

## Sports medicine: some ethical issues

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The ethical aspects of sports medicine have hitherto received little scrutiny, in contrast to its legal implications, which have recently been subject to much greater discussion. However, the differences that are apparent between sports medicine and 'mainstream' areas of clinical practice can shed new light on a number of the central issues within health-care ethics. By means of hypothetical case studies, this paper seeks to examine some of these issues within a sports medicine context. Specific attention will be paid to the concepts of autonomy and paternalism, issues to do with truthfulness, and the question of conflicting professional loyalties. It is suggested that the ethics of sports medicine warrant further and more detailed examination.

**Keywords:** Ethics, sports medicine, physiotherapy

Over recent years, there has been a growing interest in the ethical implications of health care in general, and medical practice in particular. There are over half a dozen major journals devoted to ethical issues in health care, and a steady proliferation of textbooks. One of the best known texts<sup>1</sup> has now entered its third edition and seems destined to be as much a 'standard work' on the subject as many of the classic works in medicine and surgery.

Much of the attention in this field has been given to high-profile issues, such as those to do with the beginning and end of life and/or those concerned with medical technology<sup>2-4</sup>. More recently, the ethics of resource allocation and other aspects of health policy have received considerable attention<sup>5</sup>. Although by no means ignored, the ethics of the routine clinical encounter, in which life and death issues are not at stake, have been scrutinized noticeably less. When the more 'minor' issues of health-care ethics are addressed, this is often within the specific context of the ethics of nursing<sup>6</sup> rather than in the primary medical focus of health-care ethics. In addition, while there have been studies on the ethical issues that arise in community settings such as general practice, the main ethical focus has

tended to be on health care as it occurs within a hospital setting<sup>7</sup>.

Sports medicine is an area of practice which has not featured largely within health-care ethics, and yet the specific, and sometimes unique, features of this field of practice shed new light on many of the standard debates in health-care ethics.

### Specific features of sports medicine

There are a number of ways in which sports medicine differs from the predominant form of practice in 'mainstream' medicine, physiotherapy and allied fields. Whereas mainstream medicine and physiotherapy are, as we have noted, hospital-centred, sports medicine is generally pursued in private practice, at sports clubs, health centres, and, of course, at the track- or pitch-side. Injured sports participants do, of course, find themselves in hospital, but when they do they tend to encounter practitioners in specialities such as orthopaedics, rheumatology and emergency medicine, rather than a specialist in sports medicine.

This removal from the institutional setting also helps to explain the rather different relationships that exist between sports medicine practitioners, their employers, official sports organizations, professional colleagues and patients. The pattern of relationships encountered in hospital practice does not usually exist in the context of sports medicine.

Another distinctive feature of sports medicine is the link between the pathology concerned and a specific recreational or professional activity. A sporting injury has a direct and immediate impact on participation in this activity; this has particular psychological<sup>8</sup> and, in the case of professional sports persons, financial implications. The fact that injury is directly connected with a pursuit or occupation that is of personal significance to the individual helps to explain another factor, which is that many sports participants are fairly knowledgeable about sports injuries (which is not to say that they do not misunderstand some of the processes involved), and show particular concern for their physical well-being.

Probably the most obvious difference between sports medicine and mainstream medicine and physiotherapy is the fact that, setting aside the presenting injury, the patients treated are generally healthy. Indeed, many sports persons are, almost by definition, healthier than the average individual.

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This, coupled with the fact that most of the conditions encountered are musculoskeletal rather than systemic, largely explains the scarcity of life and death cases in sports medicine.

Considerations such as these create a specific context for the ethics of sports medicine, and cause us to take a rather different perspective on some of the classic ethical issues in health care. Before doing so, however, it is important to clarify what is included within the phrase 'ethics of health care'. The term 'medical ethics' has often been used to cover a range of issues. In addition to genuinely ethical, or moral, considerations, it has frequently referred to matters of etiquette or professional courtesy, particularly when employed in the sense of 'professional ethics'. Remarks such as 'it is not ethical for a consultant to see a patient without a general practitioner's referral', or 'health professionals should not be seen to disagree in front of a patient' may raise some moral issues, but the primary underlying concern is often with the formalities and courtesies of interprofessional dealings. Matters such as these should be considered under the heading of 'professional etiquette', and 'medical ethics' or 'health-care ethics' should be reserved for those instances where there are distinctively moral issues at stake. Of course, some situations may come under both of these headings.

