Sports and occupational medicine: two sides of the same coin?

In September 2005, the government notified National Health Service (NHS) Chief Executives that ‘Sport and Exercise Medicine’ was to become a specialist NHS discipline and that they should consider the future delivery of such services [1].

Recognition came following an extensive consultation programme throughout 2004 [2]. The consultation documentation outlined in detail how the speciality would be established with the core aims of

(i) providing a holistic approach to the management of medical conditions and injuries in those who wish to exercise;
(ii) providing advice on the prevention of further injuries by the safe use of physical exercise and the treatment and prevention of illness and
(iii) promoting general wellness through the increased use of exercise and physical activity.

Evidence was provided for the need for this new speciality by quoting that ‘10 million of the total annual 29 million sporting injuries are substantive resulting in patients being unable to work or continue their usual activities’. This
statement would infer that sport has a detrimental effect on sickness absence levels; however, the document also quoted that physical inactivity causes 8 million days lost from work each year, with an overall cost of £1.8 million pounds. It went on to state that through the speciality ‘there is the potential to improve rehabilitation processes with additional benefits such as reduced absenteeism from work’ [3]. A more recent Dutch study has also shown a statistically significant higher mean duration of absenteeism among employees not practising sports [4].

In further support of the new discipline, examples were quoted that have shown that high levels of physical activity have been achieved where sports and exercise medicine are recognized as a medical speciality [5]. With ∼10% of attendances at accident and emergency departments being for sport-related injuries, the benefits of establishing the speciality also extend to the secondary care sector, as many of these injuries would be more appropriately managed by sports and exercise practitioners using properly supervised exercise rehabilitation programmes [6,7].

The new discipline will also have to address the needs of our elite sportsmen for which the sports doctor will not only require the knowledge of acute trauma, such as head and eye injuries, but also experience of drug and doping procedures and exercise physiology. They will have to be capable of advising individual players and team managers about length of absence following injury and the most appropriate rehabilitation programmes to get them back to full activity. These are all skills that are basic to the occupational physician and having reviewed the proposed training programme for the new sports physician, there would seem to be opportunities to link some of the future training needs of the sporting physician with those of the occupational and public health physician.

Both specialities aim to prevent ill-health arising from work and to promote good health. The introduction of sports and exercise services could assist employers and occupational health services reduce lost time from work due to sporting and other injuries, through early injury management and rehabilitation programmes. More proactive primary care management of chronic musculoskeletal problems such as back pain and upper limb disorders would help to conserve secondary care resources, and help to prevent the over medicalization of these common health conditions. This will only be achieved once the public, managers and the medical profession recognize the long-term benefits that can be gained from a more proactive approach to rehabilitation with support for an earlier return to physical activity and an earlier return to temporarily modified work (or sport for the elite athlete).

A sport and exercise service would be able to work alongside workplaces and their occupational health departments to more effectively tackle key public health targets such as obesity and smoking. The former is still an area that employers worry about with a recent survey of human resources professionals indicating that 47% felt that obesity negatively affected employee output and 30% felt that it was a valid medical reason for not employing a person [8]. With obesity levels set to rise in the future it is likely that public health improvements will only result if exercise participation is increased. Exercise programmes have been shown to be effective for the management of many chronic medical conditions such as diabetes, heart disease, asthma, osteoarthritis and depression.

The discipline of sport and exercise medicine has now arrived, and the 2012 Olympics will further help its development. Occupational medicine can sit back and watch this development or else it can recognize the shared skills and joint training opportunities that may arise from working with it to produce doctors who are able to appreciate the interactions between work, health and play. Anything that can help to promote the understanding of what occupational health is all about and how the workplace can impact upon health must surely be good for our speciality.

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References


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