

A shared pursuit of excellence



by Michel D'Hooghe,
Chairman of the UEFA
Medical Committee

We often talk about the evolution of top-level football and the consequent evolution of the team doctor's role. This has become an important issue in recent years, as medicine for elite athletes has developed from general medicine to sports medicine and now to sport-specific football medicine. The aim of those who offer medical care and support to footballers is now to ensure not only that they are best prepared for the general types of medical situation that occur in a sporting environment, but also that they are specialised in managing situations that are most common in the football environment.

Identifying standards for football medicine is, of course, easier said than done, especially within a large sports medicine community such as that of European football, where medical parameters can vary as widely as cultures. So it was especially satisfying for me and my colleagues on the UEFA Medical Committee to be eyewitnesses to the fruition of UEFA's most significant education initiative to date – a project designed to set benchmarks, teach expert skills and share best practice on a pan-European basis. UEFA's Football Doctor Education Programme was launched by a workshop held in Vienna in February and is designed not only to teach skills to the doctors at UEFA's member associations but also to teach them to disseminate these skills within their own countries. This idea of "cascading" knowledge has already borne fruit with a seminar in Scotland which promoted the content of the UEFA Football Doctor Education Programme to a wider domestic audience.

As the new project is outlined elsewhere in this issue, there is no need to go into greater detail here. Suffice to say, it represents an important step forward for the UEFA Medical Committee. The role of the team doctor is constantly evolving and becoming ever more demanding. Professional competency is, of course, the prime requisite. But in the modern game other qualities are also required. Medical services need to be fully integrated into the "team behind the team" and contribute actively in areas such as player equipment, training loads and warm-up routines, as well as drawing up diets and promoting healthy lifestyles.

This means the team doctor is required to spend time in the role of what you might call a "managing coordinator". The doctor needs to be the communication point for the players and the sole contact person between the medical team and the sports and technical staff. There is also a clear need to find the correct balance between the confidentiality guaranteed to players and the responsibilities and allegiances owed to the club. This is not always an easy task and today's team doctor needs good communication skills, an acute sense of respect and total commitment to the common cause.

In practical terms, one of the team doctor's fundamental roles is to establish links with specialist areas – not only orthopaedics, pharmacology, cardiology and so on, but also areas not traditionally considered to be the responsibility of the doctor, such as psychology, sports science and nutrition. The UEFA Football Doctor Education Programme sets out to address all these issues and promote a shared pursuit of professional excellence within the extensive family of European team physicians.

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UEFA • medicine matters

UEFA Football Doctor Education Programme

The evolution of the modern football doctor in recent years has seen the role develop significantly from the part-time physician shared by many clubs and in attendance on matchday to the full-time, highly specialised medical team manager found in today's game.

Football doctors are sports medicine specialists and now, even more specifically, football medicine specialists with a unique set of skills geared towards the support of a modern football team and its players. As these players have become ever more financially valuable assets, and as absences from injury have now been clearly shown by the UEFA injury study to correlate with success on the field, the importance of an effective team doctor has never been greater.

As a direct result of this evolution in the role of the football doctor, the UEFA Medical Committee began identifying a potential need to share excellence and expertise in the field of football medicine throughout the European football family. The means to do so were eventually established in the form of the UEFA Football Doctor Education Programme, a three-stage training course for doctors from all 53 UEFA member associations that kicked off, for the first group of doctors, earlier this year.

The programme aims to use the experience and specialisms of UEFA Medical Committee members and external

specialists from the wider UEFA family to provide doctors with unique, elite, football-specific training. Attending doctors are given the chance to learn advanced skills and share their ideas and experiences with each other at group workshops designed to identify the key skills required by the modern-day football physician. The overall aim of the programme is to teach and impart best practice, and to ensure that all doctors working in UEFA competitions have the knowledge, skills and advice to exercise a high level of expertise in their field.

