establishing some sort of formal education in sports medicine since the beginning of ASMF in the early 1960s but it never really got going until the late 1970s when Ken Fitch, by then President of ASMF, 'decided to do something about it ... I went to the Royal Australian College of General Practitioners in Melbourne, saw a guy called Wes Fabb ... and said "Look, why don't we have an elective in sports medicine" ... they agreed to fund \$3000 for us to have a meeting ... this meeting produced a course syllabus that was going to be undertaken in one or two years, resource materials and references and everything. Because SMA couldn't do it [not being an educational body], we did a combined certificate with RACGP in sports medicine.'

The timing was right because the College was beginning to develop electives and sports medicine was one of two, geriatrics being the other, to accredit candidates.

The course was run in Toorak in Melbourne at the home of the College of GPs and was welcomed enthusiastically by the young and aspiring practitioners of the time. In fact it had been eagerly anticipated. Peter Brukner heard about the course



Former SMA president Peter Larkins presenting an award during his time in the top job.

when he returned from three years working in London and was in the first group of about twenty doctors to go through. His first lecturer and later his mentor was Fred Better, a Polish Olympic hockey player and a doctor who had immigrated to Australia in 1957 and worked as a remedial gymnast until he was able to get Australian registration to practice as a doctor in 1970. Better 'gave the first lecture I think, none of which I could understand. He had a very heavy Polish accent and I thought, "What am I doing here?" Fortunately I think that was the only lecture he gave because that wasn't his strong point. My first impressions of Fred were not very good but he was a wonderful man and he became a mentor to a lot of us over the years.' This course was run on Tuesday afternoons for several months and predated any graduate sports medicine education the medical schools around Australia were offering by many years.

**"The sort of personalities you get in sports medicine are very strong personalities anyhow, capable of arguing pretty vociferously, but once the argument has been settled, it's back to the bar."**

ASMF's engagement with international sports medicine had a fine start with the 1974 World Congress of FIMS in Melbourne. The Council were inspired to keep this engagement alive and decided to integrate their annual ASMF conference into the Pan Pacific Sports Medicine conference in Singapore in 1977, titled 'Sport and Recreation for all', and again in Hawaii in 1979 at the Pan Pacific's 'The Child in Sport' conference. During the 1980s ties with international sports medicine bodies and activities were strengthened, initially with an opportunity for President Bill Webb and Tony Parker to visit

China and give talks in three cities to a burgeoning Chinese sports medicine community. The following year China held their first international conference of the Chinese Sports Science Society and Parker was invited back to speak again, at which point he 'met more people and I basically then started to make friends with the pioneers in China in sports medicine. Professor Qu Mian-Yu and Professor Yang Tian-Le, the founders of the Sports Medicine Society in China.' In 1982 the Queensland group had staged a very successful Conference '82 to coincide with the Brisbane Commonwealth Games. They built on this success as, following in Howard Toyne's footsteps ten years previously, Parker and Kevin Hobbs, the SMA Qld President, wooed FIMS and were rewarded with ASMF again hosting the XXVI World Congress in 1986, this time in Brisbane. As did the Melbourne organisers in 1974, Parker found himself caring for some of the delegates who were a little out of their depth and 'put up six of them in our house so that they could get here because of the costs and all those sorts of things.'

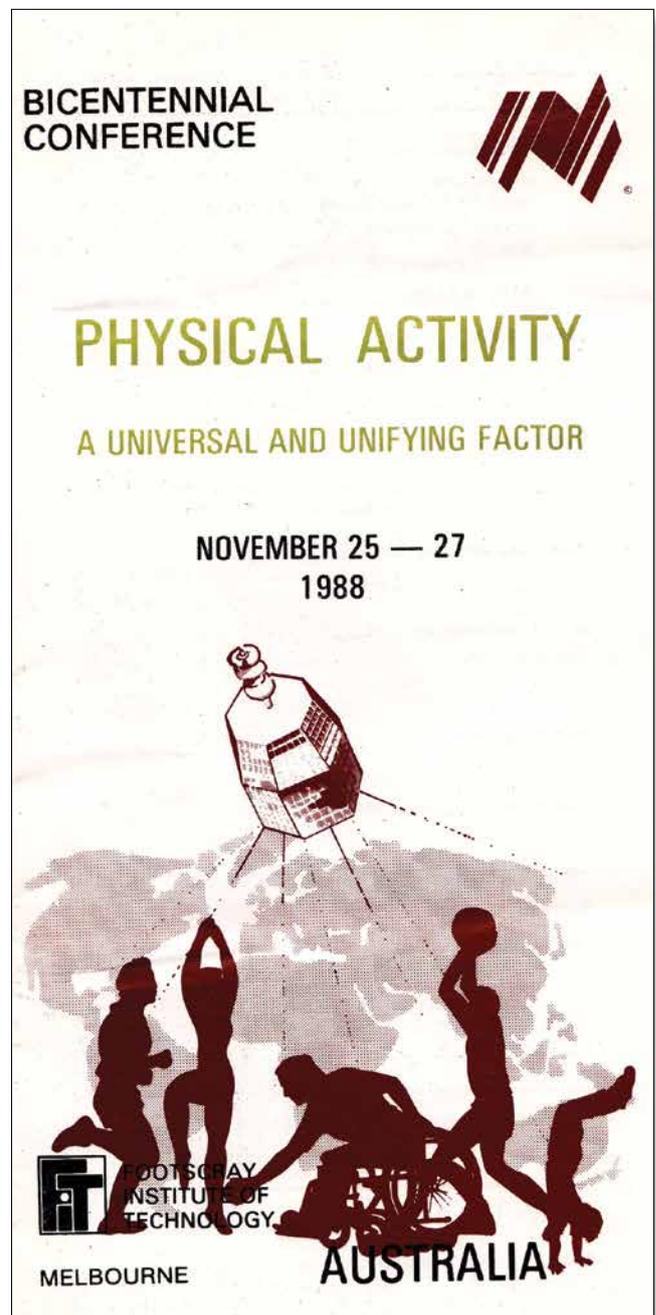
He is convinced 'that you have to be engaged as often as possible in international events, particularly when you're more distally located ... the '74, '86 and 2000 [pre Olympic] Congresses plus other SMA Conferences have all made essential contributions to our international reputation. As the actual size of the meetings increases, the numbers of people from different areas increases and then there are other initiatives and collaborations ...'. Today, and for quite a long time now, Australia has been highly regarded in sports medicine and this has been largely 'driven by sport itself, and the international success and reputation of Australia in sport has been supported by the AIS and other institutes, SMA, and sports medicine and sports science professionals.'

The Sydney 2000 pre-Olympic Sports Science and Medicine Congress was hosted by SMA with Tony Parker as Chair of the Organising Committee and more than 1300 delegates attending, 60% of whom were not from Australia.<sup>6</sup> It was a one week Congress with thirteen keynote presentations, thirty-four symposiums with anywhere from a handful to sixty papers, and hundreds of poster presentations.<sup>7</sup> The attraction that the event had for researchers and clinicians around the world was a clear sign of the quality of sports science and sports medicine on offer, although it was suggested in a Sports Health editorial at the time 'that the standard of our clinical sports medicine practice is clearly in front of the rest of the world, in some cases, by decades. This means that in order to provide a meeting with sufficient challenge for our own clinicians, visiting overseas speakers rarely add

much academic value to meetings ... whenever we travel to overseas meetings such as the ACSM [American College] annual extravaganza, the range and quality of the Australian presentations and lectures tends to dominate much of the clinical and scientific curriculum.<sup>18</sup>

During the Games themselves, the Medical Director Brian Sando and Assistant Medical Director Peter Fricker led an official team with four sports psychologists, seven physiotherapists, eight massage therapists, two doctors, a nutritionist and two clinic administrators. This was only the tip of the medical iceberg though as each sport had their own official sports medicine personnel, sports trainers were in abundance on the sidelines, and volunteers were wherever they were needed. Working for events such as the Olympics or Commonwealth Games or for other elite sporting events and teams is often seen as a career pinnacle for clinicians in any of the sports medicine and science disciplines. However it is interesting that these achievements are not usually the ones practitioners describe if they are asked what they are most proud of. That question produces responses like 'promoting safety in sport', encouraging 'women's sporting role models for the local community', 'encouraging a strong public health focus', 'development of the sports trainers course', 'good professional standing, and mentoring lots of physios and doctors over the years', 'promotion of sports medicine to GP's, trainees and medical students', 'trying to improve safety and performance at all levels of sport including amateur community level', 'promoting exercise as medicine more than forty years ago would be hard to beat', 'being involved in grassroots sports medicine and being influential within SMA for many years', 'writing and implementing the constitution and Chair of Children in Sport'.<sup>9</sup> While international events are glamorous and exciting, and the greater good of sports medicine in Australia is served by participating in them both practically and academically, few would argue that is all there is to care about.

Certainly one of the other responsibilities SMA has always taken seriously is the dissemination of news and research aimed at those who may never come close to an international event. This material is focused on education, promoting injury management, physical activity and better health and together, the literature produced for the public, the professions and the sports trainers is vast. Today there are fifteen injury specific Fact Sheets addressing some of the most commonly occurring sports injuries; twenty-six Sport Fact Sheets including Australian football, rugby, basketball, gymnastics, lawn bowls, tennis, skating, walking, and others; policies and guidelines



on Active Children, Active Older People, Active Women, Health Conditions and Screening, Hot Weather, and Infectious Diseases. Periodicals include the longstanding *Journal of Science and Medicine in Sport and Sport Health*.

SMA has been producing this type of literature for decades. Mark Brown, a physiotherapist and member of both APA and SMA, was a 'voracious reader of SMA information resources and guidelines that were published in the '80s and early '90s.



SMA president Michael Kenihan photographed with former CEO Gary Moorhead and Professor Wendy Brown.

