

Ethical issues concerning New Zealand sports doctors

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J Med Ethics 2005;31:88–92. doi: 10.1136/jme.2002.000836

Success in sport can provide a source of national pride for a society, and vast financial and personal rewards for an individual athlete. It is therefore not surprising that many athletes will go to great lengths in pursuit of success. The provision of healthcare for elite sports people has the potential to create many ethical issues for sports doctors; however there has been little discussion of them to date. This study highlights these issues. Respondents to a questionnaire identified many ethical matters, common to other areas of medicine. However they also raised problems unique to sports medicine. Some of these ethical difficulties arise out of the place of the sports doctor within the hierarchy of sport. Yet others arise out of the special relationship between sports doctors and individual players/athletes. This study raises some important questions regarding the governance of healthcare in sport, and what support and guidance is available to sports doctors. As medical and scientific intervention in sport escalates, there is a risk that demands for enhanced performance may compromise the health of the athlete, and the role the sports doctor plays remains a critical question.

Confidentiality and patient best interests as central concerns—may be compromised by the unique structure in sports medicine. Management staff may demand access to confidential health information about a player/patient, making demands that may not be in the best health interests of the individual patient. How doctors deal with these requests is of increasing ethical concern. Another potential source of ethical concern, of which little is known, is the influence of a contract on medical practice. In the era of the sports contract, doctors may find it increasingly difficult to maintain accepted professional standards without compromising the health and welfare of the athlete/patient.

Although we may hypothesise about the concerns of sports doctors in their work, little is actually known about the identification and resolution of clinical ethical problems by this group of health workers. Since 1980, material has been published in the sports medicine literature on the topic of ethics and sports medicine.¹ However most of it has been in the nature of opinion rather than based on collected data identifying the actual ethical concerns of this group.^{2–4}

The intention of the study was to identify and map these ethical issues by canvassing appropriate clinicians. This study identified a number of areas of potential ethical conflict for sports doctors and obtained their personal responses through a questionnaire. Eighteen respondents revealed concerns experienced in clinical practice. The results of this study are presented as a preliminary to further research incorporating more extensive interviews and robust analysis of qualitative data.

This project was reviewed and approved by the Ethics Committee of the University of Otago.

METHOD

As little was known about the ethical problems experienced by sports doctors, a questionnaire was developed to access a wide range of data. Although this technique did not provide in-depth information about an individual doctor's experiences, it did offer a framework of issues and concerns facing this group. The use of questionnaires as instruments of data collection has acknowledged limitations that will be explored later.

The questionnaire was administered at two venues within the months of October and November of 1999. These were the annual conference of Sports Medicine New Zealand in Queenstown, New Zealand, and at a postgraduate residential training weekend for students in the postgraduate diploma programme in Sports Medicine at University of Otago, Dunedin, New

Support has become increasingly important in New Zealand culture, both to society and to the individual. For society, achievement in the sporting arena can provide a sense of national pride. Professionalism in sport also offers the potential for huge financial and personal gains as well as national and international acclaim for the individual athlete. The possibility of vast rewards creates immense pressure on individuals to succeed in sport, and indeed many go to great lengths to achieve success. It is not difficult to understand how healthcare professionals working with elite athletes or teams might also experience pressure. This can take the form of pressure to return the athlete to sport more quickly than is medically indicated, and to reduce the effects from injury and high training levels. For example, a doctor might face unrealistic expectations from an athlete or coach who insists upon an inappropriately rapid return to sport after injury, or demand results that challenge a doctor's accepted standards of judgement and clinical decision making. Another possibility for ethical conflict arises from the doctor's position within the sport management hierarchy. The traditional doctor-patient relationship—which holds confi-

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Received 19 June 2002
In revised form
18 November 2002
Accepted for publication
18 March 2003

Zealand. Inclusion criteria limited the study to medical doctors working in the field of sports medicine. Forty five questionnaires were distributed of which 18 were returned. This represented a response rate of exactly 40%.ⁱ

The questionnaire was designed to explore and identify ethical issues facing sports doctors. Questions were set to elicit three different forms of data. The first were statistical data providing information about such matters as the length of time the respondent had been providing medical services to sports teams. The second were data obtained by the deliberate use of open-ended questions. This provided respondents with an opportunity to describe in their own words the typical problems encountered in the course of their clinical work. For example, "What (if any) are some of the ethical issues unique to working with sports teams as compared with the provision of other medical services?" The analysis of replies to such open-ended questioning was achieved by the identification and collation of central themes in the responses. Direct quotes from respondents have been used in reporting the data. Quotes are used for two purposes throughout this paper; firstly, to capture the particular theme expressed by a number of respondents, and secondly, to ensure that the voices of the respondents are maintained and expressed. The third form of data emerged from questions that were designed to gain the respondents' opinions on general issues of concern in sports medicine including attitudes to the use of painkillers in sport, and the World Anti-Doping Agency (WADA) list of banned performance enhancing drugs. These responses will not be discussed in this article.

