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Sports Medicine

Pioneers and Specialization

Introduction

Sport mattered to doctors more than just in a medical sense. When he was Dean of St. Mary's medical school, Lord Moran (Charles Wilson) was well known for recruiting sportsmen. It was claimed that in the middle of interviews with prospective medical students Moran would bend down below his desk and retrieve a rugby ball, which he then threw at the interviewee. If the interviewee caught the ball he was admitted; if he threw it back he earned a scholarship. For Moran, who had been decorated as a medical officer in World War One and served as Churchill's doctor, sport taught character and made for good doctors.¹ This, probably apocryphal, story gives an insight into the nature of the strong sporting tradition amongst doctors from the late nineteenth century. As we have seen in Chapter 1, Victorians were preoccupied by matters of the body and doctors were inclined to promote the benefits of exercise for physical and mental health. In the nineteenth century the cult of athleticism, with its mantra of *mens sana in corpore sano*, was an important part of a public school education which many of those entering the medical profession had enjoyed.² It is perhaps unsurprising that many doctors wished to continue their association with sport in some form. Although the most famous sporting doctor was W.G. Grace, the sport of choice for many doctors was rugby union. Between 1871 and 1995, when the game was amateur, doctors provided 68 England internationals; the fourth largest occupational group. Rugby union was also imbued with notions of amateurism that complemented not only attitudes towards sport but also the idea of gentlemanly medicine. The London teaching hospitals had begun playing the game in the 1860s and in 1874 the United Hospitals' Cup began. The tournament rapidly became infamous for the intensity of play and the antics of its spectators, especially at the final. The clubs and cup were both an opportunity to demonstrate athletic prowess and riotous behaviour and a vehicle for the expression of corporate pride and social – i.e., middle-class – solidarity.³

Sports medicine has combined the professional with the personal for many doctors. The main purpose of this chapter is to show how this personal interest evolved, which in Britain culminated with the bestowal of specialist status on

sport and exercise medicine in 2005. In the quest to attain specialty status, however, sports medicine (and sports medicine practitioners) were subject to a perpetual tension and debate over its scope and definition, namely the extent to which it served the needs of both elite sport or the fitness of national populations or both. Using the British experience as the main case study, this chapter looks at how doctors got involved in sport in two ways. First, how the relationship between sport and medicine was placed on a more formal relationship through the establishment of sports medicine organizations.⁴ Second, the role of the football club doctor highlights how for much of the twentieth century the practice of sports medicine was mainly undertaken by practitioners who had no association with 'official' sports medicine. Instead, the position of the football club doctor owed much to the wider social and medical context in which the role of the general practitioner developed.

The story of sports medicine not only provides an insight into its development as a medical sub-discipline but it also highlights a wider process of professionalization. Harold Perkin has emphasized that a professional society is not just one dominated by professionals. Instead, professionalism permeates society from top to bottom. First, professional hierarchies extend to most occupations as they become subject to specialized training and also claim expertise beyond the common sense of the layman. Second, a professional, social ideal, based on merit, embeds itself in society. Finally, professionalization is not a neutral process contingent solely on the acquisition of knowledge because professionals also compete for economic power, political influence and social status.⁵

Moreover, medical specialisms have tended not to have had fixed definitions. Instead they have evolved, making any definition problematic. Orthopaedics, for example, at first focussed on spinal deformities on children, hence 'paedics'. Later, the rehabilitation of injured industrial workers came under its remit. During World War One there was a major expansion of orthopaedics as a specialism as it was widely used in the rehabilitation of injured soldiers who now found themselves in specialist 'fracture clinics'.⁶ In the early nineteenth century specialism had actually been associated with quackery and was viewed with suspicion.⁷ The transformation of a specialism into a specialty has tended to combine scientific, political, institutional and therapeutic factors. Orthopaedics elevation to specialty status in the inter-war period, for example, owed much to medical politics.⁸ It also gained academic respectability as medical schools developed orthopaedic departments and specialized surgical programmes. For orthopaedics, the establishment of the Nuffield chair of orthopaedics at the University of Oxford in 1937 was particularly important from an academic perspective.⁹

Of particular importance in defining sports medicine has been its nature as a medical practice. Unlike other specialisms, sports medicine does not lay claim to particular body parts (e.g. dentistry), diseases (e.g. cancer), life events

(e.g. obstetrics), age groups (geriatrics) or functions (e.g. accident and emergency). This is because, as Vanessa Heggie has argued, sports medicine is a holistic practice.¹⁰ Rather than a specialty in which diseases are understood in terms of processes that occur at the cellular level, sports medicine has virtually no unique diseases, treatments or technologies. Instead, sports medicine covers a wide range of interests from the treatment of injuries, to 'Sport for All' – the promotion of sport and exercise for the wellbeing of the population – to the use of and testing for drugs. Definitional difficulties, therefore, stem from the fact that it is a holism, and this has been the central issue in its struggle for recognition as a medical specialty. Any definition has been further complicated because of a 'considerable overlapping of research interests and clinical practice among the different fields'. As a result, sports medics have not been restricted to qualified doctors but have also included amongst others, coaches, trainers, exercise physiologists and psychologists.¹¹ In addition, there has been – and probably still is – a hazy area in knowing where sports medicine ends and where sports science begins, and vice versa. For example, two pioneers in the field, Ernst Jokl and A.V. Hill, have been in receipt of different titles. Jokl, from a physical education and physiology background, has been variously called, 'a pioneer in sports medicine'¹² and the 'father of sports medicine'.¹³ Hill was a Nobel-prize winning physiologist and through his research – mainly using athletes as guinea pigs – he has gained the title of a 'giant in the field of exercise physiology',¹⁴ although his work provided the bedrock for sports science.