The ethics of sports medicine should also be distinguished from the law as it relates to sport (an area which has recently received detailed consideration<sup>9</sup>). One refers to morality, the other to a set of enforceable social rules. Although it is desirable that the law should be grounded in moral principles, and that matters of moral importance should be given legal backing in many instances, none the less not everything that is illegal is immoral, and similarly not all immoral behaviour is against the law. Thus, when we speak of the ethics of sports medicine, we are not concerned with etiquette or law, but with basic issues of morality – of right and wrong, good and bad.

### Some specific issues

We are now in a position to address some specific ethical issues within the context of sports medicine. These will be considered with reference to three hypothetical case studies.

#### Case study 1: autonomy

Beauchamp and Childress<sup>1</sup> describe autonomy in terms of 'personal rule of the self while remaining free from both controlling interferences by others and personal limitations, such as inadequate understanding, that prevent meaningful choice'. Gillon contrasts the notion of autonomy with that of freedom:

In the sphere of action it is important to distinguish between, on the one hand, freedom, liberty, license, or simply doing what one wants to do and, on the other hand, acting autonomously, which may also be doing what one wants to do but on the basis of thought or reasoning<sup>10</sup>.

A basic ethical principle in health care is that of respect for autonomy. This requires health profes-

sionals to do their utmost to preserve, and perhaps also to enhance, the autonomy of their patients. The main ethical basis for informed consent is that failure to obtain consent is to undermine the individual's autonomy. Similarly, to mislead or lie to patients is to fail to give them the necessary information with which to make autonomous choices.

There are a number of factors that can threaten a patient's autonomy. Within an institutional setting such as a hospital, patients tend to find themselves in a dependent and subordinate position in relation to those caring for them. This, and the disconcerting unfamiliarity of their surroundings, can make it hard for them to voice and insist on their own wishes and intentions. An essential component of autonomy is knowledge. A number of patients have little understanding of the pathological processes affecting them and the therapeutic procedures employed in their care, and their capacity to make autonomous decisions suffers accordingly. Illness itself can have a disorienting effect on the individual, especially if it has marked psychological sequelae. In addition, and at a purely practical level, even if the patient can form perfectly autonomous intentions, illness or disability can prevent these from being physically implemented. Finally, serious, life-threatening conditions can cause some patients to become fatalistic or subject to a sort of paralysis of the will, such that they allow, or even oblige, others to make decisions for them with little participation on their part.

How do these factors translate into the sports medicine arena? The following is an adapted summary of a case presented by Bruckner<sup>11</sup>:

Shirlaine is a physical therapist treating a public high school student, who is a state-level wrestler and weight-lifter. Noting excessive muscular hypertrophy, she questions the student, Donald, and eventually elicits from him an admission that he has been taking anabolic steroids. Shirlaine points out the serious side effects of such drugs, but although Donald is aware of the attendant risks he professes not to be concerned with these, claiming that winning the state championship is the primary goal of his life. Donald's likelihood of success in the championship has been the subject of much public hope and speculation in the town, and his coach has been pushing him hard in training.

Is Donald's drug taking autonomous? It is immediately noticeable that many of the familiar threats to autonomy apparently do not apply here. Donald is not in hospital, and his relationship to his physical therapist appears to be far less subordinate than that of a hospital patient to his or her specialist. Nor is he unwell in any obvious sense. He is physically capable of enacting his decisions. Similarly, there is no reason to think that his cognitive or decision-making powers have been adversely affected by illness or disability, and it is reasonable to suggest that he has a fair understanding of the medical issues at stake. He has not taken drugs out of necessity to avert a serious threat to his health, but has done so, it would seem, to gain the 'optional extra' of heightened physical capacity.

