

## **ELECTIVE (SSC5a) REPORT (1200 words)**

A report that addresses the above four objectives should be written below. Your Elective supervisor will assess this.

### **OBJECTIVE 1:**

I feel that I was more than able to achieve this. Patients that were seen in sports injury clinics included athletes and non-athletes, and, more specifically, members of the general population who were not typically active. Firstly regarding the athletic population, the Mile End clinic is one of three Dance Injury clinics in the country, therefore a significant number of referred patients I saw were student or professional dancers. This was the first real experience I had of seeing how patients were managed, whose livelihoods depended on a form of sport, as I would imagine the professional club setting to be. Most dancers were in education at dance schools and were subject to a formal curriculum. The daily practices alone meant that they were not afforded time to rest any injury that did occur. I initially questioned why these students were not able to have more direct access to a doctor via the school given the potential toll of any injury. Unfortunately, comparing to sports like football, financial considerations were generally a limiting factor. It was interesting to observe the clinician consider styles of dancing, footwear, and student scheduling (such as exams) as part of management. It was very patient centred in that respect. General injury rehabilitation principles were followed, but the progression depended almost entirely on the patient, given the lack of interaction they had with a clinician. It seemed like a difficult balance to manage symptoms against things like interviews and exams in the interest of rehabbing an injury. I enjoyed in the clinic that not all presenting complaints were injuries, and the more holistic approach to medicine was not lost. I had suspected more acute presentations given the name of the clinic, however it was no surprise to see patients whose non-MSK/injury symptoms impact their ability to perform. Non-athletic population (or the general public) was perhaps a poor choice of words, as again in this patient group, patients presented with injuries that occurred, largely, as a result of their hobbies. Something perhaps unique therefore to SEM was that patients were keen to return to their activity and patient compliance was arguably less of an issue compared to other specialties.

### **OBJECTIVE 2:**

I was aware of a number of other treatment modalities, besides pharmacological options, in SEM. These included exercise prescriptions and physiotherapy, steroid injections guided by ultrasound, shockwave therapy and surgery if totally necessary. Ironically, I can't think of many patients who were seen in clinic that, whether a new diagnosis or follow up, had been treated pharmacologically, besides simple analgesics. Patients with complex medical problems were investigated as per normal, and then referred, to the appropriate department, where they may receive pharmacological therapy. This was not only a reminder of the perhaps limited role of drug therapy in SEM and MSK, but the clinical value of alternative modalities in accordance with the growing evidence base. I learnt more about the role of the SEM doctor in prescribing exercise. This took both the role of suggesting and trialling exercises for rehab purposes, but generally overseeing a return to full fitness and adjusting things where necessary. There is huge value in referring patients to physiotherapy, where they would likely receive specific instructions and follow up during rehab. I presume the doctor and physiotherapist to be on the same page regarding exercises, for example, albeit not always seeing patients together. It was interesting to see ultrasound guided injections being given to a range of joints and for a range of pathologies. I feel that I am generally lacking with interpreting imaging, so this was a good opportunity to understand more and observe the systematic

approach doctors took to scanning different parts of the body. I was not able to see shockwave therapy being delivered to patients, but I was familiar with its mechanism of action and means of delivery, having carried out a previous SSC research on this subject. What was most interesting to observe in practice was how doctors selected different treatments. Unlike other specialties, where the approach is more stepwise, in SEM considering the different options available, it was up to the clinician to select and refer patients for treatments, either guided by the evidence base or what they considered most suitable based on their clinical experience. It almost looked like trial and error for this reason, but educated to a significant degree.

#### OBJECTIVE 3:

It was slightly more difficult to be able to identify disease trends in SEM that reflected the population in East London. This was for a number of reasons, including the athletic and non-athletic populations seen in clinic – the dancers for instance coming in from all over the South of England – and generally the difficulty in identifying these trends! At most, I could only comment on, for example, patients of a larger body habitus and whose occupation consisted of long periods of being on their feet, coming in with symptoms that resembled plantar fasciitis. Often, these patients were of a South Asian heritage too. Of course, this is not to say that patients of other heritages would not have similar complaints, but this was noticeable nonetheless.

#### OBJECTIVE 4:

I feel that I was able to continue networking within SEM. I continue to reiterate the value of having senior doctors as mentors and teachers that are willing to pass on their wisdom to students! I was lucky that my supervisor, consultants, and registrars within the department were happy to accommodate me in every possible instance. The SEM department in Mile End was maybe smaller than I expected, therefore I got to meet and know the consultant and registrar quite well by the end of the placement. This reflects the small, yet growing, specialty of SEM. Again, I am grateful that the doctors I did meet made me feel welcome and part of the team and I was able to absorb plenty from their practice. I also met some rheumatologists, another interesting specialty, given the interactions between themselves and SEM within the department, including in the MDT, as well as some of the physiotherapy department. This included some familiar faces from the iBSc a couple of years ago which was nice too. I was able to speak to and examine some patients myself, before presenting cases to the consultant or registrar where appropriate. I enjoyed the thought process of the SEM doctor when approaching patient histories and again it was nice that the core elements of medicine were not always forgotten. I feel that I maximized my exposure during this elective, by attending virtually all clinic types I was able to in Mile End. In terms of continuing to network, I hope that these connections reflect my interest in the specialty and I hope to stay in touch with all of these doctors moving forward. Some I learnt to be involved with professional sports teams, and down the line I look forward to possible opportunities that may arise in these settings, opening my eyes to even more of the specialty. I appreciate how difficult it can be to establish these connections in the first place! But also in academic research, something which over the years I have grown to enjoy. A cherry on top was that the consultant knew of a sports physician where I will be starting F1 work, and provided me with a contact detail for them. It is nice to know that everyone in the specialty is connected and friendly with those of all levels!