The rise of the medical profession

First, it would be beneficial to place the emergence of sports medicine in the history of the professionalization of medicine. Each country has a different tradition, largely framed by its prevailing political culture. While European governments allowed self-regulation of the medical profession this took two main routes. First, those countries, such as France, that exerted tight control over all aspects of social and commercial life were more likely to regulate the medical profession through a bureaucratic regulation system in which the state identifies qualified individuals. Second, where licensed practitioners have no legal monopoly a 'modified free field' exists, usually because *laissez-faire* governments take a more relaxed attitude and are likely to grant the medical profession the right to self-regulation.¹⁵ The second route is more applicable to the UK. In America a professional monopoly arose out of a competitive individualism in which the majority of physicians remained self-employed in the private sector. Moreover, specific legislation governed the operation of physicians in each state rather than on a national basis.¹⁶

In Britain, from the late nineteenth century up to 1914, the medical profession moved from 'the margin to the mainstream of social life' through a growing

professionalization.¹⁷ Roy Porter has shown how ‘medicine used to be atomized, a jumble of patient-doctor transactions. Practitioners were mainly self-employed ... Medicine was traditionally small-scale, disaggregated, restricted and piecemeal in its operations’.¹⁸ The seeds of professionalization were sown first through the 1815 Apothecaries Act and then, more significantly, by the 1858 Medical Registration Act. The 1858 act provided the opportunity to develop the characteristics of a modern profession, although as it has been pointed out, this was an uneven process with some doctors, especially surgeons and physicians, having more power than others i.e., general practitioners.¹⁹ Neither, as Saks has argued, was this process of professionalization ‘objectively derived from the “scientific” or “non-scientific” status of the knowledge involved’. Rather than Western science being based on objective truth, all knowledge is provisional.²⁰ Instead, the process of professionalization is political. Since the 1858 Medical Act the British medical profession has attempted to extend its power and control over medicine more widely through the marginalization and exclusion of what it has deemed are unorthodox and alternative practices, such as osteopathy and homeopathy.²¹ The establishment of specific medical organizations and associations, therefore, has represented attempts by doctors, in particular, to ring-fence their own specialties through the imposition of entry qualifications. Once established, these specialties have the opportunity to gain state recognition and funding. Within sports medicine, however, this particular process has been complicated due to the prominent role of non-medics such as physical educators, trainers, coaches and sports scientists and the difficulty in pinning down a definition.

Gelfand has argued that one recurrent theme throughout the history of the medical profession has been the challenge in defining who is a member and who is not on the basis of three criteria: knowledge, ethics and institutional organization.²² It has been argued ‘that sports medicine is both structurally and culturally distinct from the broader medical profession’, thus highlighting that any process of professionalization is not fixed and has been subject to its own peculiarities.²³ The development of sports medicine in individual countries, therefore, has been dependent on three main factors. First, the prevailing political culture and the extent of state intervention; second, the sporting tradition of each country and the extent of its commercialization; and third, the tradition of sports medicine and to what extent it has been one based on the performance of elite athletes or mass recreation for the entire population.

The institutionalization of sports medicine

Early sports medicine organizations

Definitions of and attitudes to sports medicine have differed from nation to nation and have been dependent on the prevailing political culture. In addition, for

early sports medicine doctors and organizations there was a greater focus on elite athletes rather than populations. Germany played the most prominent role in the initial development of sports medicine as a medical specialism. This was a reflection of the lead Germany had taken during the nineteenth century in medical science that led to thousands of American physicians pursuing postgraduate study in the German-speaking world.²⁴ In 1910 Seigfried Weissbein edited *Hygiene des Sports*, based on a collection of papers presented at a conference of the same title. It included subjects such as the effects of sports activities on organ systems and first aid for common sports injuries. Four years later one of the first comprehensive works on sports injuries, *Die Sportverletzungen*, was published.²⁵ In 1912 the first association of sports physicians had been founded following a Congress of the Scientific Investigation of Sports held at Oberhof. Fifty doctors attended who decided to form a permanent committee for 'the scientific investigation of sports and bodily exercise'. A 'sports laboratory' was also founded at Charlottenburg near Berlin.²⁶

Other continental European countries also began to put down some sports medicine roots. In 1922, for example, the French Society of Sports Medicine published the first sports medicine journal. Sports medicine societies were also founded in the Netherlands (1922), Switzerland (1923), Poland (1937) and Finland (1939). In 1920, at the University of Giessen in Germany, the Institute for the Scientific Research on Physical Exercise was inaugurated under the stewardship of Otto Huntemüller, a professor of hygiene. He was supported by Carl Diem, then the secretary-general of the Committee on Physical Exercise of Germany and a key figure behind Berlin's bid to host the 1936 Olympic Games. One of the university's aims was to create a curriculum for German gym teachers. In 1924 the German Federation of Physicians for the Support of Physical Exercise was co-founded by Huntemüller. By 1932 a sports medicine clinic had been established at Berlin's Charity Hospital under another German leader in this field, Hermann Herxheimer.²⁷

State funding was an important factor – probably the most – in shaping sports medicine traditions. In this sense, like other European countries, sports medicine in Italy – in a professionalized sense – was more developed than in Britain by the 1930s. This was partly a product of how the fascist regime had embraced sport for political ends and contrasted sharply with the voluntary attitudes to sport and sports medicine in Britain. In 1929 the Medical Association of Physical Culture was founded. A year later an Italian Federation of Sports Physicians was established, under the auspices of the Italian Olympic Association (CONI) and comprised Italy's most influential sports doctors. During the 1930s the Italian Federation became very active in sport. They organized scientific and practical courses in sports medicine for general physicians as well as courses for coaches and masseurs. In addition, the holding of national conferences disseminated scientific knowledge. Two of the most influential Italian sports physicians of this era were Giancinto Viola and

Nicola Pende who developed a biometrical evaluation schedule for athletes. The first Italian institute of sports medicine had been founded in 1929 in Bologna. Between 1929 and 1931 – as a forerunner to what later happened in Eastern Europe – its sports doctors had evaluated 2,400 boys and girls as well as 342 competitive athletes to help them choose the sport most appropriate for them. In 1930 CONI established a special hospital for traumatology in Rome to provide treatment for injured sportsmen free of charge. Also in 1930, CONI approved a scheme of the doctors' federation to co-ordinate and control all medical aspects of sport in Italy. Italian sports physicians were fully integrated into the fascist state and few opposed the measure. By 1935 2,000 members had been placed in charge of medical matters within state organizations.²⁸ This investment became evident in the performances of Italian athletes at the 1932 Olympics, where they finished second, and at Berlin in 1936 when they finished third.