This is where most of my sports medicine knowledge came from as there was nothing in my undergraduate degree or from the APA after graduation.’ However, a study by Caroline Finch and Mark Hennessy into safety practices amongst community sporting clubs was highlighted for the wider membership in the last editorial of *Sport Health* for 1999 because of its startling results.<sup>10</sup> While the membership were benefiting from SMA literature this study revealed that it did not seem as if the community were. Only 36% of clubs followed the SMA infectious disease policy guidelines, which is better than the 21% who were not even aware of them. A head and neck injury policy published by SMA in 1992 was only followed by 11%, while an SMA policy on returning to sport after concussion was only followed by 6%. In many cases these clubs did have a policy on these issues, it just wasn’t an SMA one. This revealed a severe lack of engagement with the community at large on the part of the organisation that had worked so hard to be everything for sports medicine. Paul McCrory, the editor of *Sport Health*, was not happy about this.

Whom are we influencing? ... I would hope that at least SMA members would follow the policy guidelines. Mind you I am afraid to even ask that! ... we have abandoned our responsibility in this area to first aiders and other groups ... is there a bigger issue? Is the role of SMA simply to deal with the same ‘sportpolitik’ issues as we always have done or do we need to embrace a new philosophy? Does SMA have a role in the wider world of public health? Should we be the peak body advocating exercise, cardiovascular health, diet and nutrition, injury prevention and so forth? Where does ‘sports medicine’ end and public

health begin? So focused on our own medical paradigm, we are missing the chance to influence the wider population.

These are all pertinent questions, even though almost everything in SMA’s history, official and unofficial, personal or documented, indicates a consistent and passionate regard for population health and for safe physical activity. Gary Moorhead, who joined the organisation as CEO soon after this editorial was published, agrees that an interest in population health ‘had always been part of the organisation’s ethos and they’d had a good go at doing it. I think they ran a conference in about ’98 or ’97 where they tried to make that a major theme. They thought it was a failure [because] they didn’t seem to get an enthusiastic response. I’d been there less than a few months and was saying “I’m really keen to promote this physical activity stuff” and they were saying “too late mate. We tried it. It didn’t work.”’

So how did the inability to effect a strong injury management and physical activity message get to this stage? After spending the next ten years at SMA Moorhead thought the wake up call ‘was a lesson that if you think something is a good idea you need to keep trying. You keep trying it from different angles and it can come through. The support for the public health side of stuff went right across the organisation, even people like Brian Sando, who was the head doctor for the Olympic team ... he was passionate about public health, as were many others at that same level.’

Today Michael Kenihan, SMA’s current President, reflects that ‘since the mid ’90s the two areas that SMA has moved to – it used to be about injury management in the early days ... now it’s moved to a broader health environment where it’s about public health, and public health is now about reducing people’s injuries so they keep participating. One of the biggest factors in stopping participating is injury so you need to prevent that, and the second factor is there’s greater awareness now that disease is related to physical inactivity, such as obesity, cardiac heart disease, etc.’ Nonetheless, making your focus an effective and sustainable one is never easy. There has been a long history in SMA of searching for the right funding sources, laborious grant applications, and complex negotiations with funding or sponsorship partners. SMA’s reliance on external sources of funding to carry out large projects can mean that its directions are often swayed by the agendas of the funding and sponsorship bodies. So even if there was ‘support for the public health stuff right across the organisation’ as Moorhead remembers, if the external funding required is provided for other types of programs there is little SMA can do about it.



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**“Sports Medicine Australia has always been an umbrella body interested in any issue or activity of a medical or scientific nature that relates to the health and well being of people who are active and people who are riskily inactive.”**

Nello Marino, SMA's current CEO, explains that in recent years 'Sports Medicine Australia has spent a lot of time in the corporate sector in trying to acquire corporate support. It seems there's a greater deal of clarity about what the corporate sector wants out of a relationship ... it seems to be much easier to negotiate the corporate sector than it does government sectors.' However funding and sponsorships, despite their difficulties, have allowed SMA to maintain their conference program and consistently put out the numerous fact sheets, position statements, sports trainers material and other publications and this has largely been through SMA's 'very, very strong relationship with a number of corporate supporters, Asics, Beiersdorf, Elastoplast. Voltaren are long-term sponsors. In the case of Elastoplast or Beiersdorf we've had a 30-year relationship with that organisation, almost 30 years. So it says there's a much clearer and simpler relationship that occurs ... I often feel like it's a much more honest relationship.'

Advocacy and lobbying are another way that SMA has attempted to fulfill their agenda. Marino believes 'it's really about us continuing to knock on the door and ... lobby in the areas that we think need some attention ... sadly, there's almost a sense that there needs to be a crisis before you get that engagement. So the drugs and supplements issue [in the AFL during the first half of 2013] has given that opportunity ... to get greater accountability for sports scientists at the club level.'

That was a very public crisis at an elite level in a very popular sport. The crisis at a population level of obesity and cardiovascular disease does not seem to be given the same degree of urgency. At least in the minds of anyone associated with sports medicine. 'The health prevention dollar is just spreading all the more thinly. We're told continually that governments are about trying to prevent disease and illness but in real terms the majority of the health dollar is actually about treating.'<sup>11</sup> Part of the problem seems to be in the multiple messages coming from the plethora of organisations now operating in or around this very broad field of sports medicine and science. People are advocating for injury management, increasing physical activity, safer participation,

active participation, health promotion, and disease prevention all at the same time, while there are solid medical and scientific research and epidemiological studies to back up all these requests for funding and program implementation. Who to look towards for funding depends on which way you split the hairs. 'If it's sport and exercise ... which is a subset of physical activity, it's the organised and competition side of getting children into teams and getting adults into teams, then that funding obviously comes through sport. If it's about getting people to be more active, ie ride your bike to work, walk to work, go for a walk, which has nothing to do with sport, then it tends to be frowned upon by sport and recreation and actually the funding has to come from health departments.'<sup>12</sup> Nello Marino considers 'SMA has a genuine level of expertise and the largest portion of its members are connected to the [injury prevention and management] side of the physical activity equation. It's not to say that we aren't involved in the broader health promotion issues and physical activity promotion issues. I just think it's the part of us that's quite unique.' The messages coming from ASMF and then SMA have shifted and changed over the years, however there is no doubt that the focus has always been on sports medicine and sports science for the community, with elite sport only appearing to dominate at times because of its greater glamour.

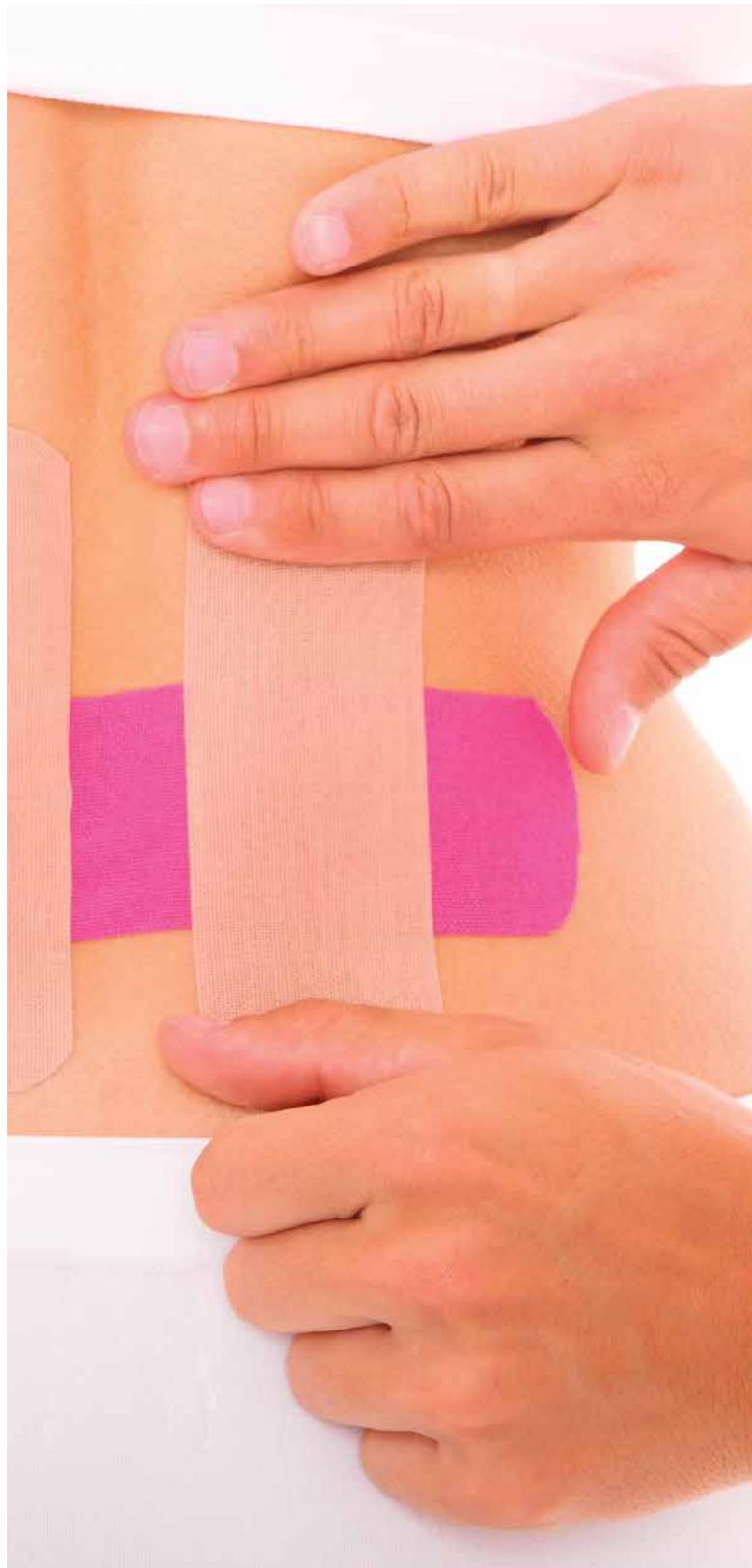
Within SMA itself, the biggest development has been the very recent completion of the OneSMA initiative. This has been an exercise in organisational management over the last several years with the aim of 'making sure that we were viable into the future because we've been too disparate ... whereas with one harmonious group nationally it's going to make that more secure.' It is also the latest of several reorganisational attempts that have come out of SMA's history of discontent. A Federation made up of eight states or territories, each with their own Boards, accounts and activities, and constitutions, but overseen by a national body is bound to experience difficulties, and create frustrations. The current President Michael Kenihan explains that 'when you actually looked at the national constitution and some of the state's constitutions they didn't even talk to each other, they were completely separate organisations with no dictated responsibility to community at all. So it was very much on a "well, if we have a good relationship with you we can do things, but if we don't we can't ... [which effectively means] it's very difficult to get something national implemented because one state may not like it or one state may not agree with it or one state may not want to fund it.'"

