

As the end of the year 2008 draws near I am reminded of Stevens the faithful servant in "The Remains of the Day" who narrates in the first person his reflections of the past. There have been sensational 2008 sporting achievements by Team GB in the Beijing Olympic/Paralympic games, Lewis Hamilton in Formula 1 car racing and Manchester United in being crowned European football champions to mention but a few. FSEM (UK) has also had a successful year and the objective of this Newsletter is to inform you of the progress that has been made, and introduce you to the future plans for 2009 and beyond.

The Annual General Meeting of FSEM (UK) was held on Thursday 11th September 2008 in Edinburgh at the Royal College of Surgeons. The main topics of discussion revolved around PMETB and CESR applications and concerns over failure of SEM applicants. The Council of FSEM (UK) is actively pursuing these issues with PMETB and hopes it will consider applications under article 14 as there was no CCT in SEM at the time that current practitioners undertook their training and gained their experience. Thank you for the active participation and response to the questionnaires concerning PMETB/Article 14 applications and Manpower in SEM. Kindly note that at next years' AGM which will be held at the Royal College of Physicians, London on Thursday 10th September 2009, there will also be an SEM Update Conference for which CPD will be available in the morning before the AGM.

The Admissions Ceremony of Fellows and Members was very well attended as



was the convivial Annual Faculty Dinner held in the magnificent surroundings of the Royal College of Surgeons in Edinburgh. Council Members sported the Faculty's new gowns! (see Council photograph back page). The recipient of the Macleod medal was Mr Ali Sher Bajwa who achieved the highest mark in all the diploma examinations of the diets held in 2007. FSEM (UK) also bestowed Honorary Fellowships to outstanding individuals – Dr Malcolm Bottomley, Mr James RC Foster, Professor Timothy D Noakes (first overseas Honorary Fellow), and Dr Dan

Tunstall Pedoe (in absentia). The respective citations are included in this Newsletter. The annual address delivered by Professor Noakes was exceptional with scientific, historic, sporting, psychological, and philosophical aspects interwoven to produce a

truly inspirational message. This is included in the Newsletter for your perusal and I am sure it will be well received by the readership.

The new FSEM (UK) office accommodation at Hill Square, kindly made available by the Royal College of Surgeons of Edinburgh was formerly opened by the President Professor Charles Galasko the following day (12th September 2008) with Council members in attendance. This provides a welcome change to the Faculty's secretariat which has also expanded



with the recruitment of Rita Capaldi on a part-time basis to aid Yvonne Gilbert's ever increasing tasks. To aid the communication process it is the Faculty's policy to send mail electronically whenever possible. Currently the Newsletter is sent to you in paper format but it too will in future be sent electronically. It is vital that any changes to your e-mail address are notified to the Faculty's secretary.

There are three requests for which we need your support. Firstly kindly ensure that you provide us with your current e-mail address if you haven't done so in the past. The full list of Fellows and Members of FSEM (UK) is not included in this Newsletter. The list up to October 2008 is found on the Faculty's website as long as permission was received by the secretariat from the respective Fellows and Members. Secondly, as you know the Lord Lyons Office is considering the Faculty's Coat of Arms, and we would welcome any suggestions particularly with regard to the motto that should accompany it. Thirdly you will find a well crafted and clear outline in the Newsletter on "*The role of the Specialist in Sport and Exercise Medicine*" compiled by Dr Richard Budgett. This is an important document and feedback is invited and welcomed.

In the summer of 2008 we celebrated the 60th anniversary of the NHS and received "*The Next Stage*" – Lord Darzi review, an 80 page document which does not make easy reading for those unfamiliar with management speak. The key points in the proposals revolve around a commitment to measuring and rewarding quality (*see interview with Sir Bruce Keogh in BMJ June 28th; 336; 1464-5 the NHS Medical Director*) clinical outcomes, patient directed assessment, financial and non financial incentives to achieve high standards and holding commissioners directly accountable for the health outcomes in the populations they serve. In addition there is the creation of Medical Education England (MEE) as a regulatory body for medical education and a drive to promoting doctors in helping to develop their core skills in producing leadership in the NHS. In his column the President provides guidance on how the Fellows and Members can help FSEM's cause in this respect.

The Licence to Practice document produced in November 2008 by the GMC "*Licensing and you; information for registered doctors*" is a must-read as this is the first step to revalidation. This is found on the GMC website [www.gmc-uk.org](http://www.gmc-uk.org) Although no one seems to have all the answers yet on how to conduct revalidation, relicensing (to remain practicing as a doctor) and recertification (to stay on the specialist register) seem to be agreed main components of the process. The GMC sets the rules and methods for relicensing and agrees "standards for recertification" set by Colleges, Faculties and the Academy. Dr Rod Jacques has produced "*CPD guidance for doctors undertaking FSEM (UK) appraisal*" which is included

in this Newsletter, while Professor Angus Wallace outlines the current and future picture of FSEM's Appraisal process. Related to these matters is the issue of indemnity and I would urge you to read carefully the President's recommendations in his column.

Elections were held for three posts on Council and I am pleased to announce that Mr Michael Allen, Professor Michael Cullen and Dr Simon Till have joined Council. Mr James (Jim) Foster (immediate past CEO of RCS Edinburgh) has also joined Council as the lay representative.

At the same time as this Newsletter goes to the printers, the FSEM (UK) Council is taking time out at a Strategy Seminar on the 18th/19th December organised with the specific focus of defining and outlining in a professional manner its future strategy. Highlights and emerging directions from this meeting will form a component in next year's Newsletter.

I hope you enjoy reading the contents of this Newsletter. I am grateful to all the contributors who have taken time to support it and in particular Yvonne Gilbert and Rita Capaldi in supporting me in my role as Honorary Secretary. I sincerely hope that after reading it you will not agree with Henry David Thoreau's quote "*To a philosopher all news, as it is called, is gossip, and they who edit it and read it are old women over their tea*". On behalf of the President and Council of FSEM (UK) I wish you a Merry Christmas and prosperous New Year.

**Victor Cassar-Pullicino**  
**Honorary Secretary of FSEM (UK)**

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## PRESIDENT'S COLUMN

Professor Charles S B Galasko



### Standing Orders

Our standing orders have now been accepted and the Faculty is fully constituted.

The objectives of the Faculty as outlined in the standing orders include:

- To promote for the public benefit the advancement of education and knowledge in the field of Sport & Exercise Medicine (SEM).
- Establish a career pathway or pathways in SEM.
- To develop and maintain for the public benefit the good practice of SEM by ensuring the highest professional standards of competence and ethical integrity.
- To promote as an authoritative body for the purpose of consultation in matters of professional, education or public interest concerning SEM.
- To advance the science of SEM.
- To establish the standards and competencies required for entry onto the Specialist Register in the field of SEM.

### President Elect

Professor Mark Batt has been elected as President Elect of the Faculty. He is currently Vice President. He will take up his new post in September and will become President in September 2009 at the Council meeting after the Annual Diplomates Day and Faculty dinner. Professor Batt has worked extremely hard to help develop the Specialty and Faculty and I want to congratulate him on his election.

### Honorary Secretary

Victor Cassar-Pullicino has been re-elected as Honorary Secretary for 2008-2012. He also has contributed significantly to the development of Sport and Exercise Medicine and the Faculty and I would like to congratulate him.

### Council

There have been several changes in the Council during the past year:

1. Professor Alan Maryon-Davis, who was the representative of the Faculty of Public Health resigned from council when he was elected President of the Faculty of Public Health and has been replaced as the Faculty of Public Health's representative by Dr Jacky Spiby.
2. Dr Simon Sheard has been replaced by Dr Les Odiseng as the Representative of the Faculty of Occupational Medicine.
3. Dr Carrie MacEwen has resigned as Chairman of the Examinations Committee following her election as Vice President of the Royal College of

Ophthalmology. Dr MacEwen will remain on Council as the Representative of the Royal College of Ophthalmology.

4. Dr Tom Beattie has been elected as the new Chairman of the Examinations Committee and joins Council.
5. Dr Jane Dunbar has been elected as Vice President of the Examinations Committee.
6. In September Dr Roger Evans will be replaced by Dr Christopher Brooks as the Representative of the College of Emergency Medicine.
7. Professor John Fairclough has joined Council as Chairman of the External Affairs Committee, Dr Richard Seah has joined as the FSEM Trainee Representative and Professor David Patterson has joined as Chairman of ISEM which has come into the Faculty as its Research Arm.

I want to thank all the departing Members of council for all their help, support and work they have done to help create the Faculty and the Specialty and, in particular, Dr MacEwen who has done an outstanding job as Chairman of the Examinations Committee in maintaining and improving the Diploma Examination which is becoming increasingly recognised internationally as the major examination in sport and exercise medicine.

Mr Michael Allen, Professor Michael Cullen and Dr Simon Till have been elected to Council for the period 2008-2012. I want to congratulate them and thank all who stood for election as well as those Fellows and Members who voted. They are your representatives on Council.

### Fellowship & Membership

As the Faculty has now been fully recognised we are no longer able to accept applications for Foundation Fellowship or Membership.

We have 212 Foundation Fellows including 12 Senior Fellows and 307 Foundation Members, including one Senior Member.

Membership is granted to Doctors who have passed the Diploma Examination in Sport & Exercise Medicine (UK) and have satisfactorily completed two years of Registrar training in SEM.

Fellowship is awarded to Doctors who have obtained a CCT in Sport & Exercise Medicine and/or are on the Specialist Register.

Application can still be made for Membership by election or Fellowship by election.

A medically qualified Practitioner may be admitted as a Member by election provided that the Council is satisfied that the individual's training and qualifications are equivalent to that required for Membership of the Faculty.

A medically qualified Practitioner may be considered

for admission as a Fellow by election providing that the FSEM(UK) Council is satisfied that he/she meets one of the following criteria:

- Completed a Specialist training program in SEM and been awarded a Certificate of Completion of Training (CCT) by PMETB.
- Successfully completed an application for a Certificate of Eligibility for the Specialist Register (CESR) by PMETB.
- Demonstrate a significant contribution to the development and/or delivery of SEM, either in the UK or abroad.

