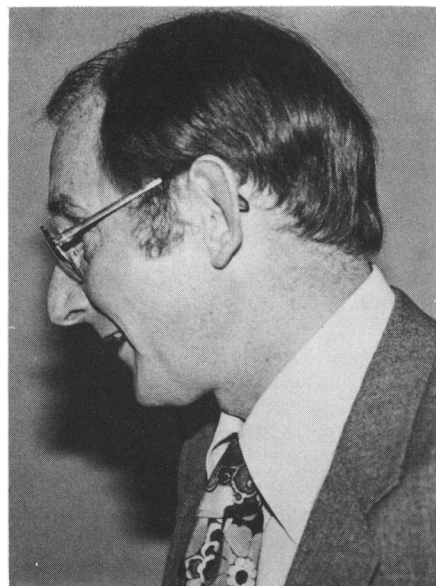


ETHICS IN SPORTS MEDICINE — THE SPORTS PHYSICIAN

P. N. SPERRY, MB, BS, MRCP, DPhysMed.

*Honorary Medical Adviser, British Amateur Athletic Board,
Hon. Medical Officer to
Great Britain Teams to World Student Games, 1965-1977*

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THE DOCTOR AND SPORT

In sports, where there is a major aim to defy nature, the doctor faces an inevitable risk of ethical dilemmas. If he assumes, rightly or wrongly, that rest and conservative management will probably cure everything in due course then, whatever else he does with a sportsman is, by definition, an experiment or a controlled risk in attempting to cut corners or accelerate healing.

In the broader picture, there are difficulties of public policy. There is some danger of spending more money on prohibitions and controlling illegalities than in actually preparing positive athletic and sports performance. Dope control has almost become synonymous with sports medicine and is a major preoccupation of many of the International Governing Bodies.

In order to serve sports medicine reasonably, the doctor must be acceptable to everyone. It is very easy for the team doctor to be regarded as hostile by management if he takes the side of the sportsman and even easier to be regarded as a hostile member of the "Establishment" by the sportsman if there is any suggestion that he shares the team management's attitude.

There are problems about the limitations of medical skills, both generally and in the individual case. In sport every coach and athlete is almost uninterested in present knowledge and its limits. The coach only starts looking for new aids at the borders of the present knowledge. Therefore, the doctor is in the land of speculation, risk, research and new ground, new theory and new fact. In practice, doctors are fairly rigidly educated, rigidly controlled, governed by rigid codes and are, therefore, not very well equipped to meet the attitudes that rule in sport and certainly coaching. Doctors are easily at a disadvantage. They do not really know the language of the trainer and coach. It is no consolation to say that the coach's mythology is not scientific because it is nevertheless the lingua franca of the sport.

Anyone can be manipulated. Coaches are experts at manipulating a team manager, a doctor or a physiotherapist and they are constantly trying to make them operate on the coaches' own ground. The biggest danger in clinical practice is for the doctor to be lured out of his own grounds of confidence into somebody else's and so begin to feel insecure in clinical knowledge.

The doctor must resist this manipulation and ensure that he conducts his clinical practice on his own ground without biased interference. Specialists, too, can be manipulated, as in the case of a surgeon who operates beyond his skill or takes risks.

Case No. 1 A promising young tennis player with persistent “tennis elbow” had been treated with ultrasound and a number of steroid injections to no avail. She could not continue playing and writing was also becoming painful. The X-ray showed some periostitis at the lateral epicondyle which most clinicians would think was an indication for rest rather than further interference. She found her way to a surgeon who had no hesitation in doing a decompression operation of the lateral epicondyle. This did not cure the symptoms and was followed by vigorous rehabilitation. After several months she was still unable to play tennis without persistent pain. She was also having considerable difficulty with study and went back to the surgeon who had no hesitation in deciding that she must be suffering from a radial entrapment neuropathy which is sometimes responsible for protracted “tennis elbows”. He carried out further surgery without success. A year after the first referral this girl was still totally unable to play tennis and almost unable to hold a pen properly. All she needed in the first place was six months of total rest.

The doctor is tempted to take this sort of risk because he thinks he can beat nature’s indications for rest. He may be correct sometimes but one of the questions he must face is whether there are particular ethical problems in sports medicine which call for different forms of professional conduct. A more subtle ethical audit or peer-group control is needed if he is taking a risk that he would not take in normal clinical practice because of different regulating mechanisms.