**“... they keep participating. One of the biggest factors in stopping participating is injury so you need to prevent that, and the second factor is there’s greater awareness now that disease is related to physical inactivity, such as obesity, cardiac heart disease, etc.”**

It is clear that these relationships have been unreliable many times over the years, but the frustration in having to spend time dealing with them is acute. Peter Larkins, President from 1994–96, becomes animated when he remembers ‘now honestly, that is the reincarnation of what I went through ... That’s what we were trying to do back then and see how long it’s taken because everyone was too protective of their territory. They didn’t want to give up their resources ... it was just like political parties fighting ... I didn’t understand why for the good of sports medicine people didn’t see that we needed to be a strong national organisation that had national policies [and resources, publications and sponsors] that every state followed.’ This was a frustration shared by many whether they were on the Executive or not and in fact lives on in the memories of so many of its longstanding members. A question about low moments in SMA’s history asked of the Fellows this year produced some heated responses that almost entirely related either to the difficulties associated with discipline groups breaking away, or the difficulties associated with ‘bickering between the states’.

When Gary Moorhead joined SMA he too came across the bickering but was advised by someone outside SMA with experience to ‘work with the people who want to work with you and don’t ... involve the others in things that require energy or initiative ... It was just great advice because there was always – and this is the point that really needs to be stressed – there was a massive positive energy about the organisation that could be tapped into.’ The history of establishing OneSMA itself has also not been easy but the positive energy still exists. After two years of extensive consultation in all the states the Australian Electoral Commission was appointed by Sports Medicine Australia to conduct a ballot of the 1,605 members eligible to vote. Of the 588 returns 560 voted yes to OneSMA. While SMA’s mission today is ‘Safety Prevention Advice’, it’s old mission of ‘The Team behind the Team’ is still a valid one and, as a Fellow survey respondent was keen to point out, ‘there is no ‘I’ in team’.

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)



## The Participants



**Everyone from the athletes to the practitioners to the trainers have played a role in the growth and success of sports medicine in Australia.**

Many feel the battle for integrity in sports medicine was hard fought in the 1970s. When Peter Duras tried to inject some life into a failing Orthopaedics Study Group by recreating it as a Sports Physiotherapy Group in 1974 he was told 'there is nothing in sports medicine that doesn't occur in orthopaedics and general outpatients.' This 'ignores the fact that sports medicine is a different field of endeavor. The risks, the injuries, are different. You have to understand the sport. You have to understand the training. You have to understand the physiology ... I struck that and within months the group I formed, which started off with a failed orthopaedic group of three ... had 200.'

Part of the problem was that sports medicine was often thought to be a less serious medical endeavor, even 'frivolous.' It was perhaps even thought that sports injuries were a self-inflicted form. Why should you take it seriously when these clowns bash themselves up? So given a road trauma victim and somebody who was badly concussed from football or ice hockey, there was always the feeling that road trauma takes precedence.<sup>11</sup> Peter Duras also found that those wanting to work in sports medicine were also considered to be less serious and often, when declaring an intention to do so, people would say things like 'well, you're going to rush around with a sponge in a bucket of water are you?' when really, 'there are some incredibly gifted people in sports medicine who had the skills to go into any form of medicine.'<sup>12</sup>

Ironically, Ron Muratore, a Fellow of SMA with experience in caring for rugby league and soccer players, considers one of the most important things he has done for sports medicine is 'getting rid of the "bucket and sponge" in Rugby League in 1980, thus reducing the risk of cross infection ten years before "infectious diseases" policies.'<sup>3</sup>

**"Peter Larkins remembers that he 'had mixed experience [when he was an athlete] that some doctors and physios ... my general experience with GPs, my general experience with physios, in my time as an athlete were that if something hurt you just stopped doing it.'"**

Sports medicine has come far in Australia since the 'jostle at the starting line' only fifty years ago and it is often thought that the battle for integrity was won some time ago. Sports medicine is now recognised and accepted as a specialty, but is often described as having its own constituents making it quite different from other areas of medicine. To understand this specialty properly it helps to come to know who these constituents are.

## Athletes

Peter Larkins remembers that he 'had mixed experience [when he was an athlete] that some doctors and physios ... like Fitch and Toyne, were just inspirational in the way they went about understanding what the athlete needed ... my general experience with GPs, my general experience with physios, in my time as an athlete were that if something hurt you just stopped doing it. That was their attitude ... [they thought] "Well, if it hurts when you do that sort of running, don't do that sort of running." [They] had no concept that the athlete didn't want to be told what they couldn't do. They wanted to be told what they could do.'

Since he gave up elite sport and became a sport physician himself Larkins can understand both sides of view. Sports medicine practitioners, whatever their discipline, will do a much better job when treating elite athletes if they pay attention to athlete psychology, which is 'one of the small facets of this huge thing called sports medicine'.<sup>4</sup> If an athlete is going to have the best chance of healing and returning to their sport with the same abilities most sports medicine practitioners would agree that psychology is an important component of any treatment. Larkins describes elite athletes as 'an eccentric mob. There is a lot of high anxiety. Everything has got to be done yesterday and there's always a championship next week or next month,



whether it's a World Championship, whether it's just a Victorian Championship and a 13-year-old gymnast girl. They live in the moment and so part of having an insight into looking after competitive people [is to] ... put yourself in their shoes ... When you're talking about their injury management you've got to be talking to them in a way that they will take on board. You have to be credible because there are too many athletes who go to see a doctor or see a physio and they get advice and they don't like the advice they hear. So they'll go and shop somewhere else until they hear someone that allows them to do things.<sup>5</sup>

Sports medicine practitioners of all disciplines talk about the need to 'speak the language' of the athlete, and to have some understanding of their sport and what it means to have to slow down or miss training sessions. 'At the end of the day the athletes are their own worst enemies because the training loads are often responsible for the injury in the first place. So you've got to look at training load changes and ... missing a session means falling behind. Physiologically that doesn't make sense but psychologically it was a real thing ... it was part of your mindset about being successful. So [it is important for doctors or physios to be able to] modify the session, knowing that they won't change it around too much but they won't miss it.'

Elite or professional athletes can also be vulnerable. After all, 'it's a huge step being selected with the expectations of your country, your friends, your coaches and even your sports medicine people, on your shoulders and then going and suddenly being presented by this vast arena with this awesome opposition and being expected to perform ... for an athlete on their first trip ... that will often manifest itself in aches and pains and a need for a little extra attention than you might think is really necessary. That's fine.'<sup>6</sup>

**“... for an athlete on their first trip ... that will often manifest itself in aches and pains and a need for a little extra attention than you might think is really necessary. That's fine.”**

Athletes also have a need to be better immediately, or at least as quickly as is scientifically and medically possible. The stakes are high for an elite athlete, and particularly for a professional athlete earning millions of dollars a year. Even without the monetary incentive the desire to get back to their peak is very real. Ken Fitch worked with many Olympians and national or state level athletes long before elite salaries had five or six '0's and says 'that most athletes work very, very hard in achieving

as rapid a recovery as possible. So it is a combination of athletes ... wanting to do the right thing and get better ... and doctors who are well trained, know what to do, use the right networking, right surgeons and good physios and so on.

Larkins agrees that 'It is a very demanding field, sports medicine, at the elite end because these are very high-demand people, the athletes. Their careers are often short. They've got one Olympics that they get to go to in their entire life. They get to compete one day. They train four years for it. So it's quite different from the person who is the social tennis player who comes in and who plays three times a week. They've got a sore elbow and they're going to miss a couple of weeks but they're back to their ultimate level in two weeks' time.'

## **The rest of us – 'weekend warriors' and 'couch potatoes'**

An important component of sports medicine history in Australia is the concern with population health, in particular the prevention of injury, and the promotion of exercise and sport to counteract chronic disease. Federal government programs included the National Fitness Council of the 1940s, the *Life Be In It* program (late 1970s), Aussie Sport (late 1980s), Maintain the Momentum (early 1990s), Active Australia (1996), Building a Healthy, Active Australia (2004) amongst others, and there have been many state-based programs.<sup>7</sup> Despite these campaigns, in 2013 obesity and chronic diseases are still a major health concern and show little sign of abating. Gary Moorhead, with both political and sports medicine experience as the advisor to the then Shadow Finance Minister Lindsay Tanner in the 1990s and then CEO of SMA from 1999, considers the physical activity message to be 'a difficult one. There's been lots of fits and starts ... how do you do this kind of stuff, it's really hard to get a handle on ... there is still a great deal of debate when you get down to the weeds. Physical activity is good, well, what sort? How much, all that kind of thing.'