The programme takes a "blended learning" approach that offers a unique combination of written reference texts, practical workshops and e-learning, designed to ensure that all participants find a method of learning that suits their needs. Workshops are delivered by known experts in the field of football medicine, and the e-learning offers tools such as enriched video (where the user can pause video footage on a subject and click on a direct link to access documents related to the exact topic being discussed) and specially designed practical exercises that interactively test what the doctors have learned at the workshops.

Perhaps the most significant aspect of the programme is that attending physicians are also given detailed instructions on how to teach the programme themselves within their own countries, a process known as "cascading". All course materials (manual, presentations, images) are made available to doctors who have passed the course so that they can be translated and adapted for use by their associations. UEFA hopes that this will help its members raise the level of shared medical knowledge across all the doctors involved in their national leagues and associations.



One of the practical demonstrations at the first UEFA Football Doctor Education Programme workshop



When dealing with an injury, every step is important and must therefore be carefully prepared

In order to ensure the quality of the programme is maintained when cascaded, doctors attending the UEFA course are assessed in both practical and written exams and only those who achieve a high mark are accredited to cascade the content. Furthermore, cascaded courses will be audited by appointed UEFA experts. By opening the programme to all 53 member associations, UEFA hopes to establish a wide range of experts who can be used to deliver cascaded courses. In many cases, particularly where neighbouring countries share a common language, associations may decide to combine their national courses, further increasing the exchange of information and ideas across the game.

The cascading principle is fundamental to the programme, the emphasis being on extending the benefits beyond the confines of the workshops and helping the medical representatives of UEFA's member associations share all the knowledge gathered with their own football families – among clubs, coaches, referees and any of the other stakeholders in football. To spread the knowledge as quickly as possible, UEFA is providing three tools: technical handbooks, 40 to 50 trained course delegates to advise the associations at any time, and an extensive online platform with countless articles for interactive e-learning. The doctors are thus forcefully encouraged to spread the knowledge gained within their countries as effectively as possible.

The UEFA Football Doctor Education Programme is divided into five main areas. The three major ones are the emergency treatment of players, injury prevention and treatment and rehabilitation, while the other two cover the

roles and responsibilities of the football doctor and anti-doping measures.

Roles and responsibilities of the football doctor

Course participants are provided with an overview of what the UEFA Medical Committee considers to be the key skills, knowledge and expertise required by the modern football doctor. Examples, experiences and best practice advice are shared by current and former team doctors from the Medical Committee, who have collectively accumulated over 200 international "caps". Topics include managing relationships within the medical team, managing relationships between clubs and national teams, preparing and executing treatment plans, planning for major tournaments, and medico-legal issues.

Emergency treatment

In this section participants are taught advanced techniques for managing and treating serious and life-threatening on-field injuries. Focal points include airway impairments, cervical spine injuries, cardiac arrests, trauma, analgesia and wound management. This module aims to teach basic skills effectively rather than focus on more complex but lesser needed techniques. The doctors are given the opportunity to discuss and analyse real-life case studies from elite football and are assessed in both a written examination and a practical scenario, where they are required to solve a real-time, on-field medical crisis. Only doctors who pass both assessments are authorised to "cascade" this part of the programme in their own countries.

Injury prevention

This module provides participants with a unique insight into the findings and practical outcomes of the UEFA injury study, one of the world's largest and longest-running sports injury studies. In doing so it equips them with the latest knowledge and skills to understand the risks and minimise the incidence of injury among players.

Treatment and rehabilitation

Participants are briefed on the key factors contributing to the effective treatment and rehabilitation of football injuries and are provided with the knowledge and skills necessary to implement the most effective treatment programmes and thereby minimise the length of players' absences from competitive action.

Anti-doping measures

In this final part of the programme, participants are provided with detailed information on the role of the team



Participants follow one of the specialist presentations at the inaugural workshop in Vienna

doctor in the anti-doping process, including testing procedures, whereabouts requirements and therapeutic use exemptions. Particular emphasis is placed on how the doctor can help players avoid the risks of accidental anti-doping rule violations.