The Soviet Union experience and appropriation of sports medicine was also shaped by its political culture. Its state-run system eventually adopted a two-tier system of sports medicine. It was the first country to provide a national public health system and sports medicine through *Fizkul'tura* (see Chapter 1) became part of this health service. However, there had been no sports science heritage in Russia and it was only in 1977 that the government first used the term 'sports medicine' (*sportivnaya meditsina*).²⁹ Instead, as Katzer has argued, sports medicine emerged out of 'Soviet Big Science'. Under Stalin this led to the 'scientification' of all aspects of life with the human body a subject for interdisciplinary study, which combined hygiene, eugenics, biology, medicine and physiology with the planned end product 'the perfect "body Soviet"'. As an independent discipline sports medicine had its roots in this scientific context. By the time the Soviet Union entered the Olympics in 1952 it already had an integrated and highly centralized network of sports medical centres, which drew on the Ministry of Health, the Academy of Medical Science and the State Committee for Bodily Culture and Sport. Sports medicine experts were able to advise athletes and coaches across disciplines due to their scientific knowledge and were also involved in talent spotting.³⁰

International sports medicine organizations

With the growth of international sport from the early twentieth century, sports medicine was also placed on a more international footing. International medical conferences had originally focused on matters of sanitation while the formation in 1863 of the Red Cross was an early example of an international medical body. Moreover, the aftermath of the First World War created a greater desire for international co-operation. The formation of the League of Nations combined a promotion of peace with health initiatives through its subdivision, the Health Organization.³¹ Unsurprisingly, the first international sports

medicine organization was formed at an international gathering of athletes. The establishment of the Association Medico-Sportive Internationale (AIMS) in 1928 took place at the St. Moritz Winter Olympics, providing a forum for collaborative research within sports medicine.

At that year's Summer Games in Amsterdam, the first international AIMS Congress was held and attracted 280 physicians from 20 countries. During the 1928 Olympics, under the direction of Professor Buytendijk, a large team of international physicians and scientists undertook some 'sport-physiological research'.³² A laboratory was provided for testing on participating athletes, leading to the collection of anthropometric, cardiovascular, X-ray and metabolic data.³³ In his report Buytendijk outlined the research's aims:

The purpose of these investigations was to gain a better idea of the state of training of the Olympic competitors, and to trace any disadvantages which might accrue from the exercise of the more strenuous sports. It is needless to say that such investigations were not only of scientific importance, but must also be considered of the greatest significance for the sports world and the medical advisers.

AIMS was renamed the Fédération Internationale de Médecine Sportive (FIMS) five years later.³⁴ The organization grew rapidly and at the 1936 congress, 1,500 physicians from 40 nations attended.³⁵

Following the Second World War FIMS was recognized by the International Olympic Committee in 1952. Sports medicine gained greater credibility in 1960 with recognition from both the World Health Organisation and the International Council of Sport and Physical Education of UNESCO. In 1961 an Olympic Medical Archive was set up to collect clinical and scientific information from elite athletes around the world and used for the purposes of research on health and longevity on populations as a whole. Rather than act as a qualifying body, one of FIMS's main aims has been to stimulate both research findings and the exchange of information among sports medicine practitioners and also to foster co-operation. In addition, sports medicine courses have been set up.³⁶ While FIMS had benefited from post-war internationalization, its influence has diminished in more recent years due to the influence of the IOC Medical Commission and the World Anti-Doping Agency (see Chapter 5) and its main function has been to organize training courses for prospective sports medicine doctors.

American sports medicine and the American College of Sports Medicine

Sports medicine in America evolved out of a different tradition compared to most European countries. Initially, both the lack of a national health system and the country's federal structure constrained a coordinated sports medicine network. The American College of Sports Medicine (ACSM) was founded

in 1954.³⁷ Its reliance first on voluntary contributions and then commercial investments reflected the self-help culture of American civil society. In terms of medicine the ACSM owed its roots to long-standing interests from three different areas: physical education; cardiology and exercise physiology. In Europe it was doctors who led the way and largely excluded other professions from the field. But like other sports medicine practitioners, American interest in the subject was based around the idea of studying the healthy rather than the ill. Research on elite athletes, therefore, had an ulterior motive: it was used to better understand the differences in the capabilities of performance with an eye on the challenge of keeping healthy people healthy and improving the condition of the sick and injured. Because a majority of ACSM founders were members, the American Association for Health, Physical Education and Recreation (AAHPER) played an important role in shaping the future direction of American sports medicine. In America there was less emphasis on physiology and its application to work and the environment. Instead, a common focus for research was on the relationship between physical activity and its health benefits, something which had been reflected in the growing number of departments of physical education in universities. Another area of common research, which provided further impetus for sports medicine in America, concerned the fitness of soldiers. A campaign for teaching physical fitness had been prompted by the rejection of soldiers drafted for the army in the First World War, while wounded soldiers received remedial physical therapy to accelerate their recovery. During the Second World War future ACSM members played significant roles in running programmes for the rehabilitation of convalescing soldiers. Following the war the issue of fitness switched to American children who – in a Cold War climate – were less fit than their European counterparts (see Chapter 1).³⁸

Before the ACSM's formation there were other organizations that had an interest in sports medicine. The National Athletic Trainer's Association (NATA) was formed in 1939.³⁹ The NATA was partly a product of the boom in intercollegiate athletics and a desire for coaches for greater professional representation. Due to the link with universities there was a considerable input from the physical education profession, especially regarding the treatment of injuries through physical therapy. The NATA later developed closer relations with exercise physiologists.⁴⁰

Because of its multi-disciplinism, the ACSM had a federal structure with its three divisions – clinical, scientific and physical education – each having a degree of autonomy. Each elected their own vice-President, with the ACSM's President alternating between each group.⁴¹ In 1962 it adopted the journal, *Sports Medicine and Physical Fitness* as its official organ while seven years later it established a new professional journal, *Medicine and Science in Sports*. In 1963 its membership was 639; by 1976 this had increased to 3,460.⁴² By then physicians composed about half of its membership with the remainder made up of physical educators and sports scientists.⁴³ In 1960 the Secretary-General

of FIMS, Guiseppe La Cava, had commented that European medics were surprised that sports medicine was relatively unknown in the USA when it was widely practiced in countries like Italy and France.⁴⁴ By 2008 it was claimed that the ACSM was the largest sports medicine and exercise science organization in the world with more than 20,000 members.⁴⁵ After attending the 2001 ACSM conference Peter McCrory, then editor of the *BJSM*, not only described it as an eye opener because of its 25 parallel sessions but he also emphasized the gap between America and the rest of the world in terms of clinical sports medicine.⁴⁶ Nevertheless, divisions still existed within sports medicine in the US as it was run by six separate and competing disciplines. In addition, it was only in 1992 that the American Board of Medical Specialties recognized a subspecialty of sports medicine in four different disciplines – family practice, paediatrics, internal medicine and emergency medicine – while it was in 2003 that a sports medicine subspecialty in orthopaedics was recognized.⁴⁷