Whether a person is a 'weekend warrior', or a 'couch potato', or someone with a chronic disease the messages are still confusing. Wendy Brown, a Queensland human movement academic and former SMA National Conference Chair, says 'there's an awareness amongst the medical profession that there are benefits of physical activity but, for example, if you're a middle-aged person and you have high blood sugar ... your doctor or specialist may conclude that you have suspected type 2 diabetes. They might try to get you to improve your diet or do more physical activity, but without proper help that's not

going to happen. So you go back again, four weeks later, and if it is worse the doctor says, "Well, there is medication." It's much easier for people to take Metformin than to change their lifestyle ... changing behaviours and attitudes of the medical profession is always going to be an uphill battle ... certainly there's not enough emphasis put on promoting physical activity anywhere compared with, let's say, the amount of attention that smoking and obesity and even alcohol get. The National Prevention Taskforce, which met for two years and produced a report last year and now another from the National Prevention Health Agency, focuses on smoking, obesity and alcohol. Physical activity kind of sneaks into the last little bit of the obesity chapters in these reports, but most of the focus is on food. So PA doesn't get the attention that it should have, given all the health problems that come from inactivity.'

Inactivity is looming as one of the more serious health related problems of the 21st century. In a recent article in Sport Health Dr Ian Gillam, SMA member and exercise physiologist, says 'inactivity alone is estimated to cause 5.3 million global deaths per year compared to 5.1 million global deaths per year for smoking. The current global prevalence of inactivity is greater than that of smoking (35 per cent compared to 26 per cent for smoking) and this gap might be expected to widen in the next decade if smoking rates in Australia continue to decline ... only 44 per cent of Australian men and 36 per cent of women were achieving sufficient physical activity required to maintain health.'<sup>8</sup>

However, the proliferation of sports medicine clinics across Australia is some indication of the amount of sport and exercise Australians are doing. For most practitioners it is the community who are their 'bread and butter', not the elite or professional athletes. Peter Brukner says 'there are not enough professional athletes to go around. 95 per cent of patients at a clinic like Olympic Park are non-professional ... I think its unfortunate that the image of sports medicine is only with the elite athlete because the vast majority of sports medicine is done on non-elite athletes ... for every one elite athlete there's a hundred non-elite athletes. Not even athletes - people out walking their dog trip over and hurt their ankle'.

Indeed, there is strong evidence to show that sporting injuries in the community are high compared to other forms of injury. Caroline Finch is a member of SMA, an epidemiologist and the director of the Australian Centre for Research into Injury in Sport and its Prevention. The data she and her researchers have been collecting 'shows that the number of sports injury cases is more than double the number of road injuries treated at hospitals, and while the number of road injuries cases

has stabilised, the number of sports injuries is increasing significantly.' Sports injuries are the main reason for children visiting hospital emergency departments, a major reason for adults under forty years of age requiring emergency care, and there are over a million Australians every year with a serious sports injury.<sup>9</sup>

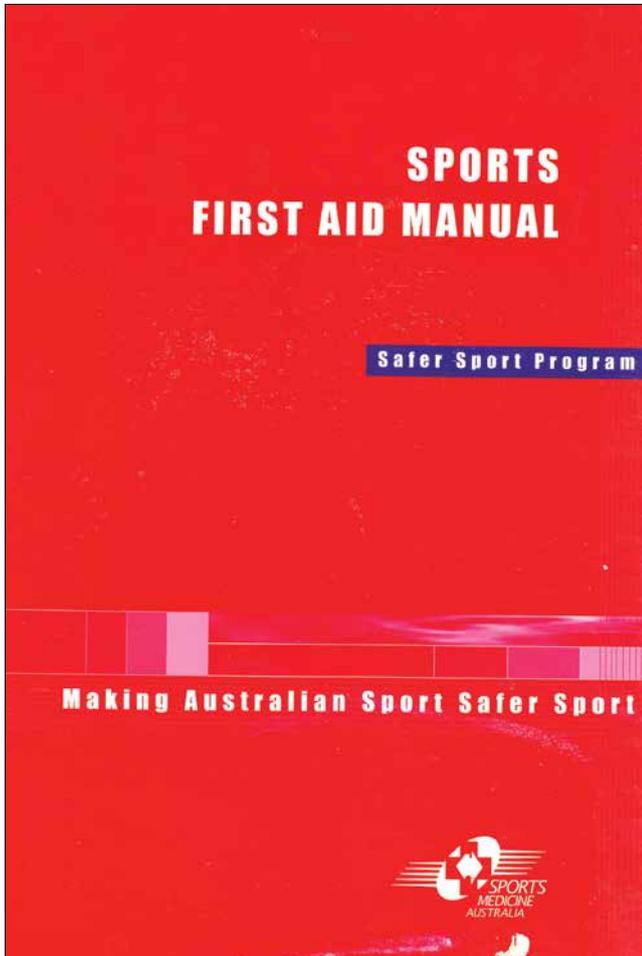
**"Athletes trust doctors who speak their language. You've got to understand sport. If you don't understand sport don't be a sports doctor."**

Although road trauma is declining and sports injuries are increasing, many practitioners describe sports medicine as being 'a bit like the Grand Prix and your streetcar. You develop new techniques [and] systems in your engines, and new safety things in your Grand Prix sports car, but they are then ... very soon applied to your streetcar.'<sup>10</sup> The Australian population may be divided between couch potatoes and weekend warriors, but with the sports medicine work that is being done at an elite level one thing we can all be sure of is that the community will benefit. Peter Brukner believes 'there is a great flow through. I think what we learn and research and so on in elite athletes then becomes standard treatment. You tear your cruciate ligament in your knee and in the old days it was only the professional footballers who get a knee reconstruction. Now everyone gets one and they benefit from that knowledge and the rehabilitation.'

Clinicians are also finding that the increased sophistication in treatments they can offer the injured jogger or weekend tennis player is matched by the knowledge these clients are gaining about injury and treatment. Michael Kenihan has been in private practice for over thirty years and considers the introduction of the Internet to be the dividing line between informed and uninformed clients. 'In the '80s we used to see a lot of very acute muscle tears and minor sprains. Now you tend to see more complex pathology because they look after their minor things themselves. They've got advice from other sources so they can manage those injuries better. So we see a lot less of that now than we used to.'

## Practitioners

'Athletes trust doctors who speak their language. You've got to understand sport. If you don't understand sport don't be a sports doctor.'<sup>11</sup> But of course doctors are not the only ones involved in sports medicine and much is made of its multi-disciplinary nature, which includes those working in



research, science, and advocacy or policy work. This issue of *Sport Health* so far has explored the circumstances and contexts within which sports medicine in Australia has developed, but often an area of medicine is shaped by the people who are attracted to it. So who are sports medicine people and why are they in this field?

'The evolution of sports medicine practitioners, this is something dear to my heart because it's what happened to me. I started as a GP with a steadily increasing proportion of my practice being sports and exercise related patients and eventually moving to a full time sports medicine practice. I started as an honorary doctor of football, then swimming, soccer, hockey, ballet ... eventually I became a paid medical coordinator and team physician of the West Coast Eagles in 1987. So that was the progression from the '60s over twenty to thirty years.' Ken Fitch's reflection on his career resembles many of his generation, and that of younger practitioners who trained in the 1970s and 1980s.

Similar stories of establishing GP clinics, showing an interest in sport and gradually developing a following abound. Peter Brukner had 'always been very involved with Melbourne University Sport and they nominated me to go to the World University Games as the first doctor who ever went with one of their teams, in 1983. So that was my first overseas trip with a team and various others continued after that.' In the meantime the practice he shared in MacKinnon was building a sports medicine clientele just as Fitch's had done ten years earlier, 'so I thought there's a demand for sports medicine here. I'll give it a crack at Olympic Park.'

Fitch and Brukner are two who have had the privilege of working with elite athletes and in international arenas, but these are not easy roles to get. Fitch considers 'the ultimate role as a sports medicine professional has got to be to represent your profession at the Olympic Games and look after the athletes of your country ... Certainly I reckon I earned my trip, when I put my hand up to go to Munich I had three overseas trips already ... Mine were ... places like Malaysia, Indonesia and Vietnam during the war with helicopter gunships all around us. The Australian Government sent an Australian soccer team up and the team doctor wouldn't go, as I'd already travelled with the West Australian team they sent me.' This was in 1970 and Australia played two games against Hong Kong and Vietnam in an Australian government goodwill gesture to the people of Vietnam during the war.

Peter Duras can date his involvement with elite sport back to his childhood when his 'love of sport and athletics in particular grew out of trailing alongside Dad [Fritz Duras, physical educator, and ASMF member] to Victorian and Australian championships that he covered with a couple of other guys. I also, as a little sports historian, developed a deep love of the Olympics and Dad got me a lot of material for me to pour over at the time ... he ended up with a lot of tickets to the Olympic events and I saw so much of them as I turned sixteen and I remember it all so graphically still. It was amazing.' These experiences have clearly helped to shape his career as a sports physiotherapist and his first involvement with elite touring was in 1981 in New Zealand where he 'worked from eight in the morning until probably 10 at night ... I just had to multi-skill. I had to watch their diet ... I had to be a baggage handler ... so you need good health. You certainly need to be able to work in a team environment where you support each other ... you're interested in stretching, in prevention, in pre-training and recovery routines ... you might be trackside if you're at athletics and swimming but you really very, very seldom get to watch the actual events.'

While Duras received his early inspiration from his father, Peter Brukner was inspired by a now famous image of Brian Corrigan at the 1968 Mexico City Olympics, in obvious distress with collapsed 10,000m runner Ron Clarke at the finishing line. Although Clarke was considered almost the best runner of his time, and Corrigan's medical team had been working on an acclimatisation program to help their athletes adjust to the high altitude of Mexico City, Clarke ran out of oxygen and staggered towards the end almost unconscious. He still managed to finish sixth but had to be administered oxygen by Corrigan and suffered permanent heart damage.