The first UEFA Football Doctor Education Programme workshop took place from 20 to 24 February in Vienna and was delivered by UEFA Medical Committee members from Scotland, Denmark, Turkey, Belgium, Italy and England, together with specialists in emergency medicine from Scotland and Germany. Of the 53 UEFA member associations, 50 were represented at this first workshop, which was delivered in two groups of 25 to encourage the best possible interaction between the participants.

This approach was hugely successful. In spite of – or maybe because of – their wide range of backgrounds and experiences, the doctors supported the programme wholeheartedly, with a number of first-team doctors from elite European national squads such as Portugal, Russia, the Republic of Ireland and the Netherlands ready to share their knowledge and experience with younger colleagues

at relatively early stages of their careers in international football. In doing so they showed they saw value in the programme and believed in its aim of ensuring the knowledge provided is rolled out effectively within and across the national associations. This pilot event thus proved that there is a family of football doctors within Europe who are ready to support the work UEFA is doing.

The participants at the initial workshop completed two of the modules outlined above, on the roles and responsibility of the football doctor and the emergency treatment of players. Having presented the first, Ian Beasley, a member of the UEFA Medical Committee and England national team doctor, reflected on the value of reviewing the ideal football doctor profile: *"I started in football in 1987 and it's now a very different role. Doctors should be a communication filter between players and managers and medical analysis, data, physios, etc., but actually working out how best to do all this is an interesting process to go through. It was really useful to hear the experiences of all the doctors [at the workshop] and to collectively identify which aspects of our role can really make a difference."*

Due to the risks inherent in teaching emergency life-saving techniques, the second module was delivered by emergency surgeons and experts in emergency medicine from SportPromote, a Scottish training organisation affiliated to the Glasgow Royal College of Surgeons. The module director, Jonny Gordon, was keen to emphasise the simplicity of the techniques being taught to the participants: *"We're doing the simple things here. We're not teaching advanced surgical techniques. It's just about the first critical moments. When the heart stops beating, the doctor will be under pressure and may even start to panic. It's an understandable reaction, since most of the doctors here don't work at hospitals in their day jobs. What we're trying to teach is simple techniques that the doctors can rely on in a stressful situation."*

Overall, the workshop was a resounding success for UEFA and put this ambitious programme on a sound footing. The participants will complete their first modules when the e-learning section opens in April and are expected to start cascading courses later this year. The first cascaded course has, in fact, already been delivered by the Scottish Football Association at Hampden Park in March, using the same instructors as on the UEFA course.

This was the first step in what it is hoped will be a revolution in medical education across European football. UEFA's course participants will attend their second workshop in February next year, where Prof. Jan Ekstrand, first vice-chairman of the UEFA Medical Committee and head of the UEFA injury study group, will provide instructions on injury prevention, supported by evidence from the world's most extensive elite sports education project.

Michel D'Hooghe, chairman of the UEFA Medical Committee, concluded: *"I am extremely proud that this Medical Committee initiative has started to bear fruit. We are at the early stages of what I hope will be a long and fruitful education process, bringing the European football family together in a shared pursuit of excellence. It is now the responsibility of the doctors to make sure that the knowledge gained will not remain exclusive and that, at some time in the future, football medicine knowledge will be embedded into the culture of European football."* ●

Cartilage injuries and management

By Prof. Mehmet S. Binnet, Dr Mehmet Armangil and Dr Kerem Basarr, University of Ankara Medical School

It is important for footballers, like other professional athletes, to have a life after their playing careers that is not marred by injury. Thankfully, health professionals can help protect these players' musculoskeletal health so that they can enjoy an injury-free retirement as well as a satisfying playing career. Retired players also need to pay more attention to diseases such as cardiac problems, diabetes, obesity and degenerative joint pathologies. The general health of retired players should therefore be routinely evaluated, and issues related to the musculoskeletal system should be assessed separately from other diseases. A simple approach can be adopted for retired footballers, for whom a general health plan can be integrated into a personalised fitness programme.