Details are available on request from the office.

#### **Office Accommodation**

The Royal College of Surgeons of Edinburgh has generously bought and converted a flat in Hill Square as our office accommodation. The Faculty has recently moved in and the first committee meeting held in our new offices was in July 2007. The offices were formally opened on Friday 12 September.

Rita Capaldi has joined the Faculty's secretariat and is working part-time.

#### **Honorary Fellows**

Council has elected four new Honorary Fellows making a total of eight. The new Honorary Fellows are:

Dr Malcolm Bottomley  
Mr Jim Foster  
Professor Timothy Noakes  
Dr Dan Tunstall Pedoe

#### **Education & Curriculum**

Sport & Exercise Medicine is not currently part of the Undergraduate curriculum although different aspects of the Specialty are covered in different parts of the curriculum.

Many Undergraduate students are interested in the Specialty and are looking for electives. Any Fellow or Member or group of Fellows or Members who feel that they could accommodate a medical student during his/her elective period are asked to contact the office. The future of the Specialty is dependent on attracting the best Medical Students and providing attractive electives is one of the most important ways of helping the Specialty develop.

Students at several Universities are also interested in creating Sports & Exercise Medicine Societies and the Liverpool University Undergraduates ran a very successful meeting in March 2008 attended by over 200 medical students from around the Country. Peter Orton and Chris Pritchard are to be congratulated on running such a successful meeting.

Any help that Fellows and Members can give their local Medical School in developing such societies will be greatly appreciated.

Our curriculum for Higher Specialist training has

been very successful and is now being used by a number of Countries as the template for developing Specialist training in SEM in their Country.

The Registrar program has continued to expand. There are now four rotations in London, two in Oxford, two in East Midlands and Trent, one in Yorkshire and South Humberside, one due to start soon in Merseyside and two due to start soon in the North West, in addition to the training program in the Armed Services. Not all the programs are funded to continue year on year. By demonstrating the benefits of SEM to the NHS, Fellows and Members can help persuade Strategic Health Authorities, PCTs and Post-Graduate Deans of the value of SEM, of investing in Registrar posts and of investing in Consultant Posts.

#### **Appraisal & Revalidation**

The Faculty continues to offer appraisal for those Doctors who are working outside the NHS and are not able to be appraised elsewhere. This year will see our first course on training Appraisers, which was rapidly over booked and future courses will be held next year. The revalidation committee will keep Fellows and Members appraised of the developments in revalidation, re-licensing and re-certification as they occur. Council has also discussed the requirements for continuing professional development. These will be posted on the website. Doctors who spend part of their time in sport and exercise medicine are expected to devote a proportional amount of their continuing professional development to sport and exercise medicine.

#### **Lord Darzi report**

The recent report from Lord Darzi and the preceding reports from the Strategic Health Authorities all emphasize physical activity as part of the strategy to stay healthy and improve health. However, these initiatives will fail without investment in sport and exercise medicine. The role of the Specialist in sport and exercise medicine includes:

1. Providing a musculoskeletal service for the management of soft tissue injuries as well as sports specific injuries. The greater the number of individuals undertaking physical activity, the greater will be the resultant number of soft tissue injuries. Already, there are inadequate facilities in the NHS to deal with such injuries resulting in delayed treatment, chronicity, more prolonged treatment, more time off work and increased permanent morbidity. Without investment in sport and exercise medicine these problems will increase. For example, around one in five non-fatal unintentional injuries in children result from sport or recreational activities and almost one third occur in places used for sport, play or recreation (Kirkwood and Pollock, BMJ Editorial, 21 June 2008).
2. The rehabilitation of both able and disabled sports

men, women and children to speed recovery from injury.

3. Leading a specialist team to deliver exercise programs for at risk and specialised groups (especially those with combined musculoskeletal and medical problems). There recently has been correspondence in BMA News indicating the lack of availability for advice regarding exercise to patients with co-existing medical problems.
4. Reducing the incidence of fragility fractures. Appropriate exercise in the at risk elderly population helps reduce the incidence of falls and the resultant fragility fractures.
5. Leading the delivery of programs to promote healthy living and exercise using a specialist knowledge of exercise physiology, nutrition and the effects of different exercise, working with public health, primary care teams and other agencies.

Many groups will be looking at providing facilities for treating soft tissue injuries and encouraging participation in physical activity. These are likely to include the more enlightened Foundation Trusts, PCTs, General Practitioner groups and Strategic Health Authorities. Fellows and Members are encouraged to discuss the benefits of investing in Sport & Exercise Medicine with the Chief Executive Officer, Strategic Officer or Commissioners of these Organisations. Some of the more enlightened Local Authorities are also likely to be involved in the wellness agenda and you are also encouraged to discuss the benefits of sport and exercise medicine with your Local Authority.

### **Manpower**

415 Fellows and Members completed the questionnaire. I am grateful to all who did so.

The results show that there are a total of 371 NHS sessions in sport and exercise medicine across the UK. This is the equivalent of one doctor practicing sport and exercise medicine per 1.62 million population.

### **Indemnity**

There have been many queries about indemnity. I have been in contact with the Medical Protection Society, Medical Defence Union and Medical Defence Union of Scotland. The Faculty has prepared an information sheet which has been circulated to all Fellows and Members and is available on the web. The position is likely to change and, therefore, the current position paper may rapidly become out of date. Because of this Clinicians are advised to ensure that their indemnity provider is fully aware of their commitments and, if your commitments change in any way, you need to discuss them with your indemnity provider before starting the new commitment. This includes advising them in good time on every occasion you accompany a team abroad as Team Doctor.

Secondly, some Providers will not provide indemnity for Doctors working for Premier Football Clubs. This does not only involve Club Doctors but involves all Doctors who may treat a Premier Football Club footballer; if the Doctor has any contractual arrangement with the Club, for example the footballer has been referred by a non-medical member of the Club e.g. Coach, Manager etc or the bill is sent direct to the Club and not to the player, irrespective of who pays the bill. If you treat a Premier League footballer you are advised to check your indemnity with your indemnity Provider before starting any treatment. If a Premier League footballer is seen in the NHS, for example as an emergency, the treating Doctors will be covered through Crown Indemnity.

### **Conclusion**

The Faculty and the Specialty have had a very successful year but we have a long way to go and help is required from Fellows and Members if the Specialty is to continue to thrive and develop.

### **PRESIDENT ELECT**

#### **Professor Mark Batt**

Professor Mark Batt has been elected as President Elect as from September 2008 and will take over the Presidency from Professor Galasko in September 2009.



Prof Mark Batt is a Consultant in Sport and Exercise Medicine at The Centre for Sports Medicine, Nottingham University Hospitals NHS Trust. He has a busy NHS practice and is a Fellow at The NHS Institute for Innovation and Improvement.

He graduated from Cambridge University Medical School in 1984 and trained in Family Medicine. He obtained a Diploma in Sports Medicine from the University of London in 1991 and completed a fellowship in Sports Medicine at the University of California, Davis (UCD) in 1993. The next two years were spent as a faculty member in Family Medicine at UCD and as a team physician at the University of California, Berkeley.

Since 1995, he has been in Nottingham as a Consultant/Senior Lecturer in Sport and Exercise Medicine at the Nottingham University Hospitals: appointed Special Professor in 2004. He has recently finished 2½ years as clinical director for Trauma and Orthopaedics. He is The Q-Active programme director – a 3 year workplace health and wellness programme based at The Queens Medical Centre – [www.qactive.co.uk](http://www.qactive.co.uk)

He serves or served as a consultant for The England and Wales Cricket Board, The Rugby Football League,

British Gymnastics, The English Institute of Sport, The Wimbledon Tennis Championships and the ATP/WTA.

He is Vice-Chairman and President-Elect of the Faculty of Sport and Exercise Medicine and past Chairman of the Specialist Advisory Committee in SEM. He chaired the work-group which produced the successful case for SEM as a specialty of medicine (2005).

His research interests include: Overuse injuries, particularly groin, low back, lower leg pain (shin splints and stress fractures), tendon disease Workplace Wellness.

He is married with two children. He enjoys a variety of sports, outdoor pursuits and gardening, none of which he does tremendously well!

## **SPECIALIST ADVISORY COMMITTEE (SAC)**

**Professor Michael Cullen**

A Specialist Advisory Committee (SAC) has a statutory responsibility to ensure that a training post's educational facilities and training environment are of a sufficiently high standard to allow trainees

to achieve their educational goals and successfully complete a period of higher specialist training, leading to the award of a Certificate of Completion of Training (CCT). Progression to a CCT is dependant on trainees achieving a satisfactory Annual Review of Competence Progression (ARCP – formally the RITA process) and it is the SAC's role to ensure that all training programmes are of sufficient quality to guarantee delivery of the complete four year SEM curriculum to the required standard. To this end the SAC is currently developing guidelines for individual components of the training programme to ensure consistency across all regions. The curriculum is due for review by PMETB in 2010 and the SAC will be monitoring the implementation of current programmes so that any adjustments we propose to the curriculum will result in an improved training experience.

In addition to it's role in approving training programmes and monitoring the quality of training, SAC members are involved in various cross-specialty JRCPTB committees and initiatives, including the development of assessment tools and the e-portfolio for trainees. These activities are extremely important in ensuring that our programmes remain equivalent to those of other larger and longer established medical specialties. The chairman or deputy is also asked to sit on The Academy of Medical Royal Colleges' Training Committee.



The SAC for Sport and Exercise Medicine is comprised of the regional Chairs of Specialist Training Committees (STC), representatives from the Faculty (President) and parent colleges, representatives from the Department of Health, the Lead Dean for the specialty (Prof David Sowden), a trainee representative and a lay member. The SAC is supported by the Joint Royal Colleges of Physicians Training Board who provide invaluable advice and guidance in addition to administrative back up.

