Ethical dilemmas faced by the team physician: overlooked in sports medicine education?

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The oldest known ethical rules for physicians are found in the 282 Hammurabi law codes (http://en.wikipedia.org/wiki/Code_of_Hammurabi), originating from 1800 BC, stating that “if a physician makes a large incision with the operating knife and kills him, ...his hands shall be cut-off.” Today, the primary aim of every physician is to help or heal their patients, or at least not to harm them in the process; what is best known as ‘primum non nocere’. The team physician faces challenges to these ethics. This paper reflects on some delicate ethical situations, on and off the pitch, related to the work of the team physician at the elite level, well illustrated in the recent soccer World Cup. The authors who are experienced team physicians having served for a total of 50 years at elite national and international levels, including at European and World Cups/Championships and Olympic Games, argue that sports ethics may be overlooked in sports medicine education.

SUBSTITUTE THE STAR?
Whenever an injury occurs the team physician typically has 30 s on the pitch or a few minutes on the sidelines to clear a player to continue to play. The physician may be pressured by the coach/manager for a quick decision, with the coach often expecting the player to be cleared to play on. The physician must consider the short and long-term risks and benefits to the player if he or she continues to play. The physician’s primary responsibility is towards the player, regardless of the coach/manager’s wishes.

As a physician, you are obliged to give the player the best possible advice, based on your assessment and understanding of the current scientific knowledge and consensus recommendations, but you are also obliged to account for the will of the player. Interestingly, these elements are part of Sackett’s Venn diagram, in his 1996 paper defining ‘evidence-based practice’.

Importantly, and what makes sports medicine/physiotherapy challenging, is that these two principles may be more starkly opposed than in a typical office consultation. For example, a player often wants to continue playing after receiving a knock on the head, but your clinical acumen may tell you the player is best sent off the field. In this case, the player may be unable to make a reasoned decision because of the desire to compete and display poor judgement because of the head injury. The physician has to decide the priority very rapidly and remember that his primary obligation is to protect the player. Firm guidance to remove the player if required. A failure to apply this principle is regularly seen in broadcast football.

RETURN TO PLAY
While international consensus recommendations provide guidance for the return of the player after concussion, the team physician may be under pressure for an early return to play. Similarly, after muscle injuries, players are returned to play after a shorter than ideal recovery. There is an ethical dilemma in terms of the loyalty of the team doctor towards the player and the club, respectively. The club pays the physician’s wages, and sometimes interprets this to mean the primary commitment of the physician is towards the club, which (of course) wants the player back on the pitch as soon as possible. But the primary responsibility as practising physician must always be with the player. In fact, the role of the team physician is to convince the club that the player’s and club’s interests are the same: to return to play as soon as possible, but also, and very importantly, to avoid recurrent injury and/or long-term negative consequences.

ACUTE, POSSIBLY LIFE-THREATENING EVENTS, ON THE FIELD
According to the rules of football, the person primarily responsible for players’ safety on the pitch is the referee. Therefore, the referee is the one who gives the team physician permission to enter the playing field. This may pose an ethical problem. Let us hypothesise a case where a player, out of play, suddenly drops to the ground, seemingly unconscious, unseen by the referee. Should you, as the team physician, the best medically qualified person in close proximity of the playing field, wait for the referee to become aware of the situation, assess the player and then ask you to enter the field, or should you enter the field without any substantial delay? The rules prohibit entry without permission, but the ethics of being a physician also make it difficult for you to remain on the sidelines while a player may have sustained a sudden cardiac arrest, wherein every second counts.

ALTERNATIVE TREATMENTS
As team physician, you likely head the medical team at the club, which may include any number of medical personnel, including physiotherapists, physiologists, nutritionists and sports psychologists. Despite these club professionals it is very common for players to seek additional or alternative opinions and treatments outside the club. As medical authority for the team it is important to be aware of all treatments and the full nutritional status and habits of the players. Treatment outside the club should only be carried out with the knowledge and full agreement of the team physician. The player may state that it is their will to seek additional advice, but the team physician has to make the player and club aware that the team physician is ultimately responsible for the player’s rehabilitation. Consequently, any physician treating the player outside the club (including second opinions), must inform and involve the team physician in any decisions. In addition, the team physician should seek evidence to support alternative treatments. Many treatments have little evidence, not least in elite sports, making the application of this principle difficult. The leading ethical principle, in these cases, appears to be ‘as long as it does not cause harm...’

IMPORTANCE OF COLLABORATION
The role of team physician requires a broad range of skills. The most important skill is to develop a good working collaboration with the manager and training staff. Prevention strategies in regular and strength training sessions rely on the attitude of the manager. In fact, some managers in elite-football are associated with higher injury incidence rates, as well as recurrences of injuries, than others. We

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believe that these differences in injury rates may be partly explained by different approaches to preventive measures and rehabilitation protocols, but they may also be the result of different training and tactical considerations. The team physician should aim for an active collaboration between the medical team and the coach/manager, continuously working on improvements as well as incorporation of new science.

**FUTURE ASPECTS**

These ethical dilemmas are encountered regularly by team physicians at the elite level. Our experience is that similar ethical questions are discussed among colleagues in sport networks and conferences whenever team physicians meet. However, there is a distinct lack of formal education in this small, but very important area of sports medicine.

We propose that sports ethics should be a mandatory topic in national and international sports physician education. For example, it should be a subject in the IOC, FIFA and the UEFA education programmes, such as the current UEFA football doctor programme, as well as being featured in regular soccer and sports medicine conferences. Journals such as ‘Sport, Ethics and Philosophy’ provide a forum to discuss sports ethics. The team physician must be very familiar with how to act ethically and be a club leader in this domain; we fear that this part of the palette of sports physician skills is too often overlooked.

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**REFERENCES**