Footballers tend to finish their playing careers with overloaded joints even if they have sustained no major injuries. Microtraumatic cartilage injuries, for example, can lead to early degenerative arthritis, causing pain and disability in daily life. The main function of cartilage tissue is to provide a pain-free range of low-energy movement by decreasing friction. Healthy cartilage lays the foundations for a problem-free playing career in which footballers expect their bodies to continue to perform optimally under extreme loads and with extreme ranges of movement. However, accidents do occur and unexpected trauma, in particular, can cause shear forces or impact resulting in cartilage injury. The knee, the biggest joint in the body, is most the frequently affected, and footballers are among the most exposed to knee damage. The prevalence of knee osteoarthritis in athletes depends on the frequency, intensity and level of their sporting activity. The estimated rate of knee osteoarthritis among footballers is 19-29%, compared with 14-20% in long-distance runners and 31% in weightlifters. In a study by Kujala et al, the risk of knee osteoarthritis was found to increase five-fold in top-level male athletes with prior knee injuries.

In addition, secondary osteoarthritis of the knee develops at an earlier age in footballers than in other sectors of the population, with its origins traceable to ligament and meniscus injuries.

Common injuries such as meniscus tears and anterior cruciate ligament ruptures are also found to be associated with a higher incidence of osteoarthritis, according to several studies. Professional athletes who have undergone surgery for ligament reconstruction or meniscal pathologies are at particular risk of early arthritis. This is seen at an earlier age than primary osteoarthritis, which is more common in elderly people, with an incidence of 25-30% in the 45-64 age group and 85% at 65+. Primary and secondary osteoarthritis are both cartilage-eroding and destructive pathologies.

All evidence indicates that footballers require a strong muscle structure to avoid injury. The muscular system acts



Knee pain can be managed with cold-application

as a dynamic support for extreme joint loading. Weak muscles lead to major injuries and increase the after-effects of microtrauma to joint cartilage. The problem with cartilage injuries is the progressive nature of the pathology due to the unique properties of cartilage tissue, which contains no blood vessels, nerves or lymphatics and is 2-4mm thick. These properties lead to delayed or insufficient healing after injury.

In addition to the lack of blood and the lack of healing response from progenitor cells in the blood, cartilage cells have a limited capacity to proliferate and regenerate. Cartilage injuries heal with a different tissue, known as fibrocartilage. This is biomechanically inferior to the original hyaline cartilage in terms of replicating the functions of hyaline cartilage, such as absorbing shock and minimising friction. Disturbed balance within the joint leads to pain during physical activity and can limit movement depending on the severity and location of the injury. These symptoms may hinder performance and interfere with everyday activities.

Impaired cartilage function leads to increased loading in neighbouring areas and further damage to the joint. A full and pain-free range of movement under any loading condition is vital for any kind of sporting activity. A non-healing cartilage problem results in symptoms which usually worsen over time, leading to early osteoarthritis – as explained, a significant problem in football medicine. Management of this disorder should be realistic and designed according to the lifestyle expectations of the

patient. Non-surgical methods are sufficient to treat most everyday problems, and obese ex-players should be encouraged to lose weight to avoid excessive loading of the knees and ankles. This seemingly easy-to-achieve goal sometimes requires considerable effort and should be part of a comprehensive programme of daily activities designed to protect the individual's joints from extreme loading.

As the number of footballers with osteoarthritic pathologies is increasing, it becomes increasingly important to prevent cartilage injuries during active playing careers and transitions into retirement. There are three major risk factors that can be managed with preventive measures:

1. excessive musculoskeletal loading;
2. high body mass index; and
3. previous knee injuries.