There are currently eighteen trainees in SEM – thirteen in the London deanery, two in East Midlands/Trent, one in North-East and two within the MoD. Of the thirteen trainees in London, three are at ST3 level and will complete the four year training programme to achieve a CCT in 2011, while the others are undertaking 'top-up' training with a view to applying via the CESR route for direct entry onto the Specialist Register. From August 2008 we will have an additional nine trainees commence at ST3 level – four in London, two in Oxford, one in South Yorkshire/Humberside, one in North East and one in the MoD. In addition to this programme approval has recently been granted to both the North West and Mersey Deaneries and it is expected that these regions will begin training in February 2009. Further regions, including Northern Ireland, anticipate commencing training in August 2009.

There are two major areas of concern for the SAC. Firstly, is the lack of recurrent funding for trainees in SEM. Those in post currently are in the most part supported by non-recurrent DH monies. In the future funding for SEM training will have to be found within existing deanery budgets. Secondly, is the lack of provision of NHS jobs for SEM doctors on completion of training. We are continually lobbying the Department of Health representatives on our committee on these matter and remain optimistic that funding and job opportunities will develop over the next few years.

The curriculum ensures that our trainees develop a broad range of expertise and clinical skills which will prove invaluable in a changing healthcare climate where the importance of physical activity is being increasingly acknowledged in both health promotion and disease management. We believe that future employment prospects for our trainees are good and are confident that SEM will emerge as an integral component of the NHS system.

## TREASURER'S REPORT

Professor Peter Helms

2007/08 has been an eventful and encouraging year for the Faculty. The move from a single room in the Royal College of Surgeons, Edinburgh to our splendid new base in Hill Square brings many advantages and reflects the growth of our responsibilities and our status, albeit with additional demands on our financial resources. We are very grateful to the Royal College of Surgeons of Edinburgh for refurbishing our present accommodation and making this available on very competitive terms. In order to deal with our increasing activities and responsibilities Rita Capaldi has joined our Faculty manager Yvonne Gilbert, in supporting our ever increasing administrative workload.

Having held our annual retention fee for Members and Fellows for the past 2 years Faculty Council has proposed that in future, fees should increase annually in line with inflation. Members and fellows are also reminded that in line with all Royal colleges and Faculties annual subscriptions should be tax allowable. Fellows and Members should quote on their tax forms annual subscriptions for the Faculty of Sport and Exercise Medicine, Royal College of Surgeons of Edinburgh.

Our Diploma Examination fees are also to be increased annually in order to reflect their full economic costs. Other essential expenditures including appraisal, inspection of training programmes and posts, and the support of Council and its constituent committees. Our accounts are audited by the Finance Department of the Royal College of Surgeons and we are currently in process of changing our accounting year from the financial year April to March to the calendar year. We are also in process of adopting a cost centre model in order to clearly identify costs associated with our various activities and to develop annualised budgets. Cost centres will reflect our current responsibilities and committee structure, including appraisal and appeals, communication, education, examinations, research and development, and training.

The Faculty has also established a high-interest bearing reserve account in order to ensure that it could continue to operate in any financial climate and to ensure that it has adequate contingency funds for unexpected capital outlays. The Faculty is in secure financial health and for this has to thank the continuing support of our Fellows and Members.



## EXAMINATION COMMITTEE

Dr Carrie MacEwen

The Exams Committee continues to develop the Diploma in Sport and Exercise Medicine in order to ensure that this exam is valid and reliable.

The examination syllabus has been completed. This reflects the curriculum and provides guidance to candidates to ensure that they are adequately prepared to sit and hopefully pass the exam. The structure of the exam is based on a blueprint which ensures that as many areas of the syllabus as possible are covered while at the same time reducing any possibility of duplication.

From the beginning of 2009 the exam structure will change in order that the objectivity of the assessment is improved. The written paper (Part 1) will consist of multiple choice questions and extended matching item questions and the clinical exam (Part 2) will consist of 12 stations of ten minutes each in duration. These stations consist of clinical scenarios which include patients/actors and direct one to one interaction with examiners. The exam will be entirely structured and standard set and will be reviewed after each sitting in order to update questions used

All Fellows of the Faculty were invited to consider applying to become an examiner. This resulted in an enthusiastic response which delighted the Exams Committee. The numbers of examiners has therefore increased and in order to provide adequate training for new examiners the intake needs to be staggered over the next 2-3 years.

I will be stepping down as the Chair of the Exams Committee following the May exam. After several years of being in this role I shall miss it greatly. I wish my successor, Tom Beattie, well. I know that the exam will be in excellent hands and will continue to flourish under his leadership.

I wish to thank Jumbo Jenner, Jane Dunbar, Jan McNeill, Tom Beattie, Shona Watt, Yvonne Gilbert, Charles Galasko, Peter Helms, Stewart Hillis, Mark Batt, Rod Jaques and Chris Brookes members of the committee for their support.



### Dr Tom Beattie

I have now taken over as Chairman of the Examinations Committee for the Faculty of Sport and Exercise Medicine from Dr Carrie MacEwen. Carrie was a superb Chairman who brought a great depth of commitment, a breath of experience of examinations and examination process. We were very lucky to have someone like this as our first Chairman. I have a hard act to follow.



The work will continue with the old Examination until November 2008 and thereafter will continue in its new format. We will still alternate the second part between Edinburgh and the Apothecaries in London, and the first part will continue between Dublin, Glasgow and London. We are indebted to our colleagues in all these areas for the facilities and ongoing support for the Examination.

Professor Peter Helms continues as lead for the vivas and Dr Jane Dunbar who is also Vice-Chairman will assume responsibility for MCQs and EMQs. All of us would welcome questions in the appropriate format or otherwise, so that we can continue to increase our bank of questions. In particular we would welcome MCQs and EMQs that did not involve knee and ankle! Clearly questions on anatomy and physiology would be more than welcome and if anyone can come up with good questions on public health and the softer side of the curriculum we would be very grateful.

We enter a new phase from 2008 and as such the Examiner's Training Day on 18 November 2008 is open to all new examiners and any of those existing examiners coming to the end of their five year stint of examining. It will be held in Edinburgh at the Royal College of Surgeons of Edinburgh the day before the second part of the Diploma in Sport and Exercise Medicine Examination.

### NOMINATIONS COMMITTEE

#### Dr Ian McCurdie

The Nominations Committee, formerly known as the Fellowship Committee, continues to be Chaired by Dr Ian McCurdie with Prof. Michael Cullen, Dr Charlotte Cowie and Mr John Aldridge as its members. The committee has had much less to do since the window for election of Foundation Fellows & Members closed in July 2008 following formal establishment of the Faculty. Doctors are still able to apply for Membership or Fellowship of the Faculty, provided they meet the requirements set out on the FSEM(UK) website. Most recent applications have been from doctors who have passed the UK Diploma in SEM, as well as some from abroad. Newly elected Fellows are likely to have either completed specialist training and gained a CCT or be existing Foundation Members who have further developed their careers in SEM and, in doing so, made a significant contribution to the specialty.

The Faculty currently has 212 Foundation Fellows, including 12 Senior Fellows and 307 Foundation Members.

The Nominations Committee will continue to receive and to scrutinize application from potential members and fellows. Two of its members, however, are increasingly occupied by other Faculty business on the SAC, including the related (but distinctly separate) work of assessing Article 14 applications.





## APPRAISAL COMMITTEE

Professor Angus Wallace

### The GMC Licence to Practise

In the Autumn of 2009 the GMC will introduce the licence to practise. It will be the licence, rather than registration, that will signify to patients that a doctor has the legal authority to practise medicine in the UK. Following the introduction of the licence to practise holding a position as a doctor in the NHS or independent sector on a permanent or locum basis will therefore require both GMC registration and a licence to practise.

At this time, only registered doctors with a licence to practise will be able to exercise the legal privileges that are currently reserved for registered medical practitioners, such as those relating to prescribing and the signing of certificates required for statutory purposes.

The licence to practise will be the first step towards the introduction of revalidation that will in future give patients regular assurance that their doctors are up to date and fit to practise.

Licences will require periodic renewal by revalidation. When revalidation begins, licensed doctors will be required to demonstrate to the GMC that they are practising in accordance with the generic standards of practice set by the GMC (as described in Good Medical Practice 2006). Licensed doctors on the Specialist or GP Register will, in addition, be required to recertify against the standards that apply to their specialty or area of practice, set by the relevant medical Royal College or Faculty and approved by the GMC.

In their document Good Medical Practice 2006 the GMC state:

**14** You must work with colleagues and patients to maintain and improve the quality of your work and promote patient safety.

In particular, you must:

- a. Maintain a folder of information and evidence, drawn from your medical practice.
- b. Reflect regularly on your standards of medical practice in accordance with GMC guidance on licensing and revalidation.
- c. Take part in regular and systematic audit.
- d. Take part in systems of quality assurance and quality improvement.
- e. Respond constructively to the outcome of audit, appraisals and performance reviews, undertaking further training where necessary.

The GMC and the NHS now require appraisals to be



carried out annually.

### The FSEM Appraisal Process

The FSEM Appraisal system was established in Spring 2005. The aim of the Appraisal is to provide a formative assessment of the Sports Medicine doctor's training, experience, performance and to develop forward plans for the next year. The appraisal is not a test. It has been designed to provide one to one guidance by a trained appraiser which is focussed on identifying the level of training which has been achieved by the appraisee, how much experience they have gained in their field, and the feedback which has been provided from the appraisee's employers. The appraisal then focuses on the identification of a forward plan for their personal job plan and for their further training, appropriate course attendance, and further experience or research. The appraisal is an opportunity to take an overall view of work content, workloads and volume, to look back on what has been achieved during the past year and then agree objectives for the next year.

It is important that the appraisal reviews performance in confidence and in a non-threatening way, to explore the potential of a post and to identify the training and career planning needs of the appraisee to fulfil that potential.