Due to the sensitive nature of some of the material revealed by the questionnaire, every effort has been made to protect the identity of the respondents. Any material that has the potential to enable a respondent to be identified has been removed.

RESULTS

General statistics

The questionnaire was distributed to 45 doctors assembled for a sports medicine conference or postgraduate residential course. Of these, 18 doctors identified themselves as having worked with individual athletes or teams in the past five years and subsequently completed the questionnaire. The 18 doctors worked for a total of 61 teams. These included 22 national teams representing New Zealand, 20 teams representing regions of New Zealand, 13 club teams, and five school teams.

When asked if they had postgraduate training in sports medicine, two respondents indicated that they had no formal training. However one is currently completing a postgraduate diploma and the other has attended relevant seminars, conferences, and practical sessions. The other 16 indicated some formal qualification in sports medicine, ranging from postgraduate certificates or diplomas, through to fellowship and specialist status within the Australasian College of Sports Physicians (FACSP).

The average time spent in the practice of sports medicine was 8.8 years per respondent. The longest period in clinical sports medicine was 22 years, with one respondent only having worked two years in this discipline. Nine (50%) respondents were contracted to a team franchise or some other professional sports body.

When asked if any other health professionals also worked in collaboration with the team, a range of responses was obtained. Most doctors worked with a physiotherapist, and

ⁱA similar questionnaire was given to the sports physiotherapists present at the two meetings, however this paper will only report on the questionnaire designed for sports doctors.

sports trainers and masseurs were also common. Around half of the respondents had a sports psychologist and nutritionist working with the team. Other health professional groups mentioned were chiropractors and podiatrists. Only one doctor stated that he/she worked alone.

Sixteen doctors (89%) attended games in order to provide medical services, while 15 (83%) also attended team practices. Fifteen (83%) travelled to "away" fixtures with the team to offer medical services. Fourteen (77.7%) of respondents stated that other health professionals travelled to "away" fixtures; these included physiotherapists and massage therapists.

Responses to open-ended questions

The responses to the open-ended questions were analysed according to themes identified by the authors (for a full list of questions see <http://www.jmedethics.com/supplemental>). Some verbatim quotes have been provided and are in italics.

Ethical issues unique to sports medicine

The first question asked "What (if any) are some of the ethical issues unique to working with sports teams as compared with the provision of other medical services?" The responses to this question were grouped under the following themes: confidentiality and privacy, tension between the medical requirements of the patient and demands to play, responsibilities of the doctor, the nature of relationships in sport.

The most commonly mentioned issue was that of confidentiality and privacy. Maintaining the confidentiality of health information of players was considered to be a problem given frequent demands for access to health information by coaches and management. There was also pressure from the media to obtain information about a player's health status. Privacy was also identified as a problem when attempting to provide patient care in confined or shared facilities, such as team rooms or shared communal training facilities.

The next issue raised by approximately half of the respondents identified difficulties between the medical requirements of the patient and the pressure to return the individual to the field. Respondents were concerned that returning an injured player to the field too early may compromise long term welfare, or that there would be some risk attached to this. Many identified the source of this pressure to return the injured athlete to the field as coming from the player, coach, or other team members:

"Tensions between getting a player back on the field rapidly and their long term welfare. Pressure from player to keep playing. Pressure from coach to keep players playing."

"The need to 'get the player back' (to the sport/game) for the sake of the game, even when there is some risk attached to this."

Some of the respondents were concerned about possible conflicts of interest. This was caused by a sense of shared responsibility to such individuals and groups as players, team management, and to the sports governing body:

"Responsibility to player, team management, and union can present conflict of interests."

A small number of respondents were concerned about the nature of the relationship between themselves and team members and how they might professionally address this issue:

"Team relationships are often very important to establish especially privacy issues. Treating players needs without creating dependence/codependent relationships."

Other concerns raised by respondents included: the use of analgesics to allow injured players to continue, the problem of inadequate assessment on the field due to time pressure, and the high expectations of national and regional teams when stakes are very high.