There are also the problems of coaches and athletes continually seeking new aids including drugs. The doctor cannot keep up with them but, as long as he realises this he can at least try to follow them.

THE NON CLINICAL EXPERT

There are problems of “sports medicine” and its interpretations with non-clinicians who run courses on the clinical aspects of sports medicine. They have varying degrees of expertise but it is not medical. Should the clinician have a function to try and control or invite some sort of control of the teaching of sports medicine, because ethical values are implicit in the matter taught?

A further problem in sports medicine is the misuse of the title ‘Doctor’. Most clinical doctors do not hold ‘doctorates’. A man with science degrees may describe himself as a “Consultant in Human Performance”. He may give medical advice quite freely. The word ‘Consultant’ in England in a health context means one thing – a medically qualified contract-holder with NHS or equivalent status but one may find, for example, a physiotherapist claiming to be a “Consultant in Sports Therapy”. This may mislead the public into assuming that there is medical expertise. One of the consequences of people holding themselves out as biological, sports or medical experts, is the use of testing and its interpretation. One result following middle distance running weekend courses held by such ‘experts’ was that the author of this paper received trunk calls from worried young lads saying they were going to die with anaemia and they ought to be on iron tablets and have full check-ups immediately. What was happening was that a coach with no qualifications was getting a fellow coach who was a lab technician to do blood counts and their interpretation of what constituted normal values was held as inflexible. There was no clinical interpretation, no clinical examination, no history and no advice. There is a belief among runners that if the haemoglobin is not a couple of grams over whatever a laboratory regards as normal, they are ill and need urgent help. The test itself may or may not be valid but the whole load of amateur advice around that particular test needs to be looked at.

FITNESS TESTING

The value of testing should be questioned seriously, especially if there is a tight budget. Some years ago a group of scientists were making a claim for nine hundred thousand pounds per annum for a nation-wide system of testing. “Sports science” was going to test the nation’s squads! There have been until now no ethical constraints on sports scientists at all. In fact it seems incredible that if a doctor wanted to do a simple trial on the use of Aspirin on any condition in hospital, it would take months to clear this with the hospital Ethical Committee, to make sure that society would exercise tight control. On the other hand, if a sports scientist wants to invade the body with cardiac examination techniques, there is no-one to whom he is answerable. There is no ethical control group and there is no supervision whatsoever. Fortunately, a recently adopted policy in the Sports Council draws attention to this situation and intends to institute some formal look at this problem of ethics in sports medical experimentation. It feels there should be no less stringent standards of ethical and professional control over experimentation in the non-medical sports fraternity than there is with the clinicians. Behind this interest is the simple question “Have they the right to experiment with the young and do they know what they are doing or why?” It is extremely difficult to validate experiments with any group of athletes and, as yet, there is little evidence that many particular tests are of any use, although there is an army of scientists invading young sportsmen daily in colleges, centres and clinics. The human body is not a machine, so there can be no “testing to destruction”.

COMMERCIAL ASPECTS

There are commercial aspects of sports medicine which are both good and bad. In spite of powerful constraints on the use of medical claims in advertising, there have been, for example, specific medical claims made for footwear in the last few years. It is true to say that these have had a very dramatic effect on footwear design, in many ways for the better, but it is nevertheless very difficult to be totally sure about advertising claims. There are many unnamed experts making guarded claims rather than openly named experts giving evidence and fighting in public. Much of the present medical ethical set-up run by the General Medical Council is almost totally against the public interest. The advantage of violent public debate about important matters far outweighs the general protection of the public by any silent conspiracy of ignorance. People are becoming informed and are asking for explanations. The medical profession and those members of it who care about the ethics of their practice are increasingly hampered by their inability to be openly frank with the public about some aspects of sport and sports medicine. They are at a disadvantage against the unqualified practitioner who is perfectly free to advertise providing that he does not say that he is a medical doctor. A case of this occurred recently in the magazine *ATHLETICS WEEKLY* where there have been repeated adverts for a new "Athletes Clinic" in the West End of London which offers "professional skills". This was being run by a combination of unqualified people in spite of specific claims about "specialist" treatment. Who should draw the attention of the athletes to the fact that these people are not what is implied by public advertisement? The General Medical Council have only limited powers of action in such cases. Perhaps a public licensing system should operate to validate "clinics" in the same way that massage parlours are subject to local authority inspection.