It was agreed from its initial development in 2005 that the FSEM Appraisal process should be bi-annual, however in 2008, due to changes introduced by the GMC, appraisals are now required to be carried out annually. The fee for Appraisal was set at £100.00 to review the written application and recommend whether applicants are suitable to proceed to a full on-site appraisal (for first Appraiser applications only). The on-site appraisal fee is £490.00, which will now be charged annually. This fee does not cover the whole cost of the Appraisal process as Appraiser's are not paid for their time, but they are reimbursed for all other expenses. Rita Capaldi, Administrative Assistant in the FSEM offices now coordinates the Appraisal system very efficiently.

### The FSEM Appraiser's Course

On 10th September 2008 the FSEM ran a very successful Appraiser's course. There were 27 Course attendees with presentations by Mr David Pitts (Educational Adviser), Prof Charles Galasko (President), Prof Angus Wallace (Chair of the Appraisal Subcommittee) and Dr Rod Jaques (Member of the Appraisal Subcommittee). The course focussed on how to carry out an appraisal and how to get the best out of it. It was successful in resolving a number of misunderstandings that attendees had about the appraisal process and the feedback at the end of the course was outstandingly good.

### The FSEM Appraisal Statistics

The total number of Appraisees registered with the FSEM is currently 31.

The number of appraisals carried out is shown in the following Table.

2005	2006	2007	2008
1	15	3	21

Because of the GMC Regulations we now expect to carry out around 27 appraisals per year.

We now have a bank of 32 Appraisers available to help us.

#### Untoward Incident Reports

“From December 2008 we have added to the Appraisal Process an opportunity for reflection. We are asking all Appraisees, in addition to submitting their Appraisal Forms, to provide us with three “Untoward Incident Reports” from the past year. These reports do not necessarily refer to “complaints” or “threatened legal actions” but rather are episodes where the outcomes of treatment are not as good as you would like and where you have learned something extra. This kind of reflective learning is becoming much more important in medical practice and we believe this will make the Appraisal process even more valuable.

#### Thanks to the Appraisers

For the appraiser, carrying out appraisals can be a difficult and sometimes a really challenging task. The appraiser has to help the appraisee to understand their strengths and weaknesses in a diplomatic way. The FSEM is really grateful to those who acted as appraisers during the past two years. These include:

Mr Mike Allen	Prof Mark Batt
Dr Jumbo Jenner	Dr Simon Kemp
Dr Colin Crosby	Dr Ian McCurdie
Dr Wendy Dodds	Dr Nick Peirce
Brigadier Graham Hopkins	Prof. Angus Wallace
Dr Paul Jackson	Dr Rod Jaques
Dr Richard Wells	

## EDUCATION COMMITTEE

### Professor Stewart Hillis



The Educational Programme of the Faculty has developed over the last year with several education meetings and interactive opportunities.

Professor Galasko took part in the undergraduate university meeting and Professor Hillis attended the postgraduate day at the Royal College of Surgeons of Edinburgh to promote interest in training in Sport and Exercise Medicine and also to extend knowledge concerning the role of the Faculty. A joint meeting was held with the Royal Society of Medicine and ISEM on sport in schools on 30th November 2007, this addressed many problems associated not only with sport but also with the promotion of exercise and healthy lifestyle behaviours in the young and included methods of teaching and delivery.

A meeting on Foot and Ankle Injuries in Edinburgh on the 8th and 9th May was organised by Prof Ribbans there were 88 registered and excellent support from industry, the feedback from the meeting has been first class regarding content and delivery.

A joint meeting was held on 15th and 16th May at Chelsea Football Club, Stamford Bridge. There were a 120 registered with 60 attendees at the Sports Medicine section. This was the scientific conference held in conjunction with the Faculty of Pre-Hospital Care and National Poisons Information Service. Topics included a session on ankle and spine injuries in rugby with discussions on the practical management and rehab. The data from UEFA football injury studies were presented. The organisational challenges of rugby games were discussed. There was a short session on nutritional preparation for team sports in regard to supplements and rehydration. Some of the major cardiovascular challenges in sport were addressed including discussion in sudden death in screening. The special problems of the adult congenital cardiac populations were also addressed.

A meeting has been organised with the Scottish Football Association and the Royal College of Physicians and Surgeons of Glasgow Wednesday 12th November 2008 at The National Stadium, Hampden Park, Glasgow.

A meeting with The European College of Sport & Exercise Physicians has been organised in December and the Faculty will be represent by several speakers including Professor Hillis.

A review of undergraduate courses has continued with contact with the UK’s universities regarding both degree courses and special study modules.

A disappointing amount of such teaching is being offered at present and methods are being developed to try to encourage innovations in the university curricular.

Discussions been held with special government and medical committees with input from the Faculty in their sport specific teaching programmes with a view to develop both central and regional meetings.

## **EXTERNAL AFFAIRS COMMITTEE**

### **Professor John Fairclough**

I have been a Consultant Orthopaedic Surgeon for twenty years at the University hospital of Wales with a special interest in Knee and Sports Surgery. I was involved in the development of the MSc and Diploma in SEM at the University of Wales Institute Cardiff where as honorary Professor I am the course director. I am the academic head of the Centre of Musculoskeletal Analysis and Therapy unit in the university which has undergraduate and post graduate research programs.



The development of the Faculty of Sports and Exercise Medicine (UK) has permitted the structured development of Specialist training and will develop in the future a structure of Sports Specialty practitioners' throughout the UK. However at present there exists a panoply of practitioners and courses at universities incorporating elements of Sports and Exercise medicine in addition to the various Sports Governing bodies involvement in this area.

It is essential there is a cohesive approach to Sports an Exercise medicine both within the medical fraternity and also within the management structures and commissioning agencies. In the rapidly changing political world the interdependence of the various aspects of sport from a medical, research, educational or participant perspective require dialogue with external agencies. The committee structure of a small number of fellows representing the various disciplines will act as a liaison group to facilitate communication and act as a conduit for external bodies. As is highlighted in Professor Galasko's column, potential difficulties of medical indemnity for members and fellows who are involved in sporting events requires dialogue with the insurance agencies and the various management bodies.

## **FACULTY OF SPORTS AND EXERCISE MEDICINE, RCPI & RCSI**

### **P E Carolan**

The Faculty of Sports and Exercise Medicine is an inter-collegiate Faculty of the Royal College of Physicians of Ireland and the Royal College of Surgeons in Ireland. The Inaugural Board first met on 19th September 2002.

There are currently approximately 550 Fellows and Members, both in Ireland and overseas.

The aims and objectives are set out in the Standing Orders on the Faculty website at [www.rcsi.ie/fsem](http://www.rcsi.ie/fsem)

Since May 2004, the Faculty has been the body recognised in Ireland for the purposes of granting evidence of satisfactory completion of specialist training in Sports and Exercise Medicine. Up-to-date information on the criteria for entry on the Specialist Register in the Division of Sports and Exercise Medicine is on the Faculty website.

### **Higher Specialist Training in Sports and Exercise Medicine**

The Faculty has developed a curriculum for Higher Specialist Training and submissions have been made to the PMGDB and HSE regarding funding the Higher Specialist Training Programme. However, to date the anticipated funding for two training posts has not become available.

### **Committees and Working Groups**

The Accreditation Committee considers applications from medical practitioners for Membership, prior to the introduction of an examination. This Committee also assesses applications for entry on the Specialist Register in the Division of Sports and Exercise Medicine, and makes recommendations to the Medical Council.

The Anti-doping in Sport meets twice yearly, and maintains updated information on Anti-doping and TUE regulations.

The Faculty held its fifth Scientific Conference in September 2008 at the Conference Centre at Croke Park. This annual conference was attended by General Practitioners and physicians engaged in or interested in Sports and Exercise Medicine. International and national experts in Sports and Exercise Medicine are invited to speak. A summary report of the 2008 meeting is on the Website. The 2009 conference is scheduled for Thursday and Friday 17/18 September, at RCSI, and we would be delighted to welcome delegates from the UK.

The GP Training Sub-Committee is currently developing a Musculoskeletal Diploma course, in association with the Irish College of General Practitioners, and it is hoped this will commence during 2009.

The out-going Dean, Dr Pat O'Neill, has attended the Council meetings of the FSEM(UK) over the past several years, and the Irish FSEM Standing Orders now provide for a representative of the FSEM(UK) to sit on its Board. We value this reciprocal arrangement and its important role in furthering the role of Sports and Exercise Medicine in Ireland and the UK.

Board of the Faculty of Sports and Exercise Medicine, RCPI & RCSI, 2008-2009.



*Front Row:* L-R: Dr Frank McGrath, Treasurer; Mr Frank McManus, RCSI Council Representative; Dr Philip Carolan, Dean; Prof Frank Keane, President of RCSI; Dr Martin McConaghy, Honorary Secretary; Dr Pat O'Neill, Outgoing Dean.

*Back Row:* L-R: Dr John O'Riordan; Mr Cliff Beirne; Dr Michael Griffin; Mr James Colville; Dr J Jenner, FSEM(UK) Representative; Dr Joe Cummiskey; Dr Mary Archer; Prof John O'Byrne; Dr Rod McLoughlin; Dr Joe Cummiskey.

Absent from the photo are Dr J Donohoe, President RCPI, and Prof N G McElvaney, RCPI Representative

## THE INSTITUTE OF SPORT & EXERCISE MEDICINE

### Professor David Patterson



Many of you will know little about The Institute of Sport and Exercise Medicine; I will briefly describe its history. Our founder, the late Mr Peter Sebastian, impressed by the lack of doctors trained in sports medicine and by the lack of any system for the training and accreditation of sports medicine doctors, founded The Institute of Sports Medicine in 1958. It became a Company Limited by Guarantee in 1965 and was registered as a Charity in the same year. The first Chairman was Sir Arthur Porritt who had been President of the Royal College of Surgeons of England and later Governor-General of New Zealand. His Royal Highness the Prince Philip, Duke of Edinburgh became its first Honorary Fellow in the 1960s. In order to encourage research and good practice, The Institute offers three prizes, The Prince Philip Medal which is an international award for outstanding research; the Duke of Edinburgh Prize for clinical or research in sports medicine in the community, and the Sir Robert Atkins Award for consistently valuable medical services to a national sporting organisation. It has also funded bursaries for MSc students and organised conferences and seminars. Our name was changed in 2005 to The Institute of Sports and Exercise Medicine in order to better reflect the breadth of the discipline.