Sports medicine pioneers

R. Tait McKenzie

An important figure in the history of American sports medicine was actually a Canadian who served in the British Army during the First World War. Robert Tait McKenzie's (c.1870–1938) influence, however, not only linked early thinking on physical training but also provided a line through to mid-twentieth century physical educationalists. One consequence of this lineage was the prominence of the physical education tradition within early American sports medicine. McKenzie was a professor of PE at the University of Pennsylvania in Philadelphia. His approach to exercise had been shaped by the writings of Archibald Maclaren, the Swedish Ling Gymnastics system as well as the use of anthropometry and the pulley-weight machines devised by Dudley Sargent, the PE director at Harvard. McKenzie was also a sculptor who based his pieces – 'The Sprinter' (1902) and 'The Athlete' (1903) – on a perception of the 'ideal physical form', which owed much to the classical Greek tradition. Importantly, the influence of McKenzie revealed the tension in sports medicine between elite sport and physical education.⁴⁸ While he enjoyed sport – at McGill University he had played football and athletics and in 1889 he won the Wicksteed medal for best all-round gymnast – during his medical career he felt that the priority was on improving the health of the general population.

In addition to his work on PE, McKenzie made an important contribution to the rehabilitation of injured soldiers during the 1914–18 conflict while serving as a major in the Royal Army Medical Corps. McKenzie promoted a physical form of rehabilitation, which Wrynn and Mason have argued was his most lasting impact on the medical field. Physical therapies were incorporated into

the overall idea of 'active exercise' such as massage and remedial baths. Group exercises included gymnastics while individual soldiers used exercise machines. Physical therapy techniques for the rehabilitation of soldiers provided an impetus for post-war physical education and physical training programmes in America. As a consequence, argues Wrynn, 'it set the stage for the emergence of a more scientific oriented training of athletes during the 1920s and 1930s'.⁴⁹

Ernst Jokl

One of the most prominent international sports medicine (and sports science) figures was Ernst Jokl (1907–97). Jokl was not only of the eleven founders of the ACSM but he also founded UNESCO's International Council of Sport and Physical Education in 1960 (renamed the International Council of Sport Science and Physical Education in 1982). As John Bale has alluded, Jokl's career is difficult to pin down.⁵⁰ However, through his wide-range of medical interests, publications, conferences and networking, it was marked with a great energy. It also reflected the broad nature of sports medicine itself; how it was difficult to define; how the field was open to a wide-range of specialisms and the difficulties in it becoming a medical specialty. His medical interests veered from exercise physiology to neurology to physical education to aviation medicine and anthropology.

Jokl himself was born in Germany in 1907. He was a good enough athlete to be reserve for Germany in the 400 metres hurdles at the 1928 Olympics. In 1931 he was made director of the Institute of Sports Medicine – probably the first in the world – at the University of Breslau (his hometown). But after the Nazis came to power he was dismissed two years later because he was a Jew and left for South Africa. There he was responsible for starting physical education departments at both the University of Stellenbosch and Witwatersrand Technical College, and was also appointed chief research officer of the National Advisory Council of Physical Education as well as being a PE consultant for the South African Defence Force. It was during his time in South Africa (1933–52) that he came to international attention through his call for boxing to be banned (see Chapter 8).⁵¹ In 1947 F.M. Alexander successfully sued Jokl for defamation of character. Alexander had been credited for the invention of the 'Alexander technique'; a therapy for improving posture. Jokl accused Alexander's supporters of being irrational, neurotic and mentally unstable.⁵² It was the story of the struggle between orthodox and alternative medicine during the twentieth century writ large. In 1952 he moved to the University of Kentucky in Lexington as professor of neurology and sports medicine and spent the rest of his life in America. He later produced a substantial study on that year's Helsinki Olympics, which, rather than a work of science, was a geographical study of world sporting performance. Jokl also became team physician for the United States Olympic Committee.⁵³

British sports medicine and the British Association of Sport and Medicine

In her highly perceptive and critically focused history, Vanessa Heggie has argued that, in terms of specialty formation, sports medicine in Britain has been ‘roughly representative of that in most other countries’.⁵⁴ When sport and exercise medicine was recognized as a specialty in 2005 the UK was one of a few countries to formally do so. However, sports medicine in Britain emerged out of a different tradition compared to other nations. A number of European nations had established sports medicine organizations earlier than Britain, which was probably a product of the European tradition of bodily instruction that stemmed from the legacy of gymnastics. In Britain the games ethic predominated. While sport was seen as healthy in a general sense it also placed an emphasis on the values of character and *esprit du corps*. Moreover, physical education lagged behind other European countries. In 1933 it was noted how PE in England had relied on schools and voluntary organizations, whereas in Germany, Italy, Czechoslovakia and Russia, the state had invested heavily in the physical education of their adolescents. ‘The tension between Britain’s amateur tradition and the desire to emulate the continental dictatorships was one of the most important themes in PE in the 1930s’, Welshman has argued.⁵⁵ Although British pioneers played an important role in its development at an international level, sports medicine at home was carried out on a largely voluntary basis. Of course, this does not mean – as Heggie points out⁵⁶ – that doctors were no less professional in their role but it does highlight how a different political culture can shape the development of a specialty. While some of its European neighbours – despite dubious motivations – benefitted from state funding, sports medicine in Britain, like sport in general, remained largely separate from the state for most of the twentieth century.