**“However, most practitioners do not have much or even any involvement with elite athletes but the thrill of getting an injured person back to their sport can still be strong.”**

Corrigan was one of the very early official Australian Medical Officers for the Olympic or Commonwealth Games. The first Australian to officially provide medical care to the Australian Olympic team was George Saunders, a masseur who travelled to Helsinki in 1952. Barrie Towers was the first Team Doctor, in Rome in 1960 and David Zuker was the first Team Physiotherapist at Montreal in 1976. For the Commonwealth Games the first physiotherapists to travel with an Australian team were Leslie Bridges and Thomas Dobson in Jamaica in 1966, at which Roger Parrish, who lived in Jamaica, also served as the Australian Medical Officer. The first Team Doctor to travel from Australia was Robert Tinning in Edinburgh in 1970, while the first Team Masseur was again George Saunders in Edinburgh. Since those days the provision of medical care to elite Australian athletes in competition has become so much more sophisticated. In Delhi at the 2010 Commonwealth Games the medical team consisted of 6 doctors, 6 physiotherapists, 6 soft tissue therapists and a clinical administrator at Headquarters, while 1 doctor, 9 physiotherapist, 9 soft tissue therapists, 1 sports psychologist, 1 dietician and 1 physiologist was appointed to particular sports.<sup>12</sup>

However, most practitioners do not have much or even any involvement with elite athletes but the thrill of getting an injured person back to their sport can still be strong. Rob Reid will 'always remember one 12-year old girl who was told that she had reflex sympathetic dystrophy of her toe and had not been able to run for two and a half years. With appropriate treatment she was able to return to field hockey with no pain, she did not have RSD, and the look on her face when



**AUSTRALIAN  
SPORTS TRAINERS  
ASSOCIATION**

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ASTA is the:  
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trainers.  
A.S.T.A. is the:  
National association of sports trainers.  
There is a branch of A.S.T.A. in every state.

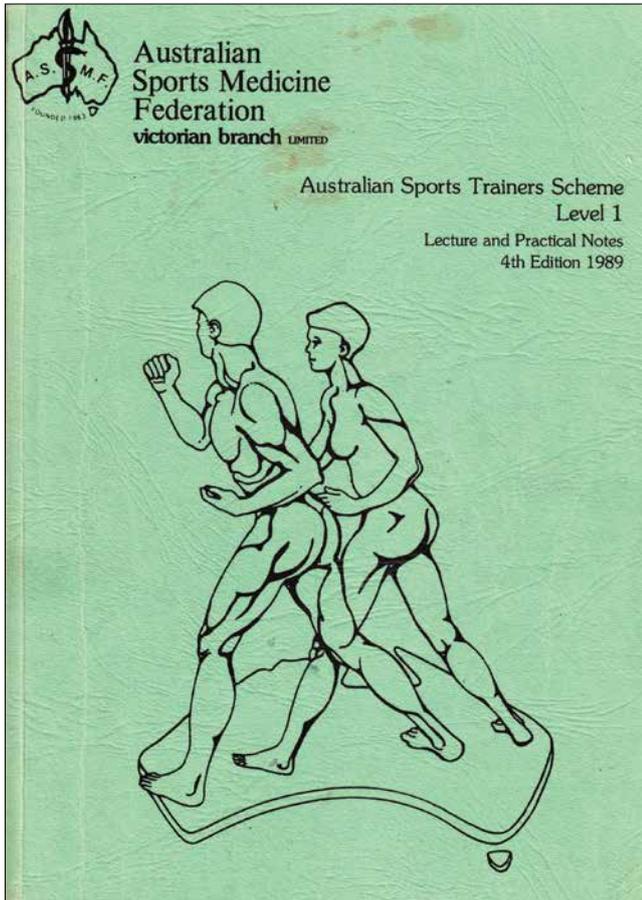


ASTA participates in sports medicine programmes in cooperation with the Australian Sports Medicine Federation (ASMF).

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her pain had gone and she was getting back into running was priceless!<sup>13</sup>

As a scientist Bob Treffene had been trained in physics and mathematics then worked in medical physics at St Bartholomew Hospital in London measuring and collecting data from swimmers. When returning to Queensland in 1975 he



'became interested in stored elastic energy and started doing just laboratory work, but then the 1976 [Montreal] Olympics came and I thought I'd better contact these swimming coaches because I might be of some use with this radiotelemetry work I was doing.' He then got involved with the recently formed SMA in Queensland and has been working with huge success with the coaches of Olympic and other international standard swimmers ever since. Although even he did not have involvement with the athletes themselves and tried to 'work directly with the coaches. Coaches do not like you interacting directly with the athletes.'

Sports medicine, when viewed through the lens of community or whole population health promotion programs, is also attractive to those with an epidemiological or health sciences background. Wendy Brown was working as an exercise physiologist in a cardiovascular health and health promotion team in a private hospital. After running educational programs, including one of the earliest workplace health promotion programs sponsored by the companies, she became very

conscious of the health disparities created by socioeconomic forces. She went through a 'changing phase' in the late 1980s and 'gradually lost interest in what I call the "further, higher, faster scientists" ... and became much more interested in the health outcomes of physical activity and my work developed from there ... doing health promotion on the ground in the places where it's needed most.'

The earlier practitioners of sports medicine often had a far more convoluted route into their main career. During the 1960s John Bloomfield did a PhD in the physiology and anatomy of elite swimmers at the University of Oregon, then a study tour of sports training and medicine facilities in Europe, before returning to Australia. 'When I got back ... nothing was being done for sport ... I toured around looking for a job for six months, I just couldn't find anything. I finally nailed a job ... at the University of Western Australia. They only wanted a physical education lecturer because the Education Department said they should have one ... I started here as a PE lecturer but I was trying to change it towards a sports science course, which I eventually did. It took me twelve years to get into the Faculty of Science.'

When asked about the key people of sports medicine many names are put forward, too many to list here. The 'group that came back post World War II started to move into private practice ... then came '56 [Melbourne Olympics] and the realisation that a lot of them had been practicing sports medicine, had self-taught and were practicing sports medicine in the '40s and '50s.'<sup>14</sup> These included the founders of AFSM and its successor ASMF in 1963. Other names were people who trained and began their careers in the 1960s and 1970s, only some of whom were interviewed for this issue or who are Fellows of SMA. Others again are considered special for the contribution they've made to their particular discipline (for example nutrition, physiology, academia).

The Order of ASMF Fellows was established in 1984 to recognise elite members of Sports Medicine Australia. Its purpose is to promote excellence in the field of sports medicine; encourage young members' research and scientific endeavours; and recognise the contribution of members to SMA. Fellows must have been a full member for at least seven years and must have attended conferences, published their own research, have higher tertiary qualifications, and have assisted with the running or management of SMA by being involved in projects or workshops or committees. To date there are 180 Fellows representing nutritionists, scientists, doctors, podiatrists, academics, physiotherapists, surgeons, exercise



physiologists and others, while ASMF also has a Life Member award and a President's award. Over the years, despite the ebb and flow in the Australian Government's support of sport, there have been forty-one Honours awarded for services to sports medicine, fifteen of which are to Fellows of ASMF and many others to members.<sup>15</sup>

Who sport and exercise practitioners are, and why they work in this field, are clearly shaped by serious considerations such as what study opportunities are available to them, their inspirations, employment opportunities, and the particular circumstances they find themselves in. It has also been suggested that there is a common answer to these questions, which is that 'sports medicine, by and large, attracts a more "fun" group.'

## Sports Trainers

When ASMF President John Hart retired in 1986 his address included the concern that 'often too much attention is focused on the elite athlete to the detriment of the myriad of sports people competing regularly on weekends throughout Australia. There is no reason why the "grass roots" of Australian sports should not benefit from recent developments in sports medicine, as well as the elite athlete.'<sup>16</sup>

Many in ASMF had been actively promoting injury management, sport for health, and basic sports medicine education amongst the community since it was first established. Some of their methods were through submissions to government, such as John Bloomfield's *Role and scope*

and development of recreation in Australia, 1972 and Jack Refshauge's submission on the role of the Federal government in sport in 1976; ASMF conference papers in 1968 in Tasmania and 1973 in Sydney; and support for the Lions Fitness Award Project as early as 1968. There was always a need for more though, in a country where sport was part of the national psyche, played by all ages in myriad conditions and levels of competition, with so much of it organised by dedicated but untrained parents and sporting diehards.

**“There is no reason why the “grass roots” of Australian sports should not benefit from recent developments in sports medicine, as well as the elite athlete.”**

Dr Kevin Hobbs, a GP and then President of SMA Queensland, had put forward the idea of an Australia-wide scheme that would train these enthusiasts in a manner that enabled them to understand basic sports medicine principles and deal with the kinds of injuries that occurred on the grounds and tracks



around the nation. The idea was to provide non-academic training for the masses in order to enable those who would have first contact with an injured sports person to know what to do. He began pushing this idea in the early 1970s, but to no avail. Eventually, recognising it was too important an initiative to let drop, Queensland set up their own scheme in 1978. South Australia took inspiration from them and did the same soon after, and at the 1980 ASMF annual general meeting in Hobart it was decided to go ahead with a national scheme based on these two pioneering ones. It took a couple more years and some negotiated funding from Beiersdorf (Australia), but in November 1982 the Australian Sports Trainers Scheme was launched, the first in the world to provide accredited training for non professionals.<sup>17</sup>

Today they 'are most visible at the football codes, AFL and NRL ... they run out with the water but the better ones are very well trained and fairly highly skilled, but they're also the backbone of community sport.'<sup>18</sup> These are the mums and dads, the coaches, and the physical educators. Their numbers grew and grew and by 1988 over 5,000 sports trainers had been accredited with at least the Level 1 course, with twice that many enrolling.<sup>19</sup> Tony Parker, from Queensland remembers 'we used to have rooms full of people from school teams and so on who would come and learn about sports medicine at that level.' Today there are nearly 7000 people who become accredited every year and many others who do courses in sports training or CPR or basic first aid, and who provide mostly voluntary service to all sports from entry level through to elite level across Australia.<sup>20</sup> Now called the Safer Sport Program Michael Kenihan sees it as 'the glue for SMA.' It was how he became involved with SMA in the first place, becoming a member of the organisation and then of the Sports Trainer's Committee in Melbourne in the early 1980s – 'that's how I cut my teeth with SMA'.