Working within the sports management hierarchy

The next question asked respondents to describe the ethical problems that could arise when providing medical services given the many layers of team management. The responses to this question mirrored the answers to the previous question. Confidentiality and privacy issues, tensions between the medical needs of team members and pressure to return them to sport, and problems regarding conflicting responsibility were once again identified by the respondents. The unique problems of a sports management hierarchy were reflected in several quotes that also highlighted the confidentiality issue:

"Unless clear chain of communication [exists] more than one medical team member could give opinions and too many management (coach/manager) directors become aware of sensitive information."

"The individual athlete's privacy—as a doctor I am used to doctor/patient confidentiality—Managers/coaches/fellow athletes do not have this awareness."

Tension between the medical needs of the player and the demands placed on the doctor by the coach/player to return an individual to sport were mentioned by five respondents.

"Management and coaching pressures on player, and [on the] doctor to clear for return early or use techniques (medical) to allow them, to possible long term detriment eg steroid injections or local anaesthetic or place too much faith in strapping/padding and the like."

Other issues raised by respondents included:

"Doctor's place in team versus confidentiality, [same with] drug use—complicated by testing. If I know illegal substance being taken who is the doctor responsible to?"

The sports doctor's responsibility

The respondents were then asked to list the people to whom they felt a sense of responsibility. In this question respondents had an opportunity to list as many people as they wished. All of the respondents listed the individual team player as someone they felt they had a responsibility to; 13 respondents (72%) identified a responsibility to the coach. Ten respondents (or 55%) felt a sense of responsibility to the manager or management team. Eight respondents (44%) identified a sense of responsibility to other team members. Seven respondents (38%) identified the sports governing body as a group they felt a sense of responsibility to. Five respondents (28%) identified a sense of responsibility to themselves. Significant other individuals or groups listed by the respondents included professional medical bodies such as the New Zealand Medical Council and the College of General Practitioner's (six respondents or 33%), other sports physicians (two respondents or 11%), and other medical team members (5.5% or one respondent) (see fig 1).

When asked how they might prioritise responsibilities in the event of a conflict, 16 respondents stated that the player's interests came first and that their primary responsibility was to them:

"I treat the player or patient as my priority as a usual doctor-patient relationship, despite whom my 'employer' is. It is also important for the players to know that the team doctor is a person whom they can trust."

"Player first all others follow—if I do this then I am probably fulfilling my obligation to medical council and others."

"Player—long term health and career prospects come first."

The following are additional responsibilities that were raised as being significant:

"Coach—they have planning requirements [regarding] next in line for team."

"[Governing body]—use of drugs or unsafe medical practices may reflect badly on them."

"Myself—must be able to live with the end result if I am to keep working."

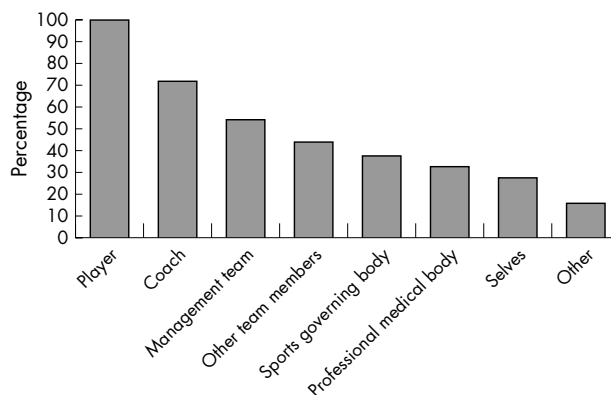


Figure 1 Groups to which sports doctors report a sense of responsibility.

"Team (as a unit or whanau) player may present dangers to them if not fit or result in the team not performing as well as it could."

The sports doctor's role

In response to the question; "Have you ever been expected to provide health care that is beyond your training or capabilities?" Fifteen respondents had not been asked to act outside of their training or capabilities. Notable exceptions included being requested to provide physiotherapy services such as manipulation or massage. One sports doctor stated that being female led to assumptions as to her role in sports medicine and a lack of regard for her medical knowledge:

"Being female, often expected to have physiotherapy skills! My sports medicine knowledge is not always taken seriously initially."

Another respondent raised an interesting concern that it was not a matter so much of skills but more of a lack of equipment:

"In the event of a major arrhythmia in a player or spectator at a match, I don't have a defibrillator, [so it is a] lack of equipment rather than lack of expertise."

Pressure from players

The respondents were then asked "Does the pressure on a player to maintain a place in the team give rise to any ethical problems for you as the doctor?" Seven of the respondents did not identify ethical problems, however others held concerns that players did not always reveal the full extent of injuries this could be of particular concern if, for example, the player had sustained a head injury. Four of the respondents identified that players were not always honest regarding the true nature of the injury for fear that the doctor would inform the coach or team management.