Sports medicine’s specialization in Britain can be traced to the formation of the British Association of Sport and Medicine (BASM) in June 1952. An early forerunner to BASM had been the Research Board for the Correlation of Medical Science and Physical Education, which was set up in 1946. This board participated in the Congress on Physical Education during the London Olympics two years later and the actual medical committee for the Games would include future founder members of BASM, Adolphe Abrahams and Arthur Porritt (see below).⁵⁷ Both were also part of the AAA advisory medical panel established in 1950. The post-war period had also seen the formation of more specific sports injuries clinics and ‘athletic advisory’ services both within the NHS and privately. Coinciding with the formation of the NHS, a sports injury clinic was formed at the Middlesex Hospital in 1948.

BASM’s future direction, and sports medicine as a specialty, was determined by a variety of factors. At its outset BASM’s aims were ambitious: to become the authoritative body on every medical aspect of athletics and exercise; to

advise on all the general principles of athletic training and sports-related medical injuries; and to conduct research into sports injuries.⁵⁸ However, compared to the input of physical education in America, in Britain the main focus was on the clinical needs of elite athletes. This outlook was mirrored in its early membership. In BASM, doctors predominated particularly those from a physical medicine and orthopaedic background. Its first executive committee could be described as patrician and paternalistic in its social make-up. While the early executive had an interest in sport, it also represented a form of 'gentlemanly medicine' through its association with elite London hospitals, which dominated the medical profession.

BASM was akin to a pressure group, part of the British voluntary tradition, which sought a voice and influence in political circles. Its original aims also highlighted how BASM aspired to act as both an umbrella and the representative organization for medicine's relationship with sport. This was illustrated in the title of BASM. Rather than 'sports medicine' it was the British Association of Sport *and* Medicine. Promoting 'sports medicine' as a specialty was probably not considered necessary, if it was considered at all. Instead, if the relationship between sport and medicine could be furthered it was to be through the professional cachet and social connections of those early members. Yet acting as an umbrella exposed a weakness that was difficult to rectify, namely that BASM has been a largely representative body rather than a regulatory one: while it could set professional standards it was unable to enforce them within the world of sport. Moreover, because the definition of sports medicine was not fixed it would eventually allow other sports medicine practitioners, particularly physiotherapists and sports scientists, to form their own associations and act in their own professional interests. Writing in 2007, John Lloyd Parry (President of BASEM, 2003–05) could still state that 'Debates about membership of sports medicine organizations continue to plague the discipline'.⁵⁹

During the 1950s BASM operated a restrictive membership policy. It was only open to medical representatives nominated by national sporting bodies and qualified doctors with an interest in sport; scientists with a similar interest were eligible for honorary membership.⁶⁰ There were over 100 members at the time of the first AGM but this had only risen to 130 by 1959. By 1968 an increased and more egalitarian membership of 441 reflected the multi-disciplinarity and complexities of sports medicine. About 45 per cent of its members were either doctors or fellows of the royal colleges. Other groups included those from a physical education background (20 per cent) and physiotherapy (8 per cent). Women made up approximately 10 per cent of the membership. Another group – about 30 per cent – consisted of members with no definable medical background. It also contained important figures from the sporting world including the athletics coaches Geoff Dyson, Ron Pickering, Frank Dick and Wilf Paish. The England team doctors, Neil Phillips and Alan Bass, as well as the FA chairman, Andrew Stephen, who was also

a GP, represented football. Former England manager Walter Winterbottom represented the Central Council of Physical Recreation (CCPR).⁶¹

British sports medicine pioneers

The two most high profile figures in those early days were Adolphe Abrahams (1883–1967) and Arthur Porritt (1904–94). Both would have an important influence not only on British sports medicine but also on its development worldwide. Abrahams, the son of a Lithuanian Jewish immigrant, was the brother of Harold who won the 100 metres final at the 1924 Olympics. A consulting physician, he also served in the Royal Army Medical Corps (RAMC). Adolphe was a useful runner and rower himself at university and his initial foray into sports medicine was as the first honorary doctor for a UK athletics team at the 1912 Olympics; he later acted as the medical officer (MO) at a number of Olympics. Abrahams was a prolific writer on medicine and sport, and in particular was influential in shaping attitudes towards women's sport (see Chapter 7).⁶² As part of the British amateur establishment, he was as much concerned with the moral dangers of sport as its physical ones. Young men, he felt, should keep sport in perspective or they may attain 'a disproportionate sense of value' from it. Instead, except for the professionals, athletics should be 'only an incident in life'.⁶³

Arthur Porritt was born in 1900, the son of a New Zealand GP. In 1923 he went to Oxford as a Rhodes Scholar to study medicine. (He returned to New Zealand as its Governor-General, 1967–72). An all-round sportsman, he competed in the 1924 Olympics where he won a bronze medal in the aforementioned 100 metres.⁶⁴ He was later a member of the IOC. Porritt enjoyed a stellar medical career. He was surgeon to the Royal Family and, uniquely, was elected President of the Royal College of Surgeons (1960–63) and the British Medical Association (1960–61) at the same time. Some of his other interests seem to fit the image of someone who was part of the upper echelons of British civil society. Not only was he the Red Cross commissioner for New Zealand in Britain but he was also a prominent freemason who was appointed Grand Master of the Grand Lodge of New Zealand. Porritt, like Abrahams, had also been part of the amateur elite that ran British sport. He was a member of the Achilles Club and was a vigorous defender of amateurism. He served on the Wolfenden Committee on Sport and despite opposition from other committee members he stated that he would refuse to sign the final report if the abolition of amateurism was recommended.⁶⁵ The amateur ethic was also reflected in his writing on training for athletics and general health, which placed an emphasis on moderation and style. In the 1920s, in combination with Douglas Lowe – another member of the amateur elite – Porritt had argued that 'athletics was a power for the good of mankind' and that 'it must be used to develop the right kind of body governed by the right kind of mind, and embodying the right kind of ideals'.⁶⁶

The changing direction of sports medicine

During the 1970s there was a change in the direction of sports medicine for which the newly formed Sports Council acted as a catalyst. This new direction was a product of first, a leisure boom and second, wider changes in public health (see Chapter 1): the rise of a 'militant healthism'.⁶⁷ The role of exercise and a greater emphasis on individual lifestyles were given higher government priority and was exemplified by the launch of the Sport Council's 'Sport for All' campaign in 1972. There was also a change in the nature of the post-war medical profession. The idea of amateurism came under attack and medicine was less gentlemanly in that sense.⁶⁸ Not only was the profession more meritocratic due to the expansion of the National Health Service but a greater emphasis was also placed on epidemiological research and social survey that promoted a new form of public health.⁶⁹ The formation of the quasi-autonomous Sports Council in 1965⁷⁰ – a recommendation of the 1960 Wolfenden Committee Report⁷¹ – had brought the prospect of state funding for sports medicine organizations in the UK, if only on a limited basis when compared to other European countries. The initial focus of the Sports Council's Research and Statistics Committee was elite sport. One of the first projects to receive a grant was the joint Medical Research Council/BOA project to study the effect of altitude on athletes in preparation for the 1968 Mexico City Olympics.⁷² But in the following decade, in light of the new public health, greater attention was paid to the recreational athlete.