In February 2005 Sport and Exercise Medicine (SEM) was formally recognised in the UK as a new specialty and the Faculty of Sport and Exercise Medicine (UK) was launched in 2006. This decision represented recognition of what has already been achieved in this field in the UK. It also highlighted the potential contribution the specialty has to make to the nation's health over a wide spectrum of medical issues. The Faculty is formally recognised as the Governing Body for Sport and Exercise Medicine in the UK.

As a result of fruitful negotiations between the two organisations, The Institute of Sports and Exercise Medicine became the Research Arm of the Faculty of Sport and Exercise Medicine (UK) in 2007. The Faculty and The Institute share the aspiration to foster high quality research at all levels and in all branches of Sports and Exercise Medicine.

Our main activities over the last months have been related to the development of our vision statement. We have also commissioned a feasibility study in regard to our wish to raise funds.

Many of you will have seen the full draft of our Vision Statement which appears on the Faculty website: <http://www.fsem.ac.uk/>. This is an attempt to

succinctly describe our new role and our aspirations. It is a step towards the development of a research strategy. We are keen to learn your views about the key research questions and topics within Sport and Exercise Medicine (SEM). We need this information from a wide spectrum of SEM practitioners as well as the related research communities. The comments we receive will help inform our thinking as we develop a research strategy for SEM.

The ISEM is a long-established organisation of elected professionals with established credentials within the specialty of SEM and is well placed to take the lead with regard to SEM research in the UK.

The ISEM has highlighted the patchy nature of existing SEM research in the UK which is partly related to the lack of any real infrastructure support, partly related to the lack of a research culture and partly related to the lack of funding. There are a number of crucial areas in which further research could enormously influence policy on health and improve performance for all – from the “weekend warrior” to the elite athlete. These include:

#### **Exercise and Health**

Research into barriers to, and predictors of, physical activity in different populations to inform effective policy and intervention strategies

#### **Prevention and treatment of injury and illness**

Injury and illness are major contributors to sporting failure and loss of productivity in the workplace. Research is needed to identify ways to reduce injury and ensure swift return to fitness and health.

#### **Improving performance and promoting success**

Research is required to improve our ability to identify talented athletes and ensure optimum training and preparation for competition.

The ISEM has been able to pinpoint various weaknesses in the infrastructure currently supporting SEM research in the UK. Our aim is to enhance this infrastructure such that high quality research is encouraged and fostered at all levels.

The development of a research culture, including research training and research leadership, within UK SEM will require considerable initial funding and effort. The ISEM believes that in order to foster this radical culture change, links between practicing SEM specialists, units involved in teaching SEM, academic institutions with established research credentials, bodies involved in the regulation of sport, and the research funding bodies, will all need to be strengthened and increased. These links do not currently exist in sufficient depth or number, for co-ordinated projects to come to fruition on a large, frequent or significant scale.

It is difficult to begin to change a research culture without the input and inspiration of those with

significant personal experience of this shared aspiration. It may therefore also be necessary to recruit individuals with a track record in SEM research to drive and orchestrate these changes. Depending on how these changes progress, it may also be necessary to find centre(s) from which the driving forces can operate, either from an established unit(s) or using a new, purpose built centre(s).

The aim of The ISEM will be to enable these necessary changes by providing the facilities, impetus and financial support. Our ultimate goal will be for these actions to achieve a critical mass of research active people in SEM in the UK together with a vibrant network nationally and internationally.

What can ultimately be achieved through this project for our elite athletes, our sporting population and for the health of the UK population in general, is enormous and highly worthwhile. The commitment of individuals who are able to see this potential and are willing to help in the accumulation of support, advice and finance required, are essential. The ISEM is currently seeking the support of individuals and organisations with an interest in developing the specialty of SEM in order to gain momentum with this project. This is a great opportunity to be involved with a project where there is clear potential for rapid, tangible progress, and where every gain made has far reaching benefits for the health of the current and future population of the UK.

Can you please give us your suggestions under each heading and send them to me by e-mail (d.patterson@ucl.ac.uk). I am grateful for your help.

## SPECIALITY TRAINEE REPRESENTATIVE

Dr Rick Seah

It is a great honour to be elected as the inaugural specialty trainee representative on the FSEM council. I am currently a Specialty Registrar on the 4-year SEM run-through training programme in northeast London. This specialty rotation will take me through various NHS posts at Royal London, Mile End, Homerton University and Newham General Hospitals, as well as other non-NHS medical and sporting organisations as part of my training.

These training experiences, along with the constant interaction with my fellow trainees, will ensure that I am able to comprehensively feedback to the council the current state of SEM training both locally and nationally.

As part of my role, I hope to offer the following:

- 1) Enthusiasm!
- 2) An appreciation of SEM trainees of differing seniorities coming from varied backgrounds with diverse experiences;
- 3) A willingness to listen and convey individuals' viewpoints to the council;
- 4) Work closely with SEM trainers and colleagues to maximise the momentum and opportunities available to the specialty in the run-up to the London 2012 Olympic Games.

I appreciate that whilst working with elite athletes often provides the main attraction, it is the injured amateur athletes and weekend warriors who will provide bulk of the workload for our fledgling specialty. Sports & Exercise Medicine has a golden future ahead of it, but only if we step up to our responsibilities of guiding medicine's newest specialty through uncertain times.



## CONTINUAL PROFESSIONAL DEVELOPMENT GUIDANCE FOR DOCTORS UNDERTAKING FSEM (UK) APPRAISAL

Dr Rod Jaques

Doctors working in sports and exercise medicine will choose to apportion their CPD activities to reflect their educational needs and their work portfolio. As a general guidance the faculty of sports and exercise medicine (UK) have suggested the following guidelines for Internal, External and Personal CPD points per annum. This will also be subdivided into Clinical, Academic and Managerial.

So the Appraiser will submit a grid similar to this, showing the points in each cell.



	Internal	External	Personal
Clinical			
Academic			
Managerial			

This system is derived from the appraisal recommendations of the Royal College of Physicians of London and the Royal College of Surgeons of Edinburgh.

### Definitions

1. **Internal CPD**  
This could include multi disciplinary team meetings and tutorials, department related educational activities, critical event meetings.
2. **External CPD**  
This could include courses/lectures attended external to your institution/department, lectures/tutorials/courses you have hosted or given external to your institution/department.
3. **Personal CPD**  
This will include personal study time e.g. to study journals, review articles, read SEM related work. Also in preparing teaching and educational material. Self accreditation of CPD will be encouraged but must show evidence of reflection, though this can be only a short note indicating whether the activity will or will not be incorporated into practice and why/why not.
4. **Clinical CPD**  
Relates to Sport and Exercise medicine related CPD encountered in clinical practice, clinical teaching.
5. **Academic CPD**  
Relates to theoretical and research based Sports and Exercise medicine CPD e.g. audits, research projects.

## 6. Managerial CPD

Relates to policies and procedures in clinical practice, staff relations, employment relations etc.

### Units of measurement

1. Normally 1 hour = 1 point
2. However Managerial meetings 1 point = one meeting (minimum 2hrs)

### Totals

1. Normally it will be expected that there should be a total of 250 CPD points spread over 5 years, so an average of 50 points per year – although many Doctors will exceed this.
2. At least 50 % of CPD will be external.
3. There should never be a year when the total CPD points is less than 25, unless there is an extenuating circumstances e.g. illness.
4. Normally Clinical and Academic points should be > 60 % of total.
5. Normally Managerial points should be < 15% of the total.

Finally your CPD activity should reflect the recommendations agreed between yourself and your appraiser at your last appraisal which will be based upon your educational and professional development needs.

## THE ROLE OF THE SPECIALIST IN SPORT & EXERCISE MEDICINE

### Dr Richard Budgett

The role of the specialist in Sport and Exercise medicine reflects the 'broad church' of the training curriculum and spans primary, secondary and tertiary care. It includes:

1. The use of physical activity and exercise as a health tool for primary and secondary disease prevention in:
  - The general population.
  - At risk populations.
  - Moderately disabled/sick population.
  - Very disabled/sick population.
2. Physical activity in special groups such as pregnancy, diabetes, the overweight and obese, children and older adults.
3. Physical activity in all groups which is also limited by co-existing musculoskeletal morbidities. Appropriately prescribed exercise and other treatment to help both the illness and musculoskeletal problems using expertise in physiotherapy, nutrition, psychology,



musculoskeletal and general medicine, as part of multidisciplinary teams.

4. To lead multi disciplinary teams to deliver exercise programmes for health and wellness.
5. Population health in primary care working with colleagues in Public Health.
6. Musculoskeletal medicine: Management of soft tissue injuries with specific focus on exercise and sports injuries. This will involve working with musculoskeletal radiologists, biomechanists, physiotherapists and orthopaedic colleagues in order to minimise the time off work and sport caused by musculoskeletal injuries and thus reduce morbidity and the number of patients progressing to surgery. It will also enhance rehabilitation and recovery after surgery.
7. Contribute to accident and emergency services involving sport and musculoskeletal injuries by keeping close links with colleagues in A&E and maintaining skills in the management of medical and trauma emergencies.
8. Psycho-social aspects of sport and exercise medicine. Psychology of exercise and health promotion. Work with psychiatric and psychology colleagues to use exercise in the treatment of mental illness.
9. Rehabilitation of both able and disabled sportsmen and women of all standards to expedite return to physical activity, work and sports participation.
10. Sport and Exercise medicine research across the whole range of the speciality from the use of exercise in the treatment of disease, to rehabilitation after surgery, to treatment of soft tissue injuries.
11. Working with Public Health colleagues, the Department of Health and the NHS in delivery of the Health of the Nation.