However, despite the dissimilarities between Donald and the classic picture of the non-

autonomous patient, there are reasons to question the authenticity of his choice. Most obvious perhaps is the influence of his coach and the psychological pressure exerted by friends, neighbours and relatives in his town. There is also the possibility that the emphasis on succeeding that exists in high-level sport has distorted Donald's goals. The immediate objective of winning state championships in two sports may have suppressed his concern for longer term welfare (just as he has ignored threats to his health, he may also have neglected his studies and his personal relationships in the process of achieving greater levels of fitness). In general, we tend to think that lack of autonomy consists in being led to do things that are contrary to what would normally be one's inclinations; the non-autonomous person is often thought of as doing, or being made to do, the opposite of what he or she wishes to. In this case, however, it is more a question of Donald being led, or leading himself, in the same direction that he himself has chosen, but excessively so. It is as if his desires have developed too much momentum and have escaped his control. On the other hand, the possibility remains that, however irrational it may seem to an outsider taking a detached, long-term view, Donald is in fact truly autonomous. Perhaps he genuinely does think that sporting success in his youth is more important than his future health, career and personal relationships. Individuals differ in the importance they attach to short- and long-term goals, and health professionals should be wary of labelling as irrational any decision they personally disapprove of or cannot understand.

If, after careful thought, Shirleine is convinced that Donald is not acting autonomously, what should she do? She may feel that she should endeavour to persuade him against his own stated wishes, on the basis that these are not in fact his 'true' intentions. In other words, she would argue that she is able to judge his own best interests better than he. This is the basis of what is known as 'paternalism'.

The health care application of paternalism involves someone other than the patient (usually the health care professional) assuming decision-making responsibility for the patient, assuming veto power over the patient's decisions, or being ready to impose her will on the patient. The paternalistic person then limits the autonomous action (or decision) of another person and treats that person as if his competence were limited<sup>12</sup>.

For many, paternalism is unacceptable, as it suggests a notion of interference in the lives of others, with the health professional imposing his or her will on others, and thereby overriding their autonomy. Those who seek to justify paternalism, on the other hand, argue that in some cases it is only by such action that the welfare of the patient can be safeguarded. They would claim that the patient has no genuine autonomy and that therefore their own actions are not an infringement of autonomy but a substitute for it. Accordingly, whether paternalistic behaviour is justified hinges largely on the factual question as to whether or not the individual's capacity for autonomous decision-making is genuinely impaired. Shirleine must decide whether

Donald's choice is genuinely autonomous and, if so, whether respecting his autonomy is a more pressing ethical demand than protecting him from the harm which his autonomous action is likely to bring upon him.

### Case study 2: truthfulness

The notion of truthfulness is an important one in health-care ethics<sup>13-15</sup>. In classic discussions of 'medical ethics', the question of whether health professionals should disclose grave diagnoses to patients often arises. However, these are not the only occasions when truthfulness is at stake:

Dr B runs a weekly sports injury clinic within her general practice, and sees a variety of sports participants of various ages and abilities. Two of her patients, John and Audrey P, have brought their 15-year-old daughter, Annabel, to see her. Annabel is a promising gymnast who has recently been experiencing recurrent episodes of back pain. Dr B could not identify any specific injury, but was struck by Annabel's lumbar hypermobility, which seemed excessive even in a gymnast. As a precaution, and in view of the persistence of the symptoms, she ordered a radiograph. The radiologist's report indicated no specific lesion, but did remark that there were early signs of degenerative changes in the spinal apophyseal joints. Dr B was immediately led to consider the effects which continued participation in top-class gymnastics might have on Annabel's spine, and wondered what, if anything, to say to her and her family.

There are a number of factors that need to be taken into account when deciding what information should be given to a patient: the certainty of the facts involved, the likely effects of telling or not telling, the question as to whether the patient 'wants to know', and the wider ethical issue as to whether the patient has a right to know the truth. In respect of the last of these, it is generally agreed that, all else being equal, patients should be told the truth about their condition. However, the other factors listed may mean that all else is not in fact equal.

In the first instance, the extent to which it is right to tell a patient certain information is influenced to some extent by how sure one is about that information. In this case, it is at best a statement of probability to say that Annabel will suffer significant pain or disability in later life. However, it should be remembered that what is at issue is not the truth in any objective sense, but the truth as it is honestly perceived by the individual practitioner. Dr B must decide on the basis of what she believes to be the case, even though events may subsequently contradict her.

The whole truth is out of reach. But this fact has very little to do with our choices about whether to lie or speak honestly, about what to say and what to hold back<sup>16</sup>.