The distribution of Sports Council funding, however, in the preceding years would be caught up in a web of politics that changed the direction of sports medicine specialization, marginalizing BASM, which made it reappraise its overall purpose.⁷³ The role of the Institute of Sports Medicine (ISM) proved particularly problematic.⁷⁴ Formed in 1965, it had been initially intended to act as BASM's academic arm but in 1974 BASM cut its links.⁷⁵ It was claimed that because of this split the ISM was used as an excuse by the Sports Council, stretching into the late 1980s, for not recognizing BASM as 'the' representative sports medicine organization in Britain.⁷⁶

The Sports Council's switch in emphasis materialized in the form of a network of Sports Injuries Clinics. 'Sport for All' now translated into the treatment of 'Sports Injuries for All' rather than for elite athletes. The scheme was short-lived, mainly because of the number of already existing informal clinics, but it did signal a gradual re-definition of the specialty from sports medicine to sport and exercise medicine. This had important consequences for BASM. It was intended for the clinics to be staffed by surgeons rather than sports medicine 'experts'. Of course, at this stage sports medicine was not a specialty due to its very generalized definition and, therefore, sports medicine practitioners, especially those who ran sports injury clinics, and BASM could not claim an expertise. Now, as BASM argued for sports medicine to become a formal

specialty, it promoted a model of new, specialized clinics, staffed by sports medicine specialists, rather than surgeons.⁷⁷ These developments accelerated a shift towards greater recognition of not only sports medicine as a specialty but also redefined the practice. As Heggie has argued, 'Sports medicine was closing ranks; its expertise could no longer be policed and maintained by a gentleman's agreement, an understanding about expertise and experience, it now needed to be proved to outside bodies, and protected from them, with paper certificates and even licenses'.⁷⁸

The fragmentation of sports medicine

As a consequence of this changing political context, attempts to convert sports medicine into a medical specialty became caught up in the micro-politics of BASM during the 1970s and 1980s. During the 1970s the status of sports medicine had actually been given a boost due to government legislation, which had been aimed at raising the status of the general practitioner. Although GPs made up the vast bulk of doctors, in medicine's traditionally strict tripartite structure their status was regarded as inferior to physicians and surgeons. The 1968 Todd Report and the Health Services and Public Health Act from the same year promoted the GP's role and professional status through providing and making compulsory their attendance at postgraduate courses. As many doctors had an interest in sport they chose sports medicine and in 1975 BASM organized its first residential sports medicine course at Loughborough, which was sponsored by FIMS.⁷⁹

Despite the potential for expansion, by the late 1970s BASM experienced a serious fracture over its future direction that revolved around a dispute between two of its most important officials: John G.P. Williams and Peter Sperry.⁸⁰ Williams felt that academic respectability for sports medicine could only come about with a strongly doctor-led organization, and he was keen for BASM to have different categories of membership.⁸¹ Sperry, on the other hand, sympathized with the daily grind of sports medicine practitioners, including physiotherapists.⁸² He wanted BASM to retain both its multi-disciplinary identity and role as an umbrella organization.⁸³ By contrast, Williams was intent on establishing and maintaining high academic standards and was frustrated with practitioners who only dabbled in sports medicine and felt that they thought of BASM as principally a club for ex-sporting doctors who saw no need for a greater recognition of sports medicine.⁸⁴ Sports medicine also began to attract sponsorship, especially from pharmaceutical companies, which increased the commercial possibilities within the discipline. As a result, different medical philosophies within BASM began to emerge with some who believed that only the overuse injuries of Olympic athletes were sports injuries whereas those who treated injuries sustained in contact sport felt that these should be given a higher priority.⁸⁵

These developments provided the background to the formation of the British Association of Trauma in Sport (BATS) in 1980. It was a splinter group within BASM that reflected the growing frustrations of doctors who wanted to push harder for the recognition of sports medicine as a specialty. Like BATS, other splinter groups and disciplines had begun to form their own representative bodies outside the BASM umbrella.⁸⁶ The formation of the Association of Chartered Physiotherapists in Sports Medicine (ACPSM) – affiliated to the Chartered Society of Physiotherapists – in 1972 had signaled the first real split in BASM's attempts to remain as the umbrella organization for sports medicine. Although many would be both members of BASM and the new organization, this society was concerned with the professional credentials of physiotherapists who had only been accepted on the NHS in 1960.

In addition to pressures from the doctors, sports science was gaining an increasing influence within sports politics and further weakened BASM's central role in sports medicine. Sports science articles had made up a considerable proportion of those published in the *British Journal of Sports Medicine* (BJSM). In 1977 and 1984 there were unsuccessful attempts to change BASM's name to the 'British Association of Sports Science and Medicine' to reflect 'the changing nature of sports medicine towards a wider base than clinical medicine' to make it 'representative of wider interests than purely clinical ones'.⁸⁷ In 1984 the sports scientists went their own way and formed the British Association of Sports Sciences.⁸⁸ Later, in 1987 the British Olympic Medical Centre, the first sports science and sports medicine facility in the UK, was opened near Harrow. It catered for elite athletes and was founded by Mark Harries and Craig Sharp who had been a member and on the committee of BASM but described himself as a founder of UK sports science.⁸⁹ While there was much collaboration between medics and scientists within sport, this charitable trust of the British Olympic Association marked another significant moment in the development of sports science as a specialty in itself, and further diminished BASM's position.⁹⁰ Moreover, while the original idea of BASM had been to supply a pool of specialists for elite sport under its aegis, the reality was that elite athletes tended to look for their own solutions and treatments with some using alternative medicine (see Chapter 6). Partly because of this stagnation, BASM's membership fell. In 1984 BASM's membership had numbered 1,375 with doctors making up 47 per cent (644)⁹¹ but dropped to around 800 by 1987.⁹²