## HONORARY FELLOWS 2008 CITATIONS

### Professor Timothy David Noakes



Professor Tim Noakes was born in Harare, Zimbabwe and graduated with a medical degree at the University of Cape Town in 1974. In 1981 he obtained an MD from the same University for his thesis 'Exercise and the Heart'. Since 1989 Tim has been Director of the MRC/UCT Research Unit for Exercise Science and Sports Medicine. He has been a prestigious and productive researcher with many published articles related to running and ultra distance events and the cardiovascular system. He has supervised 28 PhDs and numerous Masters projects. He has also had a very significant interest in rugby and rugby injuries and in the early 1990s he co-founded The Sports Science Institute of South Africa. He has played a very major part in the understanding of hyponatremic related collapse and the enhanced understanding of exhaustive exercise, through the development of the 'central fatigue phenomenon'. As an experienced runner, with more than 70 marathon and ultra-marathons, and a renowned physician his book 'Lore of Running' is now in its 4th Edition having originally been produced in 1985. His CV stretches to 64 pages and is testament to a lifetime dedicated to medicine and more specifically sports medicine. Thus it is with very great pleasure that we honour this esteemed South African, Professor Tim Noakes, with an Honorary Fellowship of the Faculty of Sport and Exercise Medicine (UK).

*Professor Mark Batt*

### Dr Dan Tunstall Pedoe

Dr Dan Tunstall Pedoe was educated at Cambridge and St Bartholomew's Hospital and thereafter working in Oxford and San Francisco. He worked for over 30 years as Physician and Cardiologist at the Homerton Hospital and Senior Lecturer at St Bartholomew Hospitals. He first became involved with sports medicine in 1980 as Medical Director of the London Marathon and has continued to be involved for 28 years having run five marathons himself with a best time of 3.10 and was elected as the first President of the International Marathon Medical Directors Association.



Dr Dan Tunstall Pedoe served three terms of three years as Chairman of the British Association of Sports & Medicine (now BASEM). He set up the London Sports Medicine Institute in 1986 which became the National Sports Medicine Institute in 1992. He was President of the Sports Medicine section of the Royal Society of Medicine and has organised and run a number of very successful conferences on Marathon Medicine, the Athletes Heart and Sudden Cardiac Death in Sport as well as publishing an internationally acclaimed book on Marathon Medicine in 2000.

He ran the module on medical aspects of sports medicine at the University of Queen Mary (Royal London) Sports Medicine Course from its inception in 1981 until last year. He finally retired from the NHS in December 2004 but has continued his involvement with Sports Cardiology, Marathon Medicine and the Royal Society of Medicine.

*Dr Richard Budgett*



## Malcolm Bottomley



Qualified in Sheffield in 1958, entered General Practice and developed an interest in SEM. Completed the BASEM course in 1982. Appointed as MO to the football association of Wales and MO to the British Amateur Athletics Board in the same year. Has been a member of BASEM for 28 years, including Chairing the Education committee from 1998-2000. Became MO to University of Bath in 1984, and became doctor to Bath RFC and the 1994 European Youth Olympics in Bath.

He established the SEM course at Bath University in 1994 and was Founding Director of Studies for the University of Bath MSc in SEM for Doctors in Distance Learning from 1994-1999, following which he retired. He still keeps a keen interest in all that's happening in Sports and Exercise medicine in the UK.

*Dr Rod Jaques*

## Mr James (Jim) Foster



Jim Foster was born in Arbroath in 1948 and educated at Hampton Grammar School (1960-62), George Heriot's School (1963-66), and the Royal Naval College, Dartmouth (1966-69). He was commissioned into the Royal Navy in 1969, and thereafter held positions of increasing responsibility. He joined the submarine service in 1970, qualified as an ocean-going Navigation specialist in 1972, completed his Diploma in Nuclear Science at the Royal Naval College Greenwich in 1973 and graduated from the Joint Service Defence College in 1991. Over this period he moved through a number of appointments from Navigating Officer in HMS Orpheus from 1970 to 1972 to Head of Submarine Command and Control Training from 1986 to 1988 and finally to Commanding Officer HMS Resolution (Nuclear Submarine) from 1988 to 1990.

In 1990 he advanced his training at the Joint Services Defence College in preparation for his appointment to Defence Concept Studies at the Ministry of Defence from 1992 to 1993. This post was at the centre of government defence policy formulation and involved the construction of corporate strategy, including costing, for the underwater warfare elements to be included in a new strategy for the defence of the UK and military capability for up to 30 years ahead, more simply Jim was at the centre of Submarine planning for the next 30 years.

Jim retired from the Royal Navy in 1993 in order to spend more time with his wife Cath and their 3 children and to establish his second career. From 1993 to 1999 he was the General Manager for The Society of Writers to Her Majesty's Signet based in Edinburgh. In this post he was responsible for the administrative and financial affairs of a Society of over 1000 lawyers.

Jim's third career started in 1999 when he was appointed Chief Executive of the Royal College of Surgeons of Edinburgh. As Chief Executive he was responsible for the overall management and strategic development of the College which has a staff of 140 and a turnover of £9.5m. The College is an organisation responsible for the education, training and assessment of surgeons and dental surgeons. It is one of the largest medical Colleges in the UK

with a membership and Fellowship of over 17,000 worldwide.

Over the period of his appointment to the College Jim has coordinated the development of a commercial trading company, the upgrading of the Symposium Hall, the creation of the Quincentenary Hall an events & conferencing facility, together with opening 10 Hill Place – a 78 room hotel. Jim retires from his post of Chief Executive of the RCSEd this year – to take full retirement this time!

Why has the Faculty chosen to honour Jim, who is not a doctor and is not involved in managing Sports injuries? Jim has facilitated the development of the new Faculty of Sport and Exercise Medicine, has helped provide our Faculty with new office accommodation and has supported our Faculty Manager, Yvonne Gilbert over many years. We are delighted to bestow on Jim one of our first Honorary Fellowships to the Faculty of Sport and Exercise Medicine for his service to the Faculty over the last 9 years.

*Professor Angus Wallace*

## **ADDRESS TO FELLOWS AND MEMBERS OF THE FACULTY OF SPORT AND EXERCISE MEDICINE (UK)**

**Professor Timothy David Noakes**

“It is an unexpected privilege to receive this Honorary Fellowship and I am sincerely touched by the support of Professor Mark Batt who nominated me and for those who favoured my nomination. I believe that sports medicine including the exercise sciences is one of the most important but yet more under-valued specialities in medicine. Its importance is that it addresses the health of the entire nation, not just those who are already ill. I am proud to be able to represent our discipline in this way and to be a small part of the future of the Faculty.

For the record I should begin by stating that I have certain hereditary qualifications for a British award. My parents are from Liverpool, in fact, from Birkenhead for those who know the area. Both parents came from families sustained by trading from that famous seaport city. My mother always assured me that my Scottish credentials are impeccable as we come from the McKenzie clan. At the end of the Second World War my parents chose to emigrate to Zimbabwe where I was born. I have retained dual British/South African citizenship although my heart has always been African; I would not make a good European. I do experience divided loyalties when my two countries compete but this is sport-dependant. Certainly there were none in the final of the 2007 Rugby World Cup! Cricket no longer evokes any passionate partisan divide: England, South Africa. Who wins? No matter! In soccer I favour Liverpool for obvious reasons and, at national level, am still undecided.

Enjoying this dual citizenship was also very helpful during the recent Olympic Games since my joint countries won one more medal than did the athletes from the United Kingdom.

Indeed it is a great time to be involved in British sport following the remarkable performances of Team GB in the recent Beijing Olympic Games. You do not need to be reminded, although the rest of world must be, that in the 1996 Atlanta Olympics, United Kingdom athletes, not yet Team GB, garnished just one medal. To progress in 12 years to the current situation in which your Olympic athletes won more than 40 medals is an achievement equalled perhaps only by Australia and East Germany in the recent past. It is an event that is of great significance to the British people – perhaps not Trafalgar or Waterloo or the Battle of Britain. But in the history of British sport it is perhaps the equivalent. Sir Winston Churchill might not have been moved to say to the effect that never in the history of British sporting conflict was so much owed by so many to so few. But he definitely would have said that this is not the end; nor is it the beginning.

But at least it is the end of the beginning. The success of the English cricket and soccer teams in the past few weeks is unquestionably because of a new found confidence in British sport – a point to which I will return in due course. Churchill would most definitely have said that you must not let success deter you in your task. Never, never give up. That would have been his eternal message.

Indeed the evidence I observe and the mood I have encountered suggests that the world has yet to see the peak of this British Olympic success; that Team GB has the capacity to improve yet further. In the years to come it will become apparent that however remarkable was your team's performance in the Beijing Olympics, it was relatively pedestrian compared to what lies ahead at your London Olympic Games and beyond. The momentum is with you: You need to aim for the Chinese, not just for the Americans.

I must add on a personal note that the success of Team GB is profoundly important for another reason – it makes sceptics like myself who were firmly convinced that success in many Olympic sports is drug-dependant, acknowledge that perhaps we are wrong. That the nation that pioneered the special concept of fair play has shown that success in Olympic competition can be achieved without compromising those traditional British values.

Indeed the success of the British athletes in Beijing raises the question: Whatever happened to the diffident, bumbling, insecure, retiring, amateurish British athlete, too timid to match the performances of assured Americans, assertive Australians, confident Chinese and robust Russians? Somehow British sport has undergone a sea change in attitude in the last 4 years and this has raised the your athletes' performances to another level. Now it is clear that the limits to your future success will be set purely by your national desire and ambition since you have already discovered the tools for success.