Second, to say that the patient has a right to know is not to say that the doctor automatically has a duty to tell. If there is a right to know there is also, presumably, a right not to know. The final decision will largely be governed by whether or not the patient wishes to be informed. This is not easy to judge: 'The logical difficulty here is that the very nature of disclosed information may determine the patient's desire to be acquainted with it, by which time of

course it is too late'<sup>15</sup>. Would Annabel wish to know of the future pain and disability she is risking? It is not clear that this question would be satisfactorily resolved by asking her parents, as parents often seem to have as much at stake in their children's sporting success as their sons and daughters themselves (and there is, moreover, no strict guarantee that parents always have their children's best interests at heart, even though this assumption is often made in discussions of health-care ethics). There is no standard solution to this question, but it is probably wise to put the burden of proof on the advocate of non-disclosure, i.e. to work on the basis of disclosure unless there are convincing reasons to suggest that this is against the patient's wishes.

If the effects of telling the truth seem to be manifestly worse than those of not telling, it might be argued that the doctor should keep silent. If the reverse were the case, this would be further justification for disclosure. An obvious question is, assuming that Annabel was told of Dr B's misgivings about possible future damage to her spine, how useful would this information be to her? Would it make a meaningful contribution to Annabel's plans for her future in gymnastics, or would it merely be a source of confusion, distress and indecision? If she were to decide to withdraw from competitive gymnastics, how would her parents react to this – indeed, to what extent would she be permitted to make such a choice for herself? The fact that Annabel is still a fairly young girl has a bearing on the issue. It is not so much that her age as such prevents her from making a rational, informed decision in the light of information about her future health. Rather, it is arguable that she is not yet sufficiently mature to form an autonomous decision in the face of the psychological pressures which she is likely to be exposed to as an aspiring athlete – much the same pressures from family, friends and coach which affected Donald in the previous case. On the other hand, it could be argued that pressures such as these are not a reason for withholding the truth in a paternalistic way, but for ensuring that the right conditions for autonomous choice are provided once the truth has been told. Perhaps the overriding ethical concern is to provide the information, to the best of one's ability, that is necessary for the patient to decide and act autonomously. Appropriate steps can then be taken to facilitate and support the patient in making these decisions, and if the whole process is rather more painful than a state of ignorance, this may be seen as an inevitable cost of autonomy.

### Case study 3: conflicts of duties

Health professionals have various duties and responsibilities. The precise nature of their professional duties and allegiances depends upon the network of relationships in which they find themselves. At times, these obligations may pull in opposite directions, and lead to an ethical conflict which the practitioner must attempt to resolve.

The following case illustrates such a situation:

John E is physician to a top-class rugby league club. Before an important fixture, he is asked by the team manager to

give the first team scrum-half a pain-killing injection for a sprain of the lateral ligament of the ankle; the club is currently short of a replacement specialist scrum-half. Having examined the injury, the doctor suspects that there is a partial tear of the anterior band of the ligament. There is, he reasons, a fair likelihood that a relatively minor injury could be transformed into a more serious one if the player were to play in the match, especially in view of the fact that the normal protective pain mechanisms would be at least partly abolished by the injection.

In this situation, Dr E may hesitate to administer the injection on the basis that he has a professional duty to protect the best interests of the players, who are entrusted to him as patients. In other words, he has a duty to protect his patients from harm (often referred to as the principle of non-maleficence<sup>1</sup>). His judgment may be that the chances of the injury being extended to a major rupture are too great to be risked, and that in order to preserve the player from likely harm, he should decline to give the injection.

However, he also has another duty – a contractual duty to the club that employs him. Since it is the club's wishes, as expressed by the manager, that their scrum-half should play in the forthcoming match, the requirements of Dr E's contractual duty to the club might appear to conflict with his professional duty to his patient. There are, however, a number of considerations which would suggest that it is the latter duty which should take precedence. In the first instance, Dr E could argue that his duty to the club is not to follow specific instructions, but to maintain and restore the health and fitness of the players within the terms of his professional judgment – it is for him to decide the precise steps to be taken in order to achieve this goal. In addition, he could claim that the interests of the club would be better served if their scrum-half were to miss the coming match in order to make a complete recovery and regain full fitness for the remaining games in the season. Perhaps the strongest argument that Dr E could advance, however, is that his duty to his patients must be his first concern, and that contractual or other responsibilities are of secondary importance. He might claim that obligations to the patient are more central to his professional role than those responsibilities associated with an employer-employee relationship; the former are part of the very definition of being a doctor in a way that the latter are not. Thus, he might argue, where it is a choice between duties to a patient and those to an employer, the patient must be put first (unless, perhaps, the duty to the patient is disproportionately minor in comparison to the contractual requirement).