From sports medicine to sport and exercise medicine

In 1998, following a series of educational initiatives, an Intercollegiate Academic Board of Sport and Exercise Medicine (IABSEM) was established. This set in chain the process of specialty formation, which led to the approval of specialty status for sport and exercise medicine (SEM) by the Department of Health in 2005. In addition, not only was SEM to treat injuries of those who undertook

physical activity but stress was also placed on injury prevention and encouraging the wellbeing of the general populace through exercise and physical activity.⁹³ In anticipation of the change in sports medicine's direction, BASM changed its name to the British Association of Sport and Exercise Medicine (BASEM) in 1999.⁹⁴ Despite the struggles within BASM, there had been a growing demand amongst doctors for sports medicine qualifications. This need also complemented the boom in the leisure and fitness industry and the growing sales in sports medicine products such as sprays and bandages.

Moreover, the Government was paying ever-closer attention to wider trends in public health, especially obesity, and the virtues of physical activity. As Zweiniger-Bargielowska has shown, these anxieties were not new and had existed since the 1890s when the sedentary lifestyles of the middle classes was cited as a cause for expanding waistlines.⁹⁵ Over one hundred years later, a report, *Forecasting Obesity to 2010*, predicted an obesity epidemic.⁹⁶ In 2006 the Parliamentary Health Select Committee estimated that the full cost of obesity and overweight people to the NHS was £7 billion per year.⁹⁷ Set against this increasing awareness of obesity, there has been a trend against participation in sport.⁹⁸

An early qualification in sports medicine had been the London Hospital diploma established in 1981. Many of the GPs who took this diploma then went on to undertake other courses. These included the Society of Apothecaries' diploma in sports medicine, which was established in 1989. Another diploma was offered by the Scottish Royal Colleges Board for Sports Medicine. This board had been set up in 1986 mainly through the efforts of Donald McLeod (President of BASM/BASEM, 1995–2002) and gave the discipline greater credibility.⁹⁹ At first these courses only catered for a relatively small number of sports medicine specialists. Higher degrees in sports medicine later became available at Nottingham and Glasgow. In 1994 the Royal Society of Medicine's sports medicine section was established with Roger Bannister as the first president. By 2005 there were eight Master degrees being offered in sport and exercise medicine. Educational developments led to the emergence of two distinct groups: first, those practitioners working in the NHS and who had an interest in sports medicine; and second, those, especially doctors, who worked privately in sports medicine, had their own clinics and whose sole source of income was the discipline. Accompanying BASM's name change to incorporate exercise medicine, there were also changes in membership regulations. Now only doctors could have full membership rights while, unless they were already full members, those from the allied professions were offered only associate membership whereas previously they had enjoyed equal rights with doctors.¹⁰⁰

Despite the membership changes in favour of doctors there continued to be tensions amongst this group. In 2001 there were 760 members of BASEM with 517 doctors (approximately 65 per cent of the membership), physiotherapists numbered 123 (16 per cent) with the rest comprising sports

scientists, chiropodists, educators, osteopaths (who had been banned 30 years previously), dental and veterinary surgeons and students.¹⁰¹ For those sports medicine doctors working in the private sector, the lack of specialist recognition caused problems over insurance. Because of government legislation, to qualify as a consultant a new specialist qualification – Certificates of Completion of Specialist Training (CCSTs) – had been introduced as a mandatory requirement from 1997. Insurance companies, like BUPA and PPP, now required that doctors work six years full-time to gain this recognition (or ten years part-time). Norwich Union would not accept anyone working in sports medicine or in musculoskeletal medicine, which threatened the financial future of those working in this area.¹⁰²

The medical care of elite athletes was now firmly the responsibility of the governing bodies of sport and backed up by UK Sport. In this sense, BASEM had little input bar its representation on various committees. With a growing emphasis on promoting exercise for the population, the change to ‘sport and exercise medicine’ seemed inevitable. The scientific scope of sports medicine was also changing and now extended to other specialties such as cardiology, respiratory medicine, gynaecology, rheumatology and neurology. Moreover, there were growing calls for the use of evidence-based medicine in research to further improve the status of sports medicine within the medical profession as well as with sporting bodies.¹⁰³ Nevertheless, the shift towards sport and exercise medicine had marked how sports medicine had evolved from a largely voluntary activity pursued by doctors who had an interest in sport to a specialty that was now under state control with a clear career path for highly trained professionals.

Sports medicine practitioner: the football club doctor

Some of the first sports medicine practitioners were football club doctors.¹⁰⁴ Doctors and others such as coaches, trainers and physiotherapists (see Chapter 6) were practicing sports medicine long before attempts were made to specialize the practice. Most of these practitioners did not contribute directly to this process. Instead, the role of the club doctor in British football highlights how much of sports medicine has developed outside of any institutional framework.

The role of the football club doctor emerged from a culture of voluntarism that was a feature of Victorian society. Most football doctors were general practitioners (GPs). After the 1858 Medical Act they found that their role had been diminished within orthodox medicine’s tripartite division of physicians, surgeons and GPs.¹⁰⁵ It reflected more generally how the middle classes were not a monolithic entity but subject to fragmentation. During the first half of the nineteenth century GPs (aka apothecaries) had been denigrated for their

association with the drug trade and their low social origins.¹⁰⁶ Moreover, it seems that the economic struggle associated with general practice meant that many GPs were themselves in poor health during the nineteenth century.¹⁰⁷ Doctors though shared a growing middle-class propensity for joining associations, and becoming a football club medical officer was part of this urban civic process.