The sports trainers became another group, like the discipline groups, that had to go through a maturing process. Sports trainers initially had Associate membership of SMA. 'In 1999, even though they were sort of created by Sports Medicine Australia and taught by Sports Medicine Australia members, they were seen as not really fitting in. So [SMA] encouraged them to form their own association. A lot of sports trainers still wanted to join SMA so we created a new kind of membership, a sports trainer membership. So they could join the organisation as sports trainer members. That provided quite a substantial membership, and also tied that group of people much more closely to the organisation, which was important

at various times when other entities came along trying to woo them as sponsor provisions.<sup>121</sup>

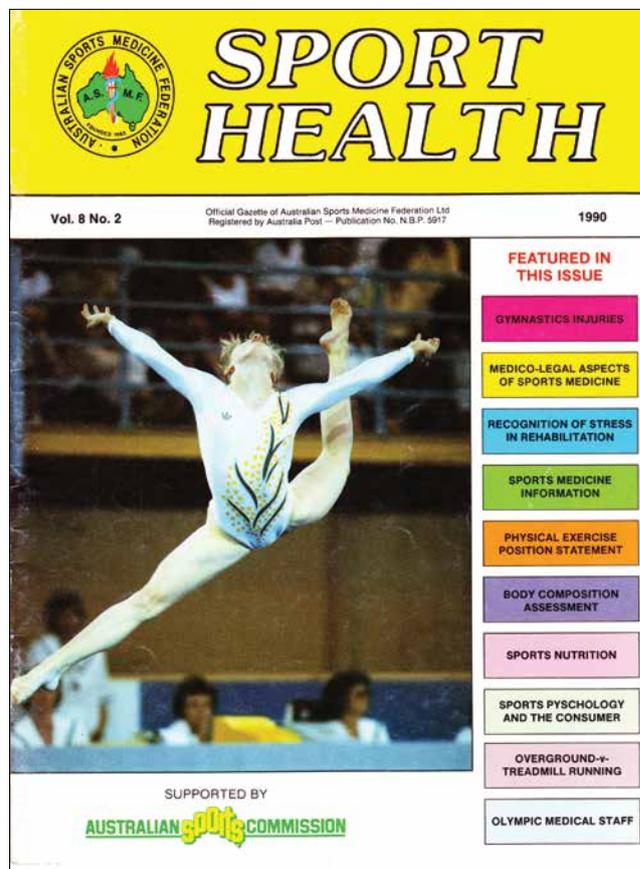
Ironically, the problem for sports trainers was the very reason their initiative was established in the first place. SMA full members were all qualified professionals with diploma or degree level training; the value of the sports trainers was not their profession, but their immediacy. It was this on the spot attendance, backed by a basic understanding of sports medicine, which made a positive difference to the degree of injury prevention and management.

## Reporters

All good marathons have their reporters to keep participants and keen readers up to date and informed, or who are outspoken and fearless with their informed opinions, or who seek to make an impact and bring about change. The marathon that has been the sports medicine evolution in Australia has had its fair share of excellent reporters, their outlets mostly being this magazine *Sport Health*, and the *Journal of Science and Medicine in Sport*, but also the numerous state and discipline based newsletters, and the sports injury prevention and management information sheets, as well as the publications produced independently by leading sports medicine practitioners and academics.

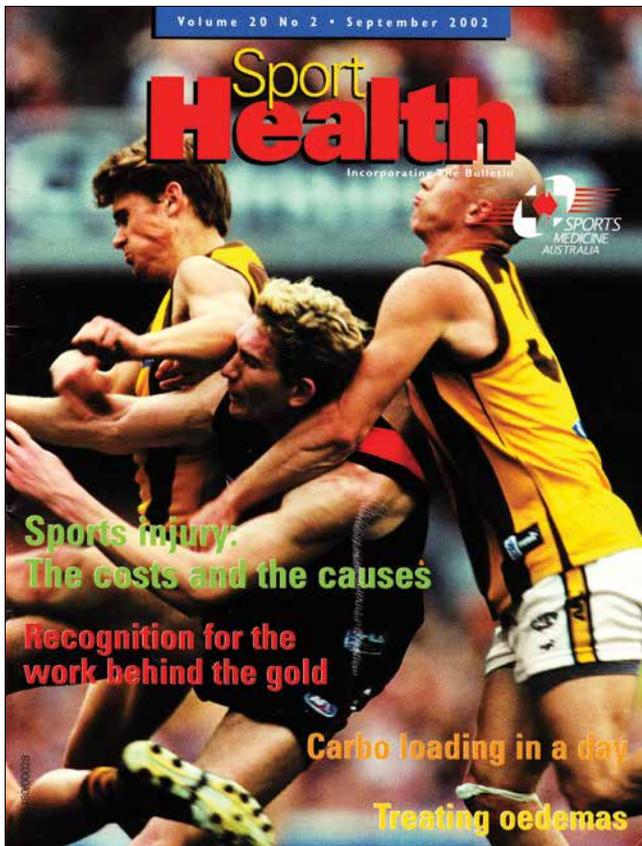
'One of your markers [for when sports medicine has developed] is when do you start to publish in that country? ... For instance in England, when Williams published his book called *Sports Medicine* in 1962 that was a sign of maturity in Britain. Here you have a book that any general practitioner, any physiotherapist, can pick up and it's authoritative, it's comprehensive. It's a landmark. It shows that country has gained maturity but is a great resource too ... the same thing has happened here with people like Peter Brukner and Karim Khan, when they published their first guide to sports injuries.'<sup>122</sup>

Many years earlier the profession was already publishing amongst itself. The 1958 first edition of 'The Australian Sports Medicine Bulletin', edited by Dr Barrie Towers the branch Secretary for ASMA NSW, included ASMA news as well as 'Sports Medicine Extracts' on topics such as 'Stress in athletes', 'Renal response to exercise' and 'A study of the electrocardiograms of 74 wrestlers'. It was certainly more of a Bulletin than a Journal, but it was a very welcome beginning and over the next few years the professionalism of its production and the seriousness of its content increased. In 1961, after the NSW branch of ASMA broke away to form



the AFSM the bulletin's name was changed to the Australian Journal of Sports Medicine, with vol.1, no1 published in May 1961. It was still edited by Barrie Towers and members could read about 'T wave changes in strenuous exercise', 'Pre-event nutrition', and the 'Physical capabilities of children' in this first issue.

Within a year or so of the amalgamation between AFSM and ASMA to form ASMF, Dr Ivan Davies, also of NSW, had joined Towers in the editorial work. Davies was a rugby enthusiast with a medical clinic in Paddington to which he introduced a dedicated sports clinic two mornings a week. Towers credited Davies with taking on the bulk of the task, which, like all the other ASMF roles, was voluntary and done after hours. In fact, in Davies' case, his wife Sally did all the typing in her spare time. Federal Council minutes regularly reflect the appreciation that Council members had for the voluntary work done towards the Journal, as well as the regard they held for its quality. At the 1965 annual meeting Howard Toyne from Victoria questioned whether the Journal had ever been



approved as ASMF's official organ, leading to unanimous agreement to formally accept it as such, and a decision that full members must subscribe to the Journal as part of their increased subscriptions. This did not seem to deter them and in 1967 the NSW branch reported that circulation had increased from 84 to 300 in the last year. These early years saw articles mostly by Australian authors, but there was also a reasonable submission from overseas authors.

The reliance on voluntary assistance and content, and the difficulties of producing a national journal in a pre-digital era, soon began to take their toll. ASMF secretary Barrie Towers and his successor Ken Fitch often used dictation tapes to communicate with each other. However, the norm was still paper and pen or the typewriter. A series of letters between October 1969 and Feb 1970 are testament to the difficulties of running a voluntary body across a geographic gulf. Emotions and misinterpretations of who said what and why were only eased by the desire of both writers to make things work. One of the issues was the proposal to make the Journal a refereed one. For Davies and Towers the Journal

was a labour of love conducted after hours and at their own personal expense. The suggestion to referee submissions represented a greater workload and a lack of faith in their own abilities to edit a quality journal. A solution was found later that year when sports scientist Dr Brian Blanksby in WA became the editor for an extra two refereed research editions every year. Peter Dornan considered this to have been a good move as 'Brian Blanksby was brilliant as an Editor. I actually did the first large epidemiological study of Sports Medicine patients in Australia – Brian made it readable.' This marked the beginning of a move towards a dual publication of a refereed Journal and what was to become the magazine *Sport Health*. By 1975 the Journal had taken on a new A4 size and become totally refereed, Davies retired due to ill health, and Towers, now on his own, decided to retire from the editorial role with him. While Davies had never been on a committee, Towers had had enough of the internecine politics of state and national branches. It was now time to pass the Journal on.