So far, it is not hard to be convinced that Dr E should decline to administer the pain-killing injection. This seems to be where his principal ethical duty lies. Indeed, it could be said that in this case the main consideration urging compliance with the manager's request is not an ethical one but a prudential one, i.e. that his own financial and career interests would be best served in this way. Suppose, however, that the scrum-half asks him for full details of his injury and the implications of playing on it, and, having heard all this, asks that he be given the injection none the less. This casts a new light on the situation, as the

player has now voiced a specific wish to receive the injection. Given that he has received a full explanation of the circumstances, and assuming that there are no barriers to his comprehension, this would seem to be a fully autonomous wish. Whereas before, a duty to the patient (in the form of non-maleficence) required that no injection be given, another duty to the patient (in the form of respect for autonomy) now seems to require that the injection should be given after all. In order to resolve this dilemma, Dr E must decide whether he attaches most weight to autonomy or non-maleficence, and faces much the same decision as Shirlaine did in the earlier case.

In the example just described, there seems to be a case to be made that the injection should be given. It is worth considering briefly another possible situation in which, although some of the key issues are the same, a different conclusion might be arrived at:

The physiotherapist for the same rugby league team is considering a player for return to match-play who has sustained an injury to the rectus femoris muscle. Although to the untrained eye the player would seem to have regained full performance, during late-stage fitness testing there is a perceptible hesitancy in the player's acceleration and signs of a slight loss of coordination during rapid changes in direction. The physiotherapist expresses his doubts to the player, who admits to feeling less than totally recovered, but none the less pleads to be passed fit; as a regular second-team player, he is eager to take advantage of a forthcoming first-team appearance to try to secure a regular place.

Similar factors operate here as in the case of the scrum-half and the team physician. Although respect for autonomy seems to suggest that the player's wish should be complied with, the chances that further, more serious, injury might occur during the course of a keenly-fought match urge the opposite course of action. However, there are additional factors to be considered which were not present in the previous example. Whereas, previously, the contractual duty to the club was at variance with the duty to protect the scrum-half from likely harm, in this case loyalty to the club coincides with and reinforces the requirement of non-maleficence. It is presumably not in the club's interest to include a second-team player who is less than fully fit when there are very likely other players who could readily fill his place (in the previous case, in contrast, there was no such alternative player). In addition, the reason why the physiotherapist might be inclined to pass the player fit – namely that this might assist him to obtain a regular first-team place – is counteracted by an equivalent reason acting in the opposite direction. While this player's future success may be furthered by allowing him to play, the future success of his team-mates is likely to be undermined in the process, as he is liable to perform at a suboptimal level while playing with a residual injury. In fact, this might expose other members of the team to a greater risk of injury themselves, through trying to compensate for the original player's lack of speed or manoeuvrability, or as a result of his mistakes. Finally, if the physiotherapist were to accede to the player's request, this would involve him in deceiving the club.

Even if, on all other grounds, the physiotherapist thought it justified to pass the player fit, the fact that this would require him to be deceitful would tend to tip the scales in the opposite direction.

There is no standard solution to conflicts of duties such as these. Each case must be considered in the light of all the relevant ethical considerations that bear upon it, and the conclusion that is determined in one case may be very different from that arrived at in another. Whether the decision reached is the 'right' one in any objective sense is often a question which cannot be answered, not least because one's initial reading of the situation, or the consequences that one predicts for various courses of action, may be overtaken or undermined by events. In much the same way, even the most careful diagnosis may subsequently prove to be erroneous. The important thing is for such a decision to have been taken honestly and conscientiously.

## Discussion

These three case studies have illustrated some of the ethical issues and dilemmas that may be encountered in sports medicine. In tackling these questions, the practitioner must pay careful attention to the specific nature of this area of practice: the sort of patients involved, relationships with other parties such as coaches and managers, and the particular psychological factors that operate in this competitive field of human activity. Although the examples given have been taken from top-class sporting activity, the same principles apply with respect to more modest levels of participation. While the extrinsic rewards will be different, the weekend golfer may derive as much intrinsic value from his or her game as those on the professional circuit, and there is an equal need in each case for careful and conscientious decision-making by the health professional.

The ethics of sports medicine have been largely neglected hitherto, and there is a need for a more explicit and detailed focus on this aspect of professional practice.

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