We need also to understand the meaning of the ceremony we are enjoying this afternoon and how it relates to this re-vitalization of British sport. For the Royal College of Surgeons is one of the world's greatest citadels of intellectual wisdom applied for the benefit of all the world's people. That the College should consider sports medicine and the exercise sciences to be sufficiently important to enjoy its patronage is simply astonishing. Those who fought for this recognition for our discipline and many of whom are here today, need to be properly acknowledged. I would argue that as is the case for British sport, this achievement is not the beginning nor is it the end. But it is certainly the end of the beginning. For to continue the upward trend in your sporting revival will require that even more emphasis is placed on education and training in sports medicine and the

exercise sciences. Especially I believe that if British sport is to challenge for an even higher position in the Olympic Games, then you will need to focus even more on the application of world-class science in the preparation of your athletes. This work will need to be even more innovative than that which you have already applied to your athletes.

I presume that the reason why I was asked to speak this afternoon was not just to heap praise on your achievements in sport and in sports medicine and the exercise sciences. Rather I suspect that you wanted me to share some pearls of wisdom, should such exist, from my 39 years in the field. So I humbly offer some ideas in the hope that they can provide some inspiration for those in the room including the diplomats and fellows whose responsibility will be to make a difference to British sports medicine and exercise science.

I chose sports medicine and the exercise sciences for my professional focus in 1969 during my first year in medical school in Cape Town. I might add that our Medical School was started by 3 Scottish medical professors from Edinburgh, which perhaps again emphasizes the reach of Scottish medicine and the debt I (and many others) personally owe to that global influence. During my training I perceived that two future trends were inevitable. First that the future direction of medicine lay in health promotion, not disease treatment. I sensed that the version of First World Medicine I was being taught even at the tip of Africa, was not cost-effective so that sometime in the future that reality would have to be acknowledged. Then we would have to direct our efforts into disease prevention.

For whatever reason I had the belief that physical activity would prove to be an important measure in the fight to promote human health. This certainty came as I was first beginning to expose myself to the demands of more vigorous physical training.

Second I realised that the care of the athlete was not a priority in my medical school. I recall that when as a fourth year medical student, I complained to an orthopaedic surgeon that I experienced knee pain whenever I ran more than 30 km, he responded: "So what is your problem? I have patients who cannot walk 30m". Later I would learn that my experience was hardly unique. So an iconic South African distance runner told me that, at the height of his career in the 1950's, he had sought medical care for a similar complaint. He was asked in the most patronizing way why did he want to run so far? If he suffered knee pain after 30km, then surely he could just run the rest of the distance on his hands!! I had also to contend with the opinions of a former Professor of Medicine at Medical School who was particularly condescending of anything that was not real medicine. So he was keen to inform the adoring martinets who surrounded

him that: "The sports sciences are Mickey Mouse". His opinion was especially helpful since it inspired me to prove him wrong.

I soon realised that if I were ever to learn anything about sports medicine, then I would have to teach myself. And an important source of that knowledge was British. From this I learned how important British sports medicine has been in global training in sports medicine and exercise science. For you have a glorious history of educating the world in our discipline and this is reflected in your 2008 diplomats who come from all corners of the world.

So the first textbook of sports medicine that I ever owned was compiled by English doctors John G.P. Williams and Peter Sperryn (1). I am also probably one of the longest (still alive) subscribers to the British Journal of Sports Medicine – my subscription dates back to 1970. I am so glad to know that the Journal is now edited by one of very best friends, Professor Karim Khan who has also written the definitive modern textbook on Clinical Sports Medicine (2), the clear successor of the Williams/ Sperryn text. Under Professor Kahn's guidance I am certain that the British Journal of Sports Medicine is destined to do what your Olympic team may take somewhat longer to achieve – to displace the North American representatives in the respective world rankings!

Thus my education was strongly influenced by British sources, many of whose iconic figures you have already honoured in this College. I would like to acknowledge the debt that I owe to them for educating me.

What have I learned from my experiences in sports medicine and the exercise sciences over the past 40 years?

First that my initial perceptions were correct – I was right that sport and physical activity would become increasingly important in health promotion and disease prevention. This is now part of the perceived wisdom. But it is important to remember that it was only as a result of the landmark publications of British scientist Professor Jerry Morris (3) and United States Professor Ralph Paffenbarger (4) in the 1970's that this link was established scientifically. We tend to forget that the knowledge subsequent generations take for granted, must be won by the hard labours of those who went before. Knowledge is not simply handed down from heaven on an inscribed stone (although increasingly those movements steeped in creationism and "intelligent design" would like this to be so). We must never forget that we stand on the shoulders of the giants who preceded us. And often those giants were at least as clever as we might consider ourselves to be. They had to be. For they discovered the wisdom we now take for granted. And to do so they had to overcome the inherent scepticism

that is such an important safeguard of our science. But which can also so often be a serious impediment to the growth of new knowledge.

What Paffenbarger and Morris's work showed is that, to be of value, physical activity must be sustained for life. We also now know that those who are physically active for life are those who have the most exciting and memorable experiences of physical activity in their school years.

So if we really want to change the health of future generations we have to return sport and physical activity to all our schools in a big way. In fact the more deprived the school, the more sport and physical activity they need. It is sobering that, despite their success in Olympic competition, this has not happened in Australia or the United States. Their children have not benefited as have their Olympic heroes, from the provision of greater opportunities for physical activity. But will the same be the case in Great Britain? The important point is that the single most important benefit of physical activity is that it improves how we feel about ourselves. And it is my opinion that those, whom life has given the least, will benefit the most from the provision of greater opportunities for sport, play and physical activity. In fact next to education, sport and physical activity might just be about the only way that the poorest and most marginalized in our society can improve their self esteem. I am reminded that humans evolved as the mammals with the greatest capacity for sustained athletic activity. We need to practice the activities for which we have evolved if we are to fulfil our potential.

But the crucial point is that the only people who are fighting for the promotion of physical activity are those of us in sports medicine and the exercise sciences. Is it a war we must not lose. Whilst in this room are the cream of the doctors who have done so much to insure the success of the British Olympic and Paralympic teams, yet we must remember that Olympic success is perhaps not the most important focus of sports medicine. It is just the obvious pinnacle that can be used to advertise the potential social impact of our discipline.

People who know me only from my writings perhaps perceive me as opinionated, perhaps even dogmatic. If I believe that something is correct, I tend to follow my conviction. I am fairly sure that this came from what I learned in training for a special South African event, the 90km Comrades marathon footrace. I have absolutely no doubt that if I had not run that race I would not be here today. My point is that in sport we learn lessons that in my view are rather more important than those we learn in the classroom. Or at least it is only in sport can we ever learn those lessons.

This indeed is the North American impression of those who graduate from Harvard.

Those who represented their University in sport are more likely to be among the more successful graduates. In the words of the author: "Employers who recruit Harvard seniors have concluded that among young people who are smart enough to have been admitted to Harvard, significant roles in athletic teams or other student groups can be better predictors of success in the work-place than are high grade-point averages" (5) (p 89). I am sure that Dr Richard Budgett sitting next to me today is a more competent Chief Medical Officer of the 2012 Olympic Games in London because he is also a Gold Medallist in one of the most demanding Olympic sporting disciplines.

My point is that if this applies to the elite of our society how much more important is it likely to be those born into lives of little opportunity? I am especially sensitive to this because of my experiences in the poor communities in South Africa, where sport has an unmatched capacity to change lives. I would hope that this will be an important focus of the future work of the members of this Faculty.

So if I had my way I would make sure that every child should train for and complete a demanding physical activity that they originally considered unattainable but which becomes attainable after 3-6 months of appropriate preparation. This would teach them how outcomes are determined by preparation and dogged persistence – the example given to us by Team GB. They would soon learn that the greatest barrier to success in anything is the mental hurdles that we construct. And behind which we hide to insure that we need never push ourselves to achieve a goal that we considered impossible, largely because we are too lazy to do what needs to be done to be successful.

Second, I suspect that I have been awarded this honorary Fellowship for my scientific contributions rather than for any special expertise in sports medicine. My scientific focus has been on two topics in the exercise sciences – the role of fluid balance during exercise and of the brain in the regulation of exercise performance. Both these have challenged the conventional wisdom. And so I have learned that no one, but especially not industry, appreciates a challenge to their carefully constructed dogmas. These conflicts with industry and my colleagues have taught me some valuable lessons. The most important of which is that we should not seek approval for what we do. We should just simply seek the truth.

To begin, the fluid balance story can be easily resolved. The reason why we humans look as we do is because we evolved as long distance hunters on the hot African savannah able to outrun any African antelope in midday heat. The only requirement was that the day had to be really, really hot – in excess of 40°C. Thus our bipedality, our absence of fur, our unmatched ability to lose heat by sweating, our

long springy legs and short arms, our height of over 160 cm and our ability to rotate our upper bodies (the basis of all hitting sports), are all evolutionary adaptations that gave us an unmatched capacity to run for prolonged periods in the heat whilst maintaining a safe body temperature (6,7). This ability can be still be observed in those hunter/gatherer populations like the Kung San in Namibia, who continue to participate in what are called persistence hunts (8). These hunters have been tracked as they ran for 6 hours in temperatures between 40-45°C whilst they drank little – less than 1 L. So humans are the most formidable hot weather running machines ever designed – nothing can match us. And all we need do during exercise is to drink according to the dictates of thirst.

When I began running in 1969 that was the prevailing view – in fact we were advised not to drink during exercise (9). And many of those who advised us so, were British. Englishman Jim Peters perhaps the greatest marathon runner of all time as he lowered the world marathon record by 7 minutes in a 3-year period in the early 1950's, advised us not to drink at all during marathon running since it would impair our performances. When another Englishman, science graduate Dr Ron Hill, won the 1970 Commonwealth Games marathon in this very city in one of the fastest times then achieved, he drank nothing during the race (10).

