

[Sports Physical Therapy]

Ethical Issues in Sports Medicine: A Review and Justification for Ethical Decision Making and Reasoning

Bruce H. Greenfield, PT, MA (Bioethics), PhD, OCS,*† and Charles Robert West, BA†

Ethical issues present a challenge for health care professionals working with athletes of sports teams. Health care professionals—including the team physician, the physical therapist, and the athletic trainer—are faced with the challenge of returning an athlete to competition as quickly as possible but as safely as possible. Conflicts of interest arise due to conflicting obligations of the team physician to the athlete and other members of the sports organization, including coaches and the team owner. The multiple stakeholders involved in sports teams challenge the traditional notion of confidentiality and autonomy. The aims of this article are to explicate the ethics of sports medicine, highlight the ethical issues, and provide some strategies and suggestions for ethical decision making.

Keywords: Sports Medicine, Ethics, Ethical Issues, ethical decision-making

In the United States, college coaches and athletic administrators are under significant pressure from students, fans, boosters, and politicians to succeed and are paid exorbitant salaries, often exceeding those of their respective college presidents.¹³ Similarly, professional sports offer municipalities, team owners, stockholders, coaches, and athletes the prospects of huge financial gains.⁸ And while the professional athlete is the direct economic beneficiary of his or her athletic ability, agents and family members serve to benefit as well from an athlete's success. Successful sports teams can arrange lucrative television contracts and attract and expend large sums of money to highly visible and successful coaches and athletes. In turn, the pressure to perform is exceedingly strong. Given the economic climate surrounding professional athletics, we should not be surprised that athletes are often viewed as commodities that are bought, sold, and traded. Not least, organizations that invest large sums of money on athletes expect returns on their performance, which include proper maintenance of their physical and mental status for ongoing competition.

Pressures for athletes to perform in high-impact sports such as football, where injuries are ubiquitous, have contributed to the rapid evolution of medicine in sports.⁷ Health care professions have developed societies and interest groups within their mainframe organizations specifically for health

care professionals focusing on care for athletes. These societies have developed journals in sports medicine, have been instrumental in developing formal residencies and fellowships, and, in many cases, have developed a cottage industry of continuing education courses in sports medicine. What has emerged is the concept of the team physician and the health care team.⁴ College and professional sports teams routinely hire a professional health care staff that includes physicians, psychologists, physical therapists, and athletic trainers to attend to the ongoing physical, emotional, and mental needs of their athletes. In some cases, large health care entities and private practitioners pay for the privilege of being the team physician, often as part of a marketing agreement between a health care center and a sports team franchise. The unique structural relationship of sports franchises has challenged the traditional fiduciary role of health care professional and their patients and has given rise to potential ethical conflicts. At the core of these conflicts are the competing obligations faced by a health care professional deciding when an athlete is ready to return to full competition. A team physician must decide, what are the rights of the athlete, family, agent, or coach to be involved in that decision? Where does the locus of control ultimately lie? Dunn et al^{7(p840)} capture potential conflict of interest in writing that the “ethics of the classic doctor-patient dyad” and, by extension, the

From the †Division of Physical Therapy, Department of Rehabilitation Medicine, Emory University School of Medicine, Faculty Affiliate Center for Ethics, Emory University, Atlanta, Georgia

*Address correspondence to Bruce H. Greenfield, PhD, MMSc, MA (Bioethics), Associate Professor Division of Physical Therapy, Department of Rehabilitation Medicine, Emory University School of Medicine, Faculty Affiliate Center for Ethics, Emory University, 1462 Clifton Road NE, Atlanta, GA 30322 (e-mail: bgreenf@emory.edu).

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physical therapist–athletic trainer dyad, “in which the physician has the primary obligation to the patient’s well-being, is challenged by the emergence of the doctor-patient-team triad.”

Notwithstanding the fact that health care professionals face conflicting obligations from stakeholders, we argue that team physicians and other health care professionals involved in college or professional sports are under unique pressures to navigate the multiple layers of team management to return an athlete to sport, particularly when he or she might not be ready. The dynamic and unique relationships of sports organization members result in potential conflicts of interest between the obligations of team physicians to their patient/athletes and those to the team organization. Because of this unique organizational structure, the ethical principles of autonomy and confidentiality do not easily translate into sports medicine because of competing obligations and lack of clarity of ethical guidelines.

To address the issues raised above, the purpose of this article is to explore ethical issues faced by health care professionals who work with professional athletes. To begin, we present an overview of current research describing ethical issues in sports medicine. We then offer some suggestions to help health care professionals improve their ethical decision-making abilities. Brief examples illustrate and provide practical decision-making strategies.

ETHICAL PROBLEMS IN SPORTS MEDICINE

Many of the ethical issues in the care of athletes often result from the unique and dynamic interrelationship of multiple stakeholders associated with sports franchises. These include the health care professionals (team physician, athletic trainer, and physical therapists); the athletes themselves; and management, including coaches, general manager, and, in professional sports, the team owner. Additional stakeholders include agents, families, the media, and fans. Because these various stakeholders often have different interests and goals, health care professionals are often conflicted about the proper course of treatment for an injured athlete. Conflicts of interest are common in these situations. Swisher et al¹⁴ sequentially surveyed a group of athletic trainers with experience working with sports teams to identify the types of ethical issues that these trainers commonly faced in working with athletes. Qualitative examination of 154 ethical issues yielded 7 themes. Among top-rated themes were interdisciplinary conflicts, including miscommunication about roles, conflicts of interest due to divided loyalties, conflicts in acting in the athlete’s best interest, and pressure to return to play from the coach, parent, supervisor, administration, or athlete.

Anderson and Gerrard³ surveyed a sample of 18 sports team physicians in New Zealand to identify and map ethical issues. The physicians identified ethical issues related to confidentiality and privacy concerns manifested by tension between medical requirements to the patients and demands to play from the patients and other stakeholders associated

with the team. The physicians reported conflicts about their responsibilities as doctors and about the precise nature of their relationship between the physician and the patient/