The process leading to the appointment of football club doctors has traditionally been informal and held little financial reward. For some doctors sport raised medical questions and interest. Following a head injury playing rugby, Neil Phillips questioned why his neurosurgeon forbade him from ever playing the game again when some years afterwards he started to play once more.¹⁰⁸ Ian Adams developed an interest in soft tissue injuries during his national service in the Paratroops because of the similar type of injuries sustained in both sport and parachute jumping.¹⁰⁹ Many clubs enjoyed long-term associations with their doctors as well as a particular practice. For some doctors the job held the potential for social climbing. Andrew Stephen, a Scot, became a club doctor at his local club, Sheffield Wednesday, just after the war when the senior partner in his practice, and the club's previous MO, had been made a club director. In 1949 Stephen himself became a club director and in 1955 its chairman. He claimed that he had 'drifted into football rather by accident than by intention' but subsequently became chairman of the FA (1967–73).¹¹⁰

From the 1960s there was a gradual change in the role of the football club doctor due to attempts to improve medical care within football. In 1961–62 the Football Association held a series of regional conferences of Football League club doctors. It culminated in a brief report that included some recommendations for future practice. Furthermore, in 1963 Alan Bass was appointed the first team doctor for the England national team, and medical appointments were made at under-23 and youth team level. Meetings of club doctors also took place but little seems to have come from them. In 1976 it was commented that the FA had 'little control of the medical credentials of those who move to the aid of most players injured on football pitches',¹¹¹ and, as we have seen in the previous chapter, it was not until 1980 that the FA had established a medical committee. While doctors were professionals with a general background in medicine, there was little or no systematic training for this position. Both Stuart Carne of Queen's Park Rangers and Barrie Smith of Aston Villa commented that 'by and large one learns on the job'.¹¹²

The demands of the job differed from club to club. Most of the early club doctor's work took place during the week. West Bromwich Albion's Issac Pitt, for example, would usually hold a weekly clinic with injured players, report their state of fitness to the board and sometimes accompany them on visits to specialists.¹¹³ One doctor currently working part-time for a medium-sized Midlands' club is present at the training ground for two hours 3–4 times per week, plus 'as and when needed'.¹¹⁴ He would also cover all home games for

the first team and the reserves. Moreover, as very few medical officers traveled to away games the home team doctor would deal with the medical problems of both teams.¹¹⁵ During the 1970s Leeds United's doctor, Ian Adams, would go in five days a week for about 45 minutes. In addition to covering all first and second team games, he traveled with the team for European games. He was only able to do this, he said, because he had very understanding practice partners.¹¹⁶ During the period they shared the job at Aston Villa, David Targett and Barrie Smith had busy full-time jobs in general and hospital practice respectively. It was not possible for both to attend the training ground on a regular basis and so they split the responsibility.¹¹⁷ It has been a complaint by some doctors who have an honorary position that clubs have still demanded 24-hour attention. The few club doctors employed on a full-time basis are on call around the clock; they travel everywhere with the team and attend all the matches.¹¹⁸

For much of the time the job, even on match days, was relatively routine. Stuart Carne has described how he and other medical practitioners would sometimes discuss local medical politics during dull games.¹¹⁹ At times, however, it could be uncomfortable. John Rowlands, a GP from Formby, said that on one of the few occasions he deputized as a club doctor – it was a legal requirement post-Hillsborough for a doctor to be in attendance two hours before kick-off otherwise the match could not proceed – he ‘just didn’t feel on top of the situation’. For one match at Macclesfield (where Chester City then played) there was a spate of major injuries; a broken ankle, a broken cheekbone and a player split his head open requiring stitches. At his next match there he was faced with the potential of a major crush in the crowd, and ‘felt that the whole thing was not right, and not organized, and a disaster waiting to happen’. Rowlands had made a round trip of 160 miles, used up his half-day off, the club had denied him a free ticket for a friend, and then offered him a paltry £5 for expenses.¹²⁰

In 1989 the FA established a Medical Education Centre, located at Lilleshall in Shropshire.¹²¹ According to its head, Alan Hodson, there remained resistance to the development of sports medicine in British football when compared to foreign competitors.¹²² Nevertheless, from 1990 the FA began to run sports medicine conferences. One was organized with the Royal College of Surgeons in Edinburgh, comprising surgeons, doctors and physiotherapists. Another two annual meetings were directed at those specifically in football.¹²³ After the Hillsborough Disaster in 1989 the FA also ran courses for crowd doctors. A number of club doctors, such as Mike Stone at Manchester United and Arsenal's John Crane, gained the sports medicine diploma through the Scottish colleges, highlighting the growing specialization of the role.

It is likely that more football clubs will appoint doctors on a full-time basis. Moreover, the threat of litigation will perhaps force football club doctors to obtain a sports medicine qualification in future as medical defence unions may have issues about supporting them if they do not.¹²⁴ Nevertheless, the

professional soccer market for sports medicine qualified doctors remains a very narrow one. A few doctors have combined work as a club MO with running sports injury clinics available to the general public.¹²⁵ However, it is unlikely that most GPs would give up their lucrative practices to specialize.¹²⁶

Conclusion

The development of sports medicine, as a specialism, over the twentieth century can also point to wider trends within medicine, health and the role of the state. First, the demand for sports medical services has been largely commensurate with both the intensification and internationalization of sporting competition. Whether for commercial reward or national prestige, sports medicine was regarded as a vital component to achieving these goals. Second, sports medicine's growth was also a product of the spread of welfarist ideas concerning public health. Physical education gained a greater importance and exercise was seen as a cheap form of preventive medicine. Third, partly because of this growing demand, the function of sports medicine was constantly redefined. Not unlike how other specialisms have developed, particularly in Britain, sports medicine was subject to medical politics that altered its original purpose. While sports science took care of the performance of elite athletes, recreational athletes became the responsibility for sports medicine in the shape of sport and exercise medicine. This scenario, where the elite-recreational athlete split was devolved, to a certain extent, was played out in most countries albeit subject to a different political culture. Because of its constantly changing nature, it further underlines Heggie's argument that sports medicine is a holistic practice. Finally, the growth of sports medicine also reflected the growth in the consumerism of medicine, especially in America where 'fitness' has become a cult and a business.¹²⁷ This in itself has highlighted prevailing discourse, and its construction, around the whole question of health. As Roy Porter argued, immense pressures had been created by a combination of interested parties – the medical profession, medi-business, the media and the advertising of pharmaceutical companies – and as a consequence, doctors and patients become locked into a scenario where everyone has something wrong with them.¹²⁸