SPORTS CLINICS

The most vexed problem with Sports Clinics is simply the question of referral. By tradition, this should only be done by the primary doctor or GP. There are many who would query this and the ethical implications need study. The "hawk-around syndrome" is well known, patients who collect doctors' opinions and clinic labels rather like others put stickers on car windscreens. They achieve a 'non-cure' from any of the places that they have visited and usually fail to co-operate for more than a few days with any set of instructions given by any of the clinics. This could not happen with more discipline on the acceptance or the referral of patients. Any doctor who accepts patients unreferred is condoning and encouraging the "hawk-around syndrome".

Case No. 2 A young rugby player attended the author's clinic with adductor strain. There was no particular problem at that time but he failed to get better simply because, even when on daily intensive physiotherapy, he would not take advice to rest. Instead, he continued to abuse his injury and naturally did not improve. He failed to keep a follow-up appointment but came back months later having found his way, unreferred, to a fellow practitioner who gladly accepted him (pausing only to abuse the previous diagnosis and treatment). He was given 600 mgs. of Phenylbutazone a day and told to exercise. He was lucky to have any bone marrow left and his pain had returned. Thus, after six months, he was back in the same condition he started with. It then took two or three months to get him off exercising, off drugs and back to the first principle of avoiding the most provocative strain and conforming to the physiotherapy which was originally prescribed and which is known to ameliorate the condition. An undisciplined acceptance of a patient, who did not get a new referral from his GP and was already under the care of a specialist for the condition, made this patient suffer for an extra three months. However, the other doctor's attitude of "there is no ethical problem; it is up to the patient to decide who will help" perhaps bears examination.

On the other hand, from the sportsman's point of view, there is a problem. Of nearly 2000 patients who came to the sports clinics, some 20% had gone uncured through other hospital departments en route. The patient may wonder that, if one in five sportsmen are not cured by their specialists, and may even be discharged as incurable or hopeless, what he can do, especially if the first practitioner does not want to know about the problems of sports medicine.

Case No. 3 A good example of the combination of the "hawk-around syndrome", together with frustration and lack of professional co-ordination is that of the long distance runner who sustained an injury which plagued him over three or four years and eventually caused him to abandon his level of sporting participation. On the day of the original injury the attending team doctor was able to make a detailed clinical note of the findings, together with a clear diagram and give initial treatment.

Subsequently, symptoms fluctuated considerably, together with performance, so that on the one hand the highest levels of sporting achievement were reached without pain but, on the other, the lesion tended to recur at times of stress and defeat. There was little doubt that the overall disability was the close admixture of physical injury of a clearly documented sort with a serious psychological difficulty of acceptance and compensation. Because of the lack of a

central co-ordinator and the sportsman's freedom to hawk himself around, there came a point when he was able to announce that his thirty-seventh different medical opinion was about to enter into a conflict with his thirty-eighth. It appeared that No. 37 either won or was manipulated into operating and No. 38 retired intact to his home country.

A sad postscript to this case is that, though subsequent operations were performed by further consultants, there is still no complete dossier of this young man's clinical history anywhere. The common thread throughout this sad story is of failure either to seek details of the previous medical interventions or of anyone to make any attempt to bring a halt to the proceedings by any form of joint consultation of all parties involved. This rather extreme example of the behaviour commonly seen at the highest levels in sport does not at first sight appear to be illustrative of normal standards of practice in the private sector or NHS medicine.

THE ROLE OF THE TEAM DOCTOR

The role of the team doctor is usually straight-forward and may occasionally be quite impossible. Although there are legal problems of drug prescription and carriage, with national teams the normal responsible conduct of clinical practice has not given rise to practical problems. It is reasonable not to invoke narcotic legislation and one may ask why the average team doctor would need to carry opiates with a team to any civilised part of the globe in any case.

The main question for the team doctor is one of mixed loyalties. The doctor sits on that hypothetical fence between the "them" and the "us" of management and team and difficulties may easily arise if there is pre-existing severe conflict between these bodies, the doctor being seen by each party as a weapon used by the other party.