This advice lasted until the development of the world's first sports drink and its rampant commercial success. The commercial success required the development of three physiological dogmas that are the opposite of our biological design forged in our evolutionary past. These are (i) that we are poorly adapted for exercising in the heat; (ii) that we must not develop any weight loss during exercise – what I call the "zero dehydration" rule; and (iii) that we need to ingest additional salt to survive as athletes. There is absolutely no scientific support for any of these ideas. In fact they are the opposite of the truth. Sadly they are also not benign untruths as they continue to cause preventable deaths (11). The most recent occurred only last week in a high school American football player in Bakersfield, California who drank himself to death to insure that he did not die from "heatstroke" during football practice? So what is the probability that a high school football player will develop fatal heatstroke? The answer is that there are about 2 cases per year amongst millions of such players in the United States (12). This low incidence must indicate that the condition is due to factors other than simply playing football in hot conditions. Like many others whose ideas have perhaps been somewhat ignored, we have proposed that there must be genetic factors, as yet unrecognized, to explain why so few develop heatstroke even when many participate in vigorous sports in the heat (13).

What I have learned from this encounter is that commerce is a very powerful regulator of what we believe (14). Not just the sports drink industry but even more so the pharmaceutical industry (15). The tactic is to present humans as inadequate invalids at great risk of a host of fictitious “diseases” for the “cure” of which only the pharmaceutical industry has the (simple) solution – a specific pill (16). But humans are not invalids. We are physically amongst the most successful organisms on Earth. And every day your great athletes prove this to be true.

The sadness was that this drinking scam could never have occurred without the active participation of “scientists” (14); perhaps not all who were involved did so as an active choice. But certainly all failed to understand the manner in which they were being manipulated. We need to stand up to the forces that wish to distort our science.

My second area of research interest is the role of the brain in exercise performance (17). You can take it from me – whether you like it or not, the brain regulates exercise performance (18) and the sooner we accept that reality, the more effectively will we be able to help our athletes.

I learned this truth from the exploits of Sir Roger Bannister, perhaps the greatest British sporting icon of the 20th Century and appropriately an Honorary Fellow of this Faculty. In 2004 at the 50th anniversary of the running of the first (sub)four minute mile, Sir Roger spoke of how his coach Franz Stampfl had convinced him that despite the wind and cold at the Oxford track on that historic day, he would nevertheless run 3 minutes and 59 seconds. Stampfl asserted that under normal conditions Bannister would be able to run 3 minutes and 56 seconds. And if he did not attempt it, he might not have another chance. Bannister then went out and did exactly what his coach had said he would.

The other side of the story is that in early 1954 the Australian John Landy who by 1954 had run the mile seven times in 4:01- 4:02, declared that the four minute mile was a brick wall through which he was unable to break. Forty six days after Bannister’s success, Landy ran close to 4 seconds faster than he had ever run before in his life. Bannister and not Landy had been the first to break the 4 minute mile barrier, probably because Bannister’s coach believed in Bannister. And Landy did not have a coach to believe in him.

The moment in the Beijing Olympics that again showed this truth that the brain, open to all manner of external influences, always forces us to exercise with reserve happened in the final leg of the 4 by 100m freestyle race for men. The French world record holder began the final 100m leg with the advantage of a full body length over the less well known United States swimmer. In response the American swam

the fastest 100m in history – much faster than he had personally swum in the 100m finals a few days earlier. And why? Because he was swimming not for himself but for Michael Phelps’s 8th gold medal. And that made the difference. For when he has swum the 100m finals he had not considered it conceivable that he could swim so fast. And so he had fulfilled his own belief. Given the right circumstances he had swum as he really could. But his brain could not access that performance in the more usual circumstances to which he was accustomed and which he understood. The reality is that we always exercise with reserve (18) and can always do better. But how we access that latent performance reserve in is the greater mystery.

Of course the success of Team GB in Beijing is most readily explained by my interventions aimed at releasing this latent British reserve! In June 2006 I was invited to speak at the annual research conference of the English Institute of Sport and even to hold a teaching session with the exercise physiologists. The title of my presentation was: The brain regulates exercise performance. So why don’t you know that? I told the conference that when testing elite athletes, the main function of the exercise physiologist is to act as a powerful placebo assuring each tested athlete that his or her physiological test results are absolutely astonishing and portend great future successes. The reality is that the Team GB athlete must believe (whether or not it is true) that he or she is receiving the world’s best medical, scientific and coaching advice (better than that provided to US, Chinese, Australian and Russian athletes) so that everything is being done to assure their success. Nothing has been left to chance. For the absence of that belief provides the seeds of doubt and disbelief that prevents the brain from producing a perfect performance.

That this message is making its way into the public domain is shown by an article in The Times two days ago. It wrote of the success of Dr Steve Peters, “British cycling’s secret weapon” in his role as the “brain mechanic”. His role, he says, is to help the athletes “work out what’s happening in their heads now, and work out what needs to happen, then we identify the barriers that are stopping their minds from working as effectively as possible, and remove them” (19).

To summarize, I would like to confirm my belief that sports medicine and the exercise sciences are as important or perhaps even more important than most of the other medical disciplines. Because the influence of our discipline can determine the future health of all the world, not just those who are already ill. Our challenge is to fulfil our discipline’s potential by changing the world!

I have also warned that there is a growing contamination of our discipline by non-science. We each need to understand how we know what we know. We need always to interrogate the evidence for

what we do and what we believe. If the absence of a decent evidence base, be wary of what you believe. For you may be acting in the interests of forces that you do not fully comprehend.

Finally the future of British sporting success lies in the brains of those who administer, coach and practice sport in your land. Collectively they will achieve what they believe they will achieve. For the outcome is predetermined by what you believe when you begin. I would advise that you collectively aim for that which you presently consider to be impossible.

For there is a miracle out there waiting to be grasped – Britain as the second most successful team in the 2016 Olympic Games. Amazing!

These are great moments for sports medicine and exercise science in the United Kingdom. Professor Batt believes that this Faculty has the responsibility to become the leading educator in this discipline globally. As your first foreign Honorary Fellow I look forward to helping you achieve this noble goal.”

#### Reference list

1. Williams JGP, Sperryn PN. Sports medicine. 2nd edition ed. London: Edward Arnold, 1976.
2. Brukner P, Khan K. Clinical Sports Medicine. Third Edition McGraw Hill, London, pp 1-1032, 2007.
3. Morris JN, Chave SP, Adam C, Sirey C, Epstein L, Sheehan DJ. Vigorous exercise in leisure-time and the incidence of coronary heart-disease. *Lancet* 1(7799):333-9, 1973.
4. Paffenbarger RS, Wing AL, Hyde RT. Physical activity as an index of heart attack risk in college alumni. *Am J Epidemiol* 1978; 108: 161-175.
5. Lewis HR. Excellence without a Soul. How a great University forgot education. Public Affairs, New York, pp 1- 305, 2006.
6. Carrier DR. The energetic paradox of human running and hominid evolution. *Current Anthropology* 1984; 25(4):483-495.
7. Bramble DM, Lieberman DE. Endurance running and the evolution of Homo. *Nature* 2004; 432(7015):345-352.
8. Liebenberg L. Persistence hunting by modern hunter-gatherers. *Current Anthropology* 2006; 47(6):1017-1025.
9. Noakes TD. Fluid replacement during exercise. *Exercise and Sport Sciences Reviews* 1993; 21:297-330.
10. Muir AL, Percy-Robb IW, Davidson IA, Walsh EG, Passmore R. Physiological aspects of the Edinburgh Commonwealth Games. *Lancet* 1970; 2(7683):1125-1128.
11. Noakes TD, Speedy DB. Case proven: exercise associated hyponatraemia is due to overdrinking. So why did it take 20 years before the original evidence was accepted? *Br J Sports Med* 2006; 40(7):567-572.
12. Mueller FO, Cantu R. National Centre for Catastrophic Sport Injury Research. Annual Survey of Football Injury Research 1931- 2007. Accessed at <http://www.unc.edu/depts/nccsi/SurveyofFootballinjuries.htm>
13. Rae DE, Swart J, Knobel GJ, Mann T, Tucker R, Noakes TD. Heatstroke during endurance exercise: Is there evidence for excessive endothermy? *Med Sci Sports Exerc* 2008; 40: 1193–1204.
14. Noakes TD, Speedy DB. Lobbyists for the sports drink industry: an example of the rise of “contrarianism” in modern scientific debate. *Br J Sports Med* 2007; 41(2):107-109.
15. Law J. Big Pharma. How the world’s biggest drug companies control disease. Constable, London. pp 1- 266, 2006.
16. Moynihan R, Cassels A. Selling sickness. How the world’s biggest pharmaceutical companies are turning us all into patients. Nation Books, New York. 1- 254, 2005.
17. St Clair Gibson A, Noakes TD. Evidence for complex system integration and dynamic neural regulation of skeletal muscle recruitment during exercise in humans. *Br J Sports Med* 2004; 38(6): 797-806.
18. Noakes TD, St Clair Gibson A, Lambert EV. From catastrophe to complexity: a novel model of integrative central neural regulation of effort and fatigue during exercise in humans: summary and conclusions. *Br J Sports Med*. 2005;39:120-4.
19. Kervin A. Footballers need the brain mechanic. *The Times* Monday September 8th 2008, p 57.

**Faculty of Sports and Exercise Medicine, Council 2008**



*Back Row (left to right)*

Dr Rod Jaques, Dr Tom Beattie, Dr Les Odiseng, Dr Ian McCurdie, Lt. Col John Etherington, Dr John Wilson, Mr Mike Allen, Dr Richard Budgett, Prof John Fairclough, Prof David Sowden, Prof Stewart Hillis, Prof David Patterson, Dr Rick Seah

*Front Row (left to right)*

Dr Jumbo Jenner, Prof Peter Helms, Dr Jackie Spiby, Prof Charles Galasko, Prof Mark Batt, Mrs Yvonne Gilbert, Dr Victor Cassar-Pullicino, Prof Angus Wallace

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