According to Hochberg, the prevalence of knee osteoarthritis could be reduced by 15-30% by avoiding squatting, kneeling and the carrying of heavy loads. The Osteoarthritis Research Society strongly recommends stringent weight control to prevent osteoarthritis, estimating that maintaining body mass index at 25 or below would reduce osteoarthritis in the population by 27-53%. As mentioned above, knee injuries such as meniscus tears and ligament ruptures are strong risk factors for osteoarthritis. Prevention

An appropriate response on the pitch can prevent complications later



programmes for sports injuries, especially anterior cruciate ligament injuries, have recently shown promising results. According to Norwegian studies, it is possible to prevent anterior cruciate ligament injuries using neuromuscular training programmes. After retiring from professional sport, moderate or low-intensity exercise and weight control can be useful to prevent osteoarthritis.

The most important preventive measure is to recuperate muscle power. Dynamic muscle balance and force need to be regained with well-designed exercise programmes featuring isometric training, which is also good for general health. Simple exercises with moderate weights play a key role in these programmes. Even 30-minute sessions combining flexibility movements with short weight-lifting activities are helpful in ensuring a problem-free everyday life.

The sudden onset of knee and ankle pain can be managed with cryotherapy (cold-application), which can decrease inflammatory swelling. Cold-application may also be used as an analgesic agent. The most simple and widespread technique is to use ice or cloth soaked in iced water (direct ice-to-skin contact for long periods should be avoided to prevent cold burns). This technique is applied over four to six sessions usually of 15-20 minutes an hour. After the oedema and/or swelling has reduced, cold-application should be terminated. Physical therapy and drugs are the next step in the event of persistent complaints, and advice from a professional physician can be helpful to determine the ideal dose and combination.

Nowadays, there are various way to evaluate the extent of cartilage injury. Besides clinical examination, widely used techniques include X-rays, computerised tomography and, in particular, magnetic resonance imaging (MRI). After a definitive diagnosis through radiological imaging, age and level of physical activity are important factors when deciding on treatment. Arthroscopic debridement, high tibial osteotomy (HTO) and arthroplasty (unicompartmental or total) are the main methods of treatment for older patients, as explained in more detail below.

Technical, biological and scientific advances in recent decades have provided better treatment options for cartilage injuries, but a simple, effective and universally accepted method has yet to be discovered.

Traditional treatments are based on the principle that stem cells in peripheral blood may promote the healing process in the defective area. In cartilage injuries not extending below the subchondral bone, there is no bleeding due to the avascular nature



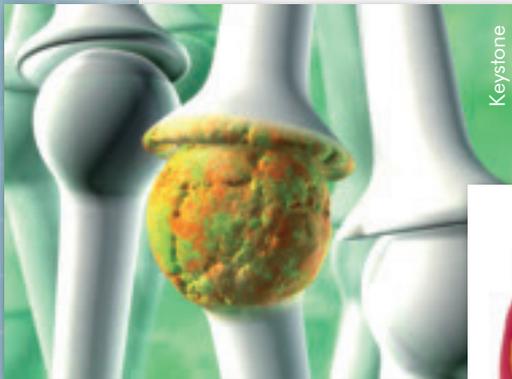
of articular cartilage. This is especially helpful in defects smaller than 2-3cm². The techniques used in such cases are almost always arthroscopic and minimally invasive.

In these kinds of minor cartilage injuries, pain and soreness are usually present in joints after normal everyday activities, but symptoms may be aggravated by meniscus ruptures. Meniscus ruptures among older patients are different from those sustained during an active sporting career. The elasticity and durability of meniscal tissue decreases with age, when small forces may damage this structure. Meniscal pathologies may be diagnosed by a sensitive joint line on palpation, clicking noises during flexion-extension movements and special physical examinations indicating a rupture.

In retired players, arthroscopic debridement can be useful for both meniscus removal and evaluation of cartilage, which is frequently damaged in patients with meniscus ruptures. Mechanical barriers to joint movement are cleaned with arthroscopic debridement and relief can usually be obtained as a result. This relief may also delay the need for joint arthroplasty in last-stage joint arthritis.