Considerable difficulties may arise under the harsh glare of publicity at major international competitions. In these circumstances the doctor has the conflict of the need for privacy of medical consultation against the evident public pressures and interest, together with the constant erosions of both his and his patient's privacy by the constant prying of the media. It is a safe rule that all communications regarding a team should pass through the team manager. In other words, the policy is to refuse all interviews, information or comment upon the medical circumstances of the team but to prepare with the team manager a suitable statement for presentation. The only exception to this is when such a duty has been specifically delegated by the manager. In any case, no public discussion of medicine should occur without the clear permission of the patient though it is rare to find a sportsman who is averse to publicity about his injuries! Nevertheless, there are occasions where no amount of confidentiality or planned giving of information is free of dangers.

Case No. 4 Prior to Olympic competition, a sportsman acquired a serious problem which clearly prejudiced his ability to do himself justice in the competition. The successful management of this condition was in conflict with the protocols planned and agreed for team management and therefore gave rise to considerable public interest. It proved extremely difficult to effect a satisfactory clinical response because the stresses of intensive publicity, together even with leaks of information from informants on hospital switchboards, all conspired to exacerbate the stresses on a minor physical illness combined with a major psychosomatic overlay. The only way of managing the patient was, with his knowledge and in his interest, to arrange an elaborate deception of the media, in close co-operation with his management.

Questions also arise of fitness to travel to competition and of fitness to compete once competition has begun. For instance, sufficient cases have arisen over the years of athletes wilfully deceiving either themselves or their managements over injuries or illness turning up at major international competitions only to be unable to take their place at the starting line. Even with good clinical facilities, it is often possible in the limited time-scales available before competitions only to relieve a sportsman of his actual pathology, while leaving him still unconditioned and unfit in competitive terms. Notwithstanding the doctor's loyalty to his patient, his loyalty to his team management should ideally lead to a situation where the patient's athletic prognosis and usefulness to the team is reviewed no less keenly than his clinical state. Occasionally, a severe dilemma may appear between the interests of the individual and team, with the doctor caught in the middle.

Case No. 5 A female athlete was taken abroad to a crucial international competition. Shortly after arrival she was brought to the team physician because of aching in one ankle. The clinical history and the tender palpable callus over the fibular malleolus were typical of a stress fracture and the doctor firmly advised management to withdraw this athlete from competition. Because this meant almost certainly sacrificing maximum points from two races and a relay, the management were reluctant to accept this decision but the firm insistence of the team physician carried the day. A subsequent X-ray confirmed the presence of a stress fracture.

In the absence of an X-ray and with less serious symptoms, it may be extremely difficult to persuade the athlete and the managers and coaches to refrain from entering competition. They are often willing to accept the chance of exacerbation of injury whereas the team doctor may feel strongly that he is rather in loco parentis in respect of a minor's health. Familiarity with the detailed prognosis of sports injuries and medical conditions is clearly paramount as a basis for giving fair and sound advice.

A team doctor has further ethical responsibilities in the more general sense within his sport especially with the assessment of suitability for general sports participation, particularly in the young. A doctor who recognises signs of intolerable stress in the young adolescent surely has some responsibility to try and help his suffering patient by alleviating stress. Examples are the young swimmer subjected to a three or four hour daily swimming programme; the 17 year old girl with psychosomatic symptoms resulting from her family's corporate compulsion to take athletic exercise, or in cases where the general suitability for sport for an individual is clearly in doubt. Since the popularisation of Olympic gymnastics by the media, many sports doctors have been troubled by a large number of quite inappropriate bodies aspiring to participate in this sport. It seems sad that sport has become such a narrowly defined affair at highest levels that keen people with an inappropriate shape simply have no prospect of top achievement. Unfortunately, the maturity and judgement of coaches is often in doubt and this leads to an unnecessary incidence of injury which represents little more than the conflict between a certain athletic movement and an inappropriate somatotype and problems for the sports medical doctor.

Case No. 6 An 18 year old athlete was presented by her governing body because of minor symptoms after severe competition. A detailed history revealed, despite achieving the highest levels in her sport for her age, an increasing and disproportionate tiredness during and after effort, together with symptoms of nocturnal dyspnoea related to a battery of cardiac murmurs typical of rheumatic valvular disease. It was evident that she had come to a stage of cardiac decompensation and this was clearly inconsistent with her level of athletic activity. Despite the firm evidence and advice given to the governing body the patient was nonetheless able to secure a medical carte blanche for athletic competition from one of London's better known surgeons who took the simple view that, if the child managed to achieve her present level in sport, then clearly she was capable of sustaining it! The fact that specialist cardiological opinion confirmed the original advice was irrelevant. This case questions the trust of the governing body management in seeking and accepting medical opinion from its own doctor.