**“In 2002 the newly appointed Assistant Editor to the JSMS, Dr John Orchard, wrote an Editorial explaining ‘Why the world needs a good Australian sports science and sports medicine journal.’”**

Over the next few years first Donald McMiken and then Bob Treffene took on the position for a brief period each. Both had great intentions but it still did not seem clear in the minds of the ASMF Council and their members what was required of such an organ. Under McMiken it was certainly moving in an academic direction, with plans to widen the Journal's scientific scope with a new panel of section editors to assist expansion. However it was still not produced in a regular or reliable fashion. McMiken's work commitments meant he resigned after only two issues, although the ASMF Executive did not realise this for quite some time (more internecine difficulties). Treffene became the Editor when Queensland, out of exasperation with the failure of a reliable and quality journal to emerge from 'a chaotic situation', decided to take it on. Treffene does not have good memories of this period and laughs when he reads on the inside cover that he was 'editor-in-chief. I had editors in other states apparently!' With very few authored submissions or book reviews coming his way, referees slow to respond, no news submitted from other branches and little interest from members across Australia, he was not interested in taking it any further. 'I had my family here sorting [the Journals] out, getting them posted and all kinds of things for nothing.'



So Treffene resigned in 1979 to be replaced by another Queensland and exercise physiologist Dr Barry Wilson. The difficulties that had held the Journal back during the 1960s and 1970s were beginning to come to an end. As ASMF became more professional, garnering greater sponsorship funds and members, and as the Executive moved to being full time and paid with a base in Canberra, the production of a reliable and refereed journal became possible. The editorial role was, and still is, voluntary but editors had secretarial, publication and management support to aid them, allowing the Journal to grow in status and quality. By the early 1980s it was beginning to represent the very academic and scientific journal that it is today and was no longer eagerly anticipated by members wanting more general news and more accessible science and medicine.

Wilson was succeeded as editor by Dr Mark Hargreaves in 1997, then Professor Caroline Finch in 2002 and Professor Gregory Kolt in 2009. Academic journals are ranked using a measurement called an Impact Factor, which calculates the number of times its articles are cited in other publications over

the previous two years. In 2009, as Caroline Finch passed the baton on to Kolt, the impact factor was 1.93 and the Journal had raised its previous ranking of 39th out of 71 journals in the sports and exercise medicine field to 16th position. The Journal, still publishing six times a year, continues to increase in status and now has an impact factor of 3.034 and is ranked 8th in its field.

In 2002 the newly appointed Assistant Editor to the JSMS, Dr John Orchard, wrote an Editorial explaining 'Why the world needs a good Australian sports science and sports medicine journal'. He was responding to the

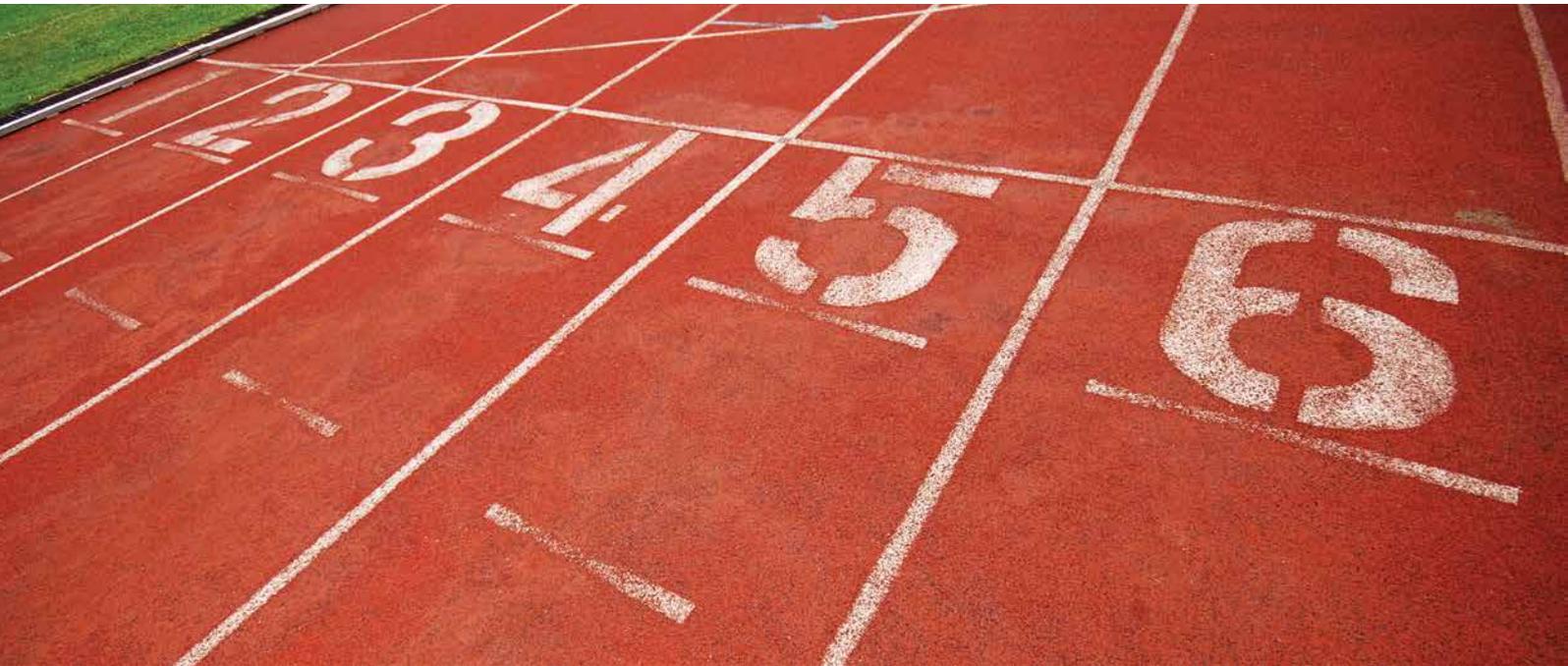
significant body of opinion that there was no point bothering with a journal at all. There is a rationalist school of thought that there are too many scientific journals ... According to the rationalists, we should leave peer-review publications to the 'big' countries in North America and Europe. No one argued that Australians don't make great authors of sports science papers, but some people think that we are too small a nation to be good publishers.'

And today, in every bimonthly issue of *Sport Health*, there is a 'top ten' list of articles cited by researchers from around the world, indicating the level of interest that sports medicine practitioners and researchers worldwide have in the *Australian Journal of Science and Medicine in Sport*.

As the journal developed its academic and scientific credentials there was less and less opportunity to reach out to the average punter interested in sports medicine. The original Bulletin, nurtured by Towers and Davies during the 1960s before slipping out of sight, began new life as *Sport Health* in 1983, the quarterly members' magazine you are reading today. Edited by Dr Barry Oakes in Victoria, then by Executive Director Terry Saunders, *Sport Health* has long since come out of the SMA office as the voice of sports medicine in Australia for members and subscribers, whether they be athletes, weekend warriors, practitioners, or sports trainers.

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

## The Wrap-up



### **In 50 years SMA has experienced enormous growth. What have we learnt, and what does the future hold?**

The defining characteristic of sports medicine and sports science in Australia has always been its diversity. Sport medicine's miscellany is apparent in its constituency (elite athletes and 'weekend warriors'); its geography (greater distances inhibiting communication in the pre digital era, and as many climate and terrain differences as Europe or America facilitating myriad sporting activities); its disciplines (traditional medicine, allied health traditions, emerging sciences); its politics (state and federal associations); the concerns of its proponents (patching up and performance for athletes, preventative health and participation for the population); and we must not forget the complex web within which these endeavours operate (made up of state and federal governments, health bodies, medical authorities, sporting associations, sporting events from the local to the global, sponsorship and funding providers, and each other).

Navigating these characteristics has not been easy or seamless, and tension has often existed between both geographical groups and the disciplinary groups within the sports medicine field, each one working to maximize their abilities and their contribution to sport and recreation through the ASMF. So it took a particular determination, vision and intellectual agility to convert this hodge-podge of characteristics into an effective pastiche.

**“Thirdly, it is a field in which there is room for any trained medical and para-medical professional with an interest in fitness, health and performance, but also, under the auspice of the Sports Trainers Program, the capacity to enable amateurs to provide basic sports medicine care, and the assurance of the safe sport message and basic medical assistance for all clubs and sporting groups.”**

This conversion was able to take place for a number of reasons. Firstly, sports medicine moved from an autodidactic enterprise to an academic one between the 1970s and 1990s. An evidence-based approach has long guided everyone, from the sport scientist on the training track to the physiotherapist in the local clinic, bringing with it professionalism and assurance. Secondly, although membership of the Federated sports medicine body was initially reliant on having a medical degree this was fought against and, of all the medicines, sports medicine has probably been the least affected by professional barriers and silos. This has brought to the field a strong sense of parity and teamwork in the provision of health care. Thirdly, it is a field in which there is room for any trained medical and para-medical professional with an interest in fitness, health and performance, but also, under the auspice of the Sports Trainers Program, the capacity to enable amateurs

to provide basic sports medicine care, and the assurance of the safe sport message and basic medical assistance for all clubs and sporting groups. These give sports medicine a very broad base and a strong framework to work with. Finally, (and luckily) while its greatest responsibility has always been the care of anyone who participates in exercise and sport, it has glamour and excitement in the care of elite athletes and participation in elite sporting events.

*The Referee* journalist 'interviewed' for the beginning of this edition worked with the elite strongmen and athletes of his time, and it is this work that also gave him an understanding of what was good for the everyday citizen enjoying a team sport or a round of athletics on the weekend. We have come a long way since then and sports medicine in Australia today is institutionalised, professional, and widely recognised as having a high standing on the world stage. Australian sports science leads the way on many fronts and the *Journal* is currently among the top ten of its field in the world, in a competition of more than 70 sports science and sports medicine journals. Learnings and techniques that have come from working with elite athletes have made their way down the ranks and are often readily applied to the benefit of the community at large.