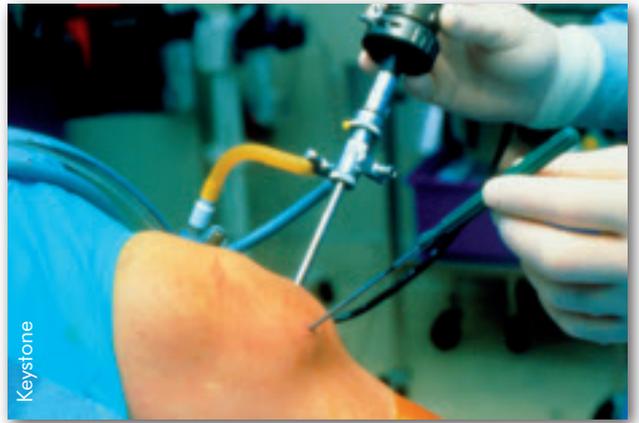
Subchondral drilling is based on making perforations in the subchondral bone with a wire and perforator, providing a passage from the injured area to bone marrow and blood. Microfracture surgery, meanwhile, is performed by making small fractures in the subchondral bone to promote healing. Both methods produce a limited healing response as they produce fibrocartilage, which (as explained early)

is inferior and often cannot meet the expectations of a professional or amateur athlete, or even an active young adult.



Osteoarthritis

Knee
osteoarthritis
x-ray



Arthroscopy of a knee joint

implantation and mesenchymal stem cell (MSC) transplantation. Autologous chondrocyte implantation involves harvesting cartilage through an arthroscopic procedure, proliferating the chondrocytes in cultures and, finally, implanting the chondrocytes by direct injection or by matrix scaffolds in a separate procedure. As for MSCs, these retain both a high proliferative potential and multipotentiality, including the potential for chondrogenic differentiation. A number of studies have reported on the use of MSC transplantation on animals, but its application in cartilage repair is still at an early stage, with more clinical studies required. Both of the above procedures, however, will probably shape the future of cartilage injury management and provide hope for top players.

The other treatment option mentioned in this article is knee arthroplasty, which involves removing the arthritic parts of the knee joint and replacing them with prosthetic implants. A decision on which type of arthroplasty to use (total or unicompartmental) should be made before the operation. Factors affecting this decision include the patient's age (especially when 60+), pain levels that limit the majority of everyday activities, and a recorded increase in physical limitations. Age, however, is the predominant factor in indications of arthroplasty.

Patients should be informed that after total knee arthroplasty they should limit their activities to make their repaired joint last longer. For example, swimming breaststroke should be avoided because it applies high levels of torque to the knees; if a patient wants to play tennis, they should be advised to play doubles; and in golf, short steps are advised to prevent excessive loading of the knee. The key issue during any activity is to avoid excessive loading of the knee while nonetheless enjoying the activity. The challenge is to achieve the ideal balance between these two concerns.

To conclude, cartilage injuries in sport cause major problems and are common in football. When planning a treatment strategy for an ex-professional player, the patient's expectations should be taken into account and managed, with the ultimate aim of achieving complete freedom in everyday life. The patient should be encouraged to explore new interests and hobbies which avoid excessive loading of the knee. Preventive measures are key, but doctors also need to take into account the differences between a normal patient and one that has been a high-level athlete. ●

Sports psychology in football

By Prof. W. Stewart Hillis, Professor of cardiovascular and exercise medicine

The concept of a “team behind the team” in club and national team football has stimulated the integration of medical support groups working closely with coaching staff. Together they take care of the preparation and well-being of their players to produce optimal individual and team performances and the best possible results.