"Potentially the player could want to go back on the field earlier than is desirable—has happened to me a few times but by testing out that player and pointing out obligations to team mates and other team stakeholders, generally I can convince the player to wait until things improve."

"Yes, often minimising injury and predicting faster recoveries than realistically expected. Pressure to get them right also in an unreasonable time."

"Yes, this can cause problems that the player may not be completely honest with the doctor about an injury, as they fear the information will go back to the coach."

"Yes, will hide injuries—especially worrisome if a head injury, will ask you not to tell coach, will ask you to inject them (may not be appropriate)."

"Yes—he is often keen to understate an injury, he may not trust you completely if he fears you will run and tell management everything risking himself and team, so you must balance your responsibilities carefully in each situation."

Sensitive information

The important issue of the handling of sensitive information about athletes/patients was addressed in the next question. Specifically respondents were asked: "Sometimes sports doctors are party to information about a team member that is highly sensitive, please identify the nature of this information from the following list:

- A team member is taking illegal "recreational drugs".
- A team member has an undisclosed sexual preference.
- The team member has a blood borne infection, eg hepatitis, HIV etc.
- The team member has a medical problem and/or is taking medication which makes competing dangerous.
- The team member is pregnant and does not want management to know and risk losing their place in the team.
- The team member is betting on the result of a game in which they are involved.
- The team member is planning to take, or has taken, a bribe regarding the result of a game.
- The team member is taking pain relieving medication to continue to play despite, and/or at the risk of sustaining a serious injury.
- The team member is taking banned performance enhancing drugs.

Some respondents indicated more than one such experience, and they were then asked if they had disclosed the information. An explanation of why they had disclosed or did not disclose this information was also sought.

Five respondents stated they did disclose the highly sensitive information identified in the previous question on eight occasions. The explanation for the disclosure differed according to the information held. Three of the respondents revealed information regarding a player's hepatitis B infection. All respondents did so for safety reasons. One doctor obtained the player's consent before revealing the information to management and other team members. The other team members subsequently received appropriate vaccination. In another case, a respondent described how having a routine screen of the whole team's hepatitis status preserved a player's anonymity.

This decision was taken due to the high incidence of hepatitis B in this region of New Zealand. In the instance of a

player using performance enhancing drugs, the doctor advised the player to declare this prior to routine drug testing.

Two doctors disclosed information about a player taking pain-relieving medication. The appropriateness of using analgesics in a playing situation was discussed with the players and the use was moderated.

One sports doctor revealed information about a player's pregnancy and with the consent of the player this was declared at a mutually agreeable date.

Five respondents did not reveal the sensitive information to any third party. The reasons for non-disclosure were because the player specifically requested confidentiality, or it was felt that the information was common knowledge, or because the doctor concerned considered that it was of no real consequence.

Pain relieving medication: "Explained risk to patient—their decision to continue or not."

Betting: "No why should I, it was for a win not a loss."

Respondents' own concerns

Finally respondents were given an opportunity to identify any issue not already covered in the questionnaire. There were a wide variety of responses to this question that raised concerns not previously considered by the investigators. For example:

"On occasions problems can arise with other health professionals ie own GP may treat for an injury—perhaps incorrectly and can feel threatened/angry to sports Doctor's involvement. Also can occur vice/versa!!"

"We need to be supported should there be outside pressure from layers or management. Where do we turn should a situation occur?"

"The now professional era and the lack of professionalism by sportspersons at times eg use of banned substances advice and supervision. Unreasonable expectations of average sports people or supporters/managers etc with some knowledge and lack of application of this, especially in isolated situation with limited immediate 'specialist' availability. When out of usual locality or arena and nil planning for illness or injury scenarios."

DISCUSSION

This research identified a range of ethical concerns experienced by a group of New Zealand sports doctors in their clinical practice. The respondents to this questionnaire were generally very experienced senior clinicians with an average of 8.8 years working as a sports doctor. As a group the respondents had a high level of postgraduate education in sports medicine and worked with elite level athletes.

The practice of medicine within sport has the obvious potential to create serious difficulties for practitioners. The study revealed that some doctors felt professionally isolated at times, with little support when faced with difficult situations.