**“Sports medicine, having traversed the roles of patching up, performance, preventative health and encouraging participation, and after fifty years with an official existence under the auspices of the ASMF, is by and large comfortable with its purpose today: to share knowledge, training and information, and to enhance the health of all Australians through facilitating their safe participation in sport and physical activity.”**

Sports medicine, having traversed the roles of patching up, performance, preventative health and encouraging participation, and after fifty years with an official existence under the auspices of the ASMF, is by and large comfortable with its purpose today: to share knowledge, training and information, and to enhance the health of all Australians through facilitating their safe participation in sport and physical activity<sup>1</sup>. So where does the future of sports medicine lie? In the introduction I describe what I have called the three generations of sports medicine practitioners. To these can be added the fourth generation, those who studied and graduated as we moved into the twenty-first century and who will be leading the way in the future. This commemorative magazine



began with a fictitious interview, in the '5 minutes with ...' style that *Sport Health* readers are familiar with, to set the scene for sports medicine in the nineteenth century. It will finish with another fictitious interview set some twenty years into the future.

References, as indicated within the article, are available at [sma.org.au/publications/sport-health](http://sma.org.au/publications/sport-health)

## 5 mins with ... Dr Ath Letic

SMA Fellow for 2030<sup>1</sup>

### What is your involvement with sports medicine?

I established the Preventative and Regenerative SuperClinic at the Victorian Comprehensive Cancer Centre (VCCC) in Melbourne in 2025, which now has twenty specialists working across the disciplines of medicine, science, nutrition, physiotherapy, podiatry and psychology, as well as a laboratory, a gym, several indoor and outdoor exercise areas and a swimming pool. I am also an immediate Past President of SMA and have been on the Network and Collaboration Committee for ten years.

### What does your typical day consist of?

Most days begin with an early meeting between our specialist team and one or other of the VCCC medical groups (medicine, surgery, haematology, infectious diseases) to discuss patients. Patient clinics take up the morning. Most are assigned to a discipline specialist depending on the nature of their illness but will invariably work with a nutritionist, physiotherapist and psychologist as well. There will usually be bedside or ward visits as well for those patients unable to come to our floor but who are still benefiting from massage or from the new Fine Movement Therapies.

Research into these therapies has come a long way in the last ten years. We have three PhD students looking at different aspects of Fine Movement and have attracted a lot of overseas interest. Its applications have found to be of benefit to a healthy but aged person, as well as diabetics and other patients with illnesses that prevent them from being mobile and active.

We also place a high premium on patient participation in their own recovery, as we do for those who are not VCCC patients but who come to us in the afternoons as clients from our local sports medicine clinics and GP networks for fitness and disease prevention activities.

### What important changes in sports medicine can you identify since you graduated thirty years ago?

Firstly, an established and sustainable focus on physical activity from state and federal government brought about by the final realisation their health dollar is better spent on prevention than cure. This has enabled sports medicine to

be recognised as an economic necessity and is therefore the happy recipient of substantial funding which has enabled preventative and regenerative clinics like ours to be attached to many of the key medical hubs around the country.

Secondly, an increased specialisation, sometimes super-specialisation, within all the disciplines. This is particularly the case in the sports sciences, which have proliferated in an extraordinary fashion. Work in the areas of micro and nano technologies in the early years of this century have led to our ability to apply functioning nanobiomaterials to tissue engineering – we now use nanocomposites for bone tissue regeneration, biofabrication for skin repair, nanofibrous scaffolds for orthopedic tissues, we can engineer cartilage and we use photobiology extensively now as a diagnostic tool. The use of stem cells for muscle and tendon repairs is also relatively commonplace.

And thirdly, sports medicine and science is now a substantial component of most medical undergrad degrees in Australia. This has happened gradually in the last fifteen years, despite previous efforts by practitioners and SMA for decades to get more SM into basic medical training. But its benefit has been to introduce sports medicine into the treatment armory of GPs, and secondly to inject sports science and medicine into other specialist areas. SM was already beginning to show its relevance to occupational medicine but has since integrated itself into others. Of course, my work in oncology is just one of those other areas.

### What have been the most significant challenges to practitioners in the 21st century?

As discipline groups became more accepted as quality providers of medical care by both the medical world and the community this has, oddly enough, since brought into play many ethical and integrity issues involving professional claims by people on the fringe of sports medicine. While professional development and accreditation processes increasingly separated those with integrity from those without, the latter have been able to utilise the vast array of social media tools available to attract unsuspecting or vulnerable clients and patients.

Getting a greater focus on sports medicine in undergraduate medical courses was a significant challenge because it relied on carefully breaking down three longstanding barriers. The first was introducing prevention into the raison d'être of medical care alongside its traditional purpose of curing. We also had to manage egos, which are notorious in all medical specialties including our own, and introduce the modus operandi of collaborative medicine into a professional world built around specialty silos.

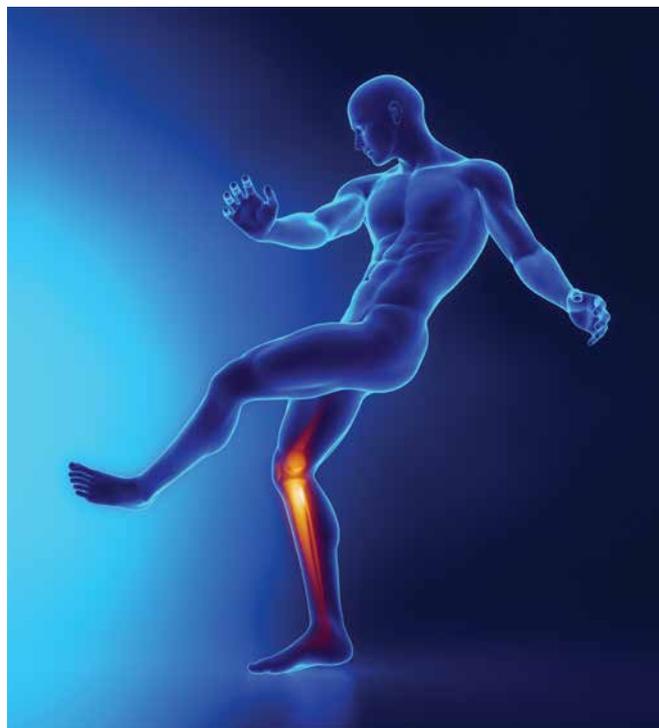
Patient compliance has always been an issue with sports medicine, as it has with all areas of medicine. If a patient does not want to adjust their lifestyle or take their medications there is usually very little that practitioners can do about it. This has always been a frustration but is increasingly alleviated with the growing use of virtual communication tools available on our devices that allow practitioners of all disciplines to send automated reminders with assessments or recordings as required by each patient.

### **How has SMA played a role in these successes and challenges?**

Greater networking with national health bodies, medical schools and state and federal governments has allowed SMA and its members to shape the message, advocate and eventually change the mindset of all those who are eventually responsible for the health of the population.

Almost completely breaking ties with elite sport has helped SMA establish a sustainable and leading role in population health issues. However this still needs to be handled carefully as there is no doubt that the ultimate 'faster, higher, stronger' sports medicine and science that is dedicated to extreme performances and rapid recoveries always evolves to become available at a population level. So we need to maintain those links with elite sport and with clinicians and researchers dedicated to performance.

The sometimes rocky relationships between discipline groups, and between the groups and SMA itself, were a historical challenge spoken of by sports medicine elders during my undergrad and early professional years. Since then I believe that the introduction of a unifying movement called OneSMA about twenty years ago, and successive efforts since such as SMA's mentoring



program and the Collaboration Committee, have enabled the disciplines to consistently work together in harmony at an organisational as well as professional level. This has created a unifying force that contributed greatly to our successes with governments and medical schools. It has also played out in the professional development and conference activities of SMA and its members. It seems to me that the rate at which all our discipline groups have been producing new research, new patient programs and new understandings has been rising at an exponential rate for most of my professional career.

### **What's the best piece of advice you could give someone?**

Stop off at one of the many genome testing centres when you get a spare couple of hours and have yourself tested for the cancers, diabetes, Alzheimer's and bad heart genes. Talk to your GP and get a referral to your nearest P&R Superclinic and you can be assured of an individual and comprehensive program, and education designed to prevent or alleviate these scourges that we can see are finally beginning to take a downward turn.

## The Record

### Presidents of the Australian Sports Medicine Federation and of Sports Medicine Australia (since 1994)

1963–65	Dr Robert Pufflett	1987–88	Dr Tony Parker
1965–66	Dr Jim Pannell	1988–90	Dr Brian Sando
1966–67	Dr Leigh Wedlick	1990–92	Dr Fred Better
1967–69	Dr Brian Corrigan	1992–94	Mr David Roberts
1969–71	Dr Owen Bowering	1994–97	Dr Peter Larkins
1971–73	Prof. John Bloomfield	1997–99	Dr Graham Allen
1973–75	Mr Howard Toyne	1999–01	Dr Shane Conway
1975–77	Dr Geoffrey Vanderfield	2001–03	Dr Anita Green
1977–78	Dr Kevin Hobbs	2003–05	Ms Marilyn Feenstra
1978–79	Dr Ken Fitch	2005–07	Dr Bruce Mitchell
1979–81	Dr Jack Refshauge	2007–09	Mr Michael Kenihan
1981–82	Dr Kevin Hobbs	2009–12	Mr Tim Pain
1982–84	Dr Bill Webb	2012–13	Mr Michael Kenihan
1985–86	Mr John Hart		

### Editors of *The Journal of Australian Sports Medicine*

1963	Dr Ivan Davies, Dr Barrie Towers
1970	Dr Brian Blanksby joined Davies and Towers to edit two refereed research editions per year
1975	Dr Donald McMiken
1976	Dr Bob Treffene
1980	Dr Barry Wilson
1989	Prof Bruce Abernethy
1997	Prof Mark Hargreaves
2002	Prof Carolyn Finch
2009	Prof Gregory Kolt

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