The physical preparation of players has improved with medical advice and the integration and development of nutritional support, fluid balance and sports science. With the ever increasing speed of the game, managing acute injuries remains a challenge, but it has been greatly helped by appropriate imaging techniques and medical treatment allowing the development of player-specific rehabilitation programmes. In club teams, day-to-day contact is made with the players, personal relationships are established, individual personalities and attitudes to injury are familiar,

and there is ongoing daily interaction between the doctor, physiotherapist, player and coach. General support can be given to injured players by listening to their concerns, giving them reassurance and setting them early goals that are challenging but achievable. In addition, strategies can be developed to counter setbacks and unrealistic expectations. Documentary evidence of successful treatment can be given and positive communication can be established with the coach, whose main interest is inevitably those players who are fit and available for team selection rather

Elite footballers play almost 60 competitive matches a year



than with those with injuries. Other tangible support may be given by suggesting facilities and services available to help rehabilitation. Coping mechanisms may be developed with regard to a certain player's performance, and support can be given in case there is a medical reason, such as injury or overtraining, for their not being selected or for their poor individual performance. Continuity of care and contact is maintained.

The medical management of national team players poses different problems. When a player reports for international duty, the first step is to examine them for carry-over injuries and, if need be, decide whether they should return to their club or remain with the national team for treatment. Early imaging can facilitate clinical decisions to the advantage of all. It is appreciated that players are on loan for international duty and the national team's medical staff therefore keeps club medical staff up to date about the condition of their players. A player's commitment to their national team is usually absolute and bolstered by the expectations and positive feedback of family, friends and club coaching staff. This may, however, be influenced by their attitude towards playing friendly matches within a very busy club season of competitive domestic and international matches. The club versus country issue may also be aggravated by pressure from their club coach about the risk of injury in a non-competitive match and the subsequent possibility of losing their place in the club's starting lineup.

Psychological management of athletes

In light of these observations, physical assessments and clinical treatment need to be complemented by means of a holistic approach to players that includes psychological management. Sports psychology has an important role to play in the management of both individual and team athletes, although this medical specialism has been most widely applied to individual sports to date. The psychological management of footballers has thus far generally been assumed by motivational consultants whose training and background vary.

The preparation of any athlete includes psychological elements such as concentration and goal setting, mental rehearsal, pre-competition routines, rituals for managing anxiety and coping strategies for success, failure and potential injury. The specific application of these techniques varies greatly across sports, as does the level of support available from coaches and medical staff. Below are a few examples:

- In individual track and field athletics, athletes are able to compete on the basis of their own abilities on the day of the competition and their preparation and individual performance allow them to remain in control. They are also available most of the time for advice and support from their coach.
- In elite tennis, particularly in singles competitions, a coach can give encouragement and advice to promote

To maintain team spirit, it is important for all players to participate in activities such as warm-ups



their player's confidence between points. Players can develop their own rituals, for example the number of times they bounce the ball before serving, and they can use the time between serves to hurry or delay play. In doubles, each player can communicate verbally and non-verbally with their partner regarding the placement of serves, and after a winning point this can be complemented by high fives and fist bumping. Fluids and snacks can be given between points and interaction can be had with the coach to build or repair confidence.

- In golf, visualisation can be practised and utilised, particularly in putting, whereby the player conjures up a mental picture of their next strike, the potential line of the ball and its drop into the hole. In some team sports, the format of the game also lends itself to encouragement and support from other players and coaching staff.
- In cricket, discussions can be had and support can be given to a bowler by the captain and other players between balls and after a wicket has been taken. Discussions and encouragement among batsmen are also possible between shots.
- In American football, the division of the teams into defence and offence means that mutual support can be given between each play. The stop-start nature of the game and the rotation of players also mean that there is a greater chance for players on the field to be encouraged from the sidelines and more opportunities for those not in the starting lineup to be introduced during the game.

The general principles and practices of sports psychology can also be applied in both club and national team football and the development of individual players can be supported by individual members of the "team behind the team".

The main psychological qualities required in football include sustained concentration, i.e. the ability to remain focused before, during and after each game. This is a special challenge in football, where players may face up to 60 competitive matches a year (compared with perhaps four or five competitions a year in track and field athletics). Players who are regulars within their club teams have the opportunity to build self-confidence, which promotes perseverance in difficult situations. They can also influence the team's overall performance by showing enthusiasm, assuming responsibility and taking a positive approach. Selection for the national team, however, creates a new set of potential problems, not least as a result of the increased level of internal and external expectations.