Many of the ethical issues experienced by sports doctors are common to other areas of medicine, yet others are peculiar to the practice of medicine in sport. In response to the first open-ended question "What (if any) are some of the ethical issues unique to working with sports teams as compared with the provision of other medical services?", respondents identified a wide range of issues. Confidentiality of health information was the most common concern raised by respondents. Although confidentiality is problematic in all aspects of healthcare, in the field of sport the demand from coaches, management, the media, and fans for personal health information about an athlete/patient is likely to be much more frequent and this issue has been raised by other authors.²⁻⁵ Coaches and management staff are not part of medical tradition, which holds private health information sacred. When sharing information about an individual athlete, sports doctors may be concerned about how that

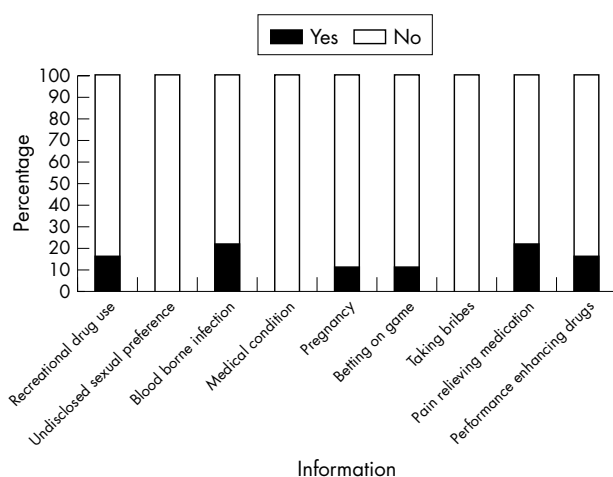


Figure 2 Highly sensitive information sports doctors have come to know about players, including three zero responses.

information is used. Some contracts between a sports doctor and the sports governing body may also instruct the sports doctor to share information not normally divulged within the traditional doctor-patient relationship, therefore it would be important to understand the full influence that a contract might have.⁶ The second most frequent problem respondents identified as being unique to sports medicine was the tension between the long term welfare of a player/patient and premature demands to return a player to the game. This concern has previously been raised as a problem for sports doctors.^{7,8} Respondents may consider this issue unique because of its frequency, and possibly also in relation to the place of the sports doctor within the sporting structure. The central difference between the practice of sports medicine and that of a doctor in general practice is the doctor-patient relationship. The sports doctor may find this relationship compromised by the added association with the sporting hierarchy and the demands of the team. This issue may be explained by the "conflict of interest" issue, which was the third most commonly identified problem unique to the practice of sports medicine also identified in question one. Conflicting duties may result from responsibility to someone other than the patient/player. Although all doctors identified the patient as someone to whom they felt a primary sense of responsibility, sports doctors identified responsibility to other individuals and groups. When asked how these might be prioritised in the event of a conflict, 89% of sports doctors stated that they would place the patient above all others. However a sense of responsibility to others may still need to be balanced and mitigated.^{7,9}

The ethical issues raised by the respondents include features unique to the practice of sports medicine by virtue of the position of the sports doctor. Ethical issues in this area of healthcare are bound up with the position of the sports doctor within the structure of the sports management. This relationship calls for an analysis of the source of significant ethical concerns—the sports doctor's role in a hierarchy of sports management that does not have the same regard for traditional notions of confidentiality, privacy, or the patient's long term welfare. This gives rise to some important questions. The first of these relates to the practice of medicine within the sporting context. How should the position of sports doctor be structured? Half of the respondents in the questionnaire were bound by contractual obligations, yet little is known about the effects of a contract on the doctor-patient relationship.⁶ It is still uncertain as to how a contract may influence the doctor's obligations to the medical traditions of confidentiality and providing benefit to the individual patient/player. Questions can also be asked about

the source of moral guidance used by sports doctors when dealing with a difficult individual or team issues. Do the ethical guidelines of the medical profession adequately meet the needs of doctors in sport? This question will be explored in further research.

Problems associated with the use of questionnaires have been identified earlier. While the interview is the favoured instrument for gathering qualitative data, this study sought information on a range of ethical concerns affecting sports doctors best identified by questionnaire. Despite the size of this study (n = 18), the aim was to chart broad ethical issues experienced by sports doctors in their everyday practice. The aim was descriptive rather than definitive and has provided an outline from which the authors are planning to undertake more in-depth interviews based upon the experiences and issues highlighted in this study.

CONCLUSION

Before this study, little was reported about the ethical issues that concern sports doctors. This survey has begun the process of identifying contemporary problems that are wide ranging and demand further study.

ACKNOWLEDGEMENTS

The authors wish to thank the respondents to this survey and acknowledge the contribution this group made to this paper. The authors also wish to thank Professor Donald Evans.

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