SAFETY

The sports doctor, particularly if in direct relationship with a governing body, has a further duty, even if it may be described as "political", in respect of the general medical aspects of sport. This may well give rise to serious personal differences of opinion but has nonetheless to be faced. On occasions, sports facilities are notoriously bad. For instance, in athletics, if a pole vault or high jump landing is inconsistent with safe competition, the attending doctor should take active steps in such circumstances to prevent injury. It often happens that during spells of intensive competition, he becomes all too obviously aware of states of gross over-fatigue and loss of form in star athletes. This is usually due to chronic stress combined with quite excessive travelling and competitive requirements put upon the sportsman by his governing body's fixture list. It is often obvious that an athlete is habitually under-achieving simply through over-competition. However, his management is all too frequently prepared to sacrifice the athlete's performance and even the team points that go with his poor performance rather than lose the box office appeal of the stars. Once decompensation occurs and the athlete becomes an untreatable patient, what should be the role of the team doctor then?

It has recently become evident that deliberate foul play in certain sports is directly responsible for many sports injuries. It could be argued that the medical profession, on becoming aware of such trends in the style of play in sport, should be among the first to initiate the political changes which should lead to elimination of dangerous unfair play.

SEX TESTING

Sex testing has become standardised and universally compulsory in major international competition in recent years, though its ethical basis has been challenged firmly by sports doctors. While at present it is part of the team doctor's obligation to ensure an accurate and sensitive handling of these test procedures, it may be asked whether the medical profession at large should condone such tests at all. The profession does not normally encourage prejudice against its patients and, should one be found to have a chromosomal abnormality, to debar "her" from competition would seem wrong. Does a doctor really have the right to take part in such test protocols with their disastrous implications when, for instance, the finding of certain chromosomal abnormalities can do no more than disenfranchise a female competitor? It may well be asked why similar testing should not be operated against male participants and one sadly

comes to the conclusion that male chauvinism alone would ensure that no such tests occurred, while victimising females. Even if this is not a bad enough admission to face, is it not even worse to consider the fate of a disqualified female who now finds no acceptance in either the male or female camp? Should the International Olympic Committee be petitioned for special events for the chromosomally aberrant, or should this nasty little problem continue to be swept under the world's carpets?

DRUGS

The role of drugs in modern sport raises ethical problems no less than technical ones. Any doctor in charge of a team's welfare simply has to inform himself about the nature of the drugs he and his team are using, especially vis a vis the prevailing regulations about doping in that sport. There is no excuse for prescribing stimulants in any form for sportsmen. The management of asthma may raise problems but these should be capable of circumvention, given sufficient notice and professional help, long before the acute situation of international competition arises. Sports doctors have the ethical responsibility to secure a fair deal for their patients. This may mean, for instance, campaigning in favour of obviously safe drugs, eg codeine for the treatment of diarrhoea, even if this means arguing against the technical experts in the field who are of necessity concerned, not with the clinical management of suffering patients, but with the chemistry of their detection machines. Hence the present conflict over the recognition of codeine as a permitted drug between different governing bodies.

In the question of anabolic doping, it is clear that medical bodies have a significant role to achieve both through education of public and governing bodies and in the conduct of their own clinical practice. The present attitudes of informed hypocrisy will not change international custom. For instance, a prominent sportsman in an event where anabolics are strictly forbidden, is open in his description of his arm weakness which invariably follows a break in his steroid maintenance therapy after an injury. Nonetheless, his official view is that he does not take anabolic steroids!

The doctor who deliberately plays with the fine line between therapy and cheating is hardly to be encouraged. The use of anabolic steroids during a spell of medical rehabilitation can easily lead to abuse, as exemplified by the case of a rehabilitation specialist who used substantial doses of Dianabol on a young athlete after a meniscectomy because of the athlete's impatience to return to a particular competition. Perhaps a more mature and considered approach would have been to take full cognizance of doping regulations, even if recovery might have been prolonged, even this point being unproven. Finally, the team doctor must accept a positive role by being both the confidant and guide to his patients whom he must put first at all times. Only by so doing will he be able to minimise the harm of any adverse circumstances.

A team doctor is a part of the team management and not a 'prima donna' in charge of everyone else. Notwithstanding his clinical duty of confidentiality which he must preserve, he is responsible in general terms to his team manager.