Psychological management on the national team

Promising young players may be brought into their senior national teams to gain experience in that environment, knowing they are unlikely to play. Just being selected will be enough to satisfy their immediate ambitions. Better established players that are regular starters for their clubs



Selection for the national team can create its own difficulties, especially in case of injury

will have different expectations. They are generally in control of their game, which, at club level, allows them to produce their best performances. When they are promoted to the national team and are challenged at a new level, different psychological problems are met. All elite players secretly feel they are the best in their position, otherwise they would not survive the pressures of the modern game. Each also has their own strategy for preparing for a game, all the while knowing that these individual preparations may feel like a waste of time if they are then not selected to play. This leads to a period of uncertainty leading up to kick-off which could be called the "worst three hours". It is perhaps best illustrated by walking through the build-up to a national team match.

As matchday approaches and the national team is preparing, the nation is buoyant with the natural excitement of international competition. The match is a sell-out and seats at a premium. Family, friends and acquaintances contact the players, coaches and backroom staff with requests for tickets; knowing one of the players is a great source of pride for family and friends looking forward to the big game.

Within the squad, the mood is good. Training is going well, with the usual increase in focus among the players, many of whom are rivals at club level but, perhaps surprisingly, bond on the national team and enjoy the novelty of playing side by side.

During training, it is very important for the coach to size up those likely to be in the starting 11, but if this

happens too soon it can send messages to the players regarding their chances of starting the game. This is particularly the case if the team's preparation follows a regular pattern, and it may result in some players withdrawing or responding aggressively to a perceived rejection.

The potential of not being selected can lead to anxiety or anger which may be focussed on the coach and back-room staff. Not only may these negative thoughts be evident while with the national team; they may also influence the player's attitude when they return to their club. If they were not involved in the match at all, they may feel that the week of preparation could have been put to better use as a break, with minimal club training and increased family time.

The players will know who is in the starting lineup the day before the match at the latest, as specific roles and positions must be determined. The squad as a whole, however, comprises 26 players (typically 3 goalkeepers and 23 outfield players). In addition to the starting 11, 7 will be selected for the substitutes' bench. The other 8 will be in the stands and play no role in the game. Ideally these unselected players should remain upbeat and supportive of the team but it is often difficult to overcome the extreme disappointment of being left out. It is important for the coach to know how to deal with these players and how to tell them they have not been selected. Approaches vary but all rely on each player's team spirit and commitment to the squad. Ideally the coach should have one-to-one discussions with the players to explain the decision and give them time to come to terms with it, so that the impact of the "worst three hours" can be minimised. In the immediate build-up to a game, however, this may not be possible.

The substitutes may not be announced until the team's last meeting before the game and this meeting is often not attended by the medical staff, who are unaware of the chosen substitutes and therefore do not target the

others with appropriate support. The substitutes may even be announced on arrival at the dressing room.

The medical staff's priority is to support the players involved in the match, but they must also think about how they can help the others. This can be difficult and their direct contact with the players may be limited as they prepare the medical equipment for the game, but small things can be considered. Below are just a few examples:

- Unselected players should stay in the dressing room until the others start their warm-up.
- If the squad has numbered drinks bottles, those of the unselected players should be subtly removed and not noticeably discarded, so as not to emphasise the unselected players' exclusion.
- With the help of administrative staff, the unselected players should be guided to the appropriate area in the stands and have easy access to the dressing room at the end of the game. If possible they should sit with the members of the medical staff not on the bench, so that team cohesion is maintained.

In summary, the medical "team behind the team" cannot have a direct influence on the result of a match, as this depends on the coach's tactics and the players' performance. However, through preparation and foresight they can play an important part in maintaining the confidence and physical and psychological well-being of the squad as a whole. ●

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Dialogue is crucial to the relationship between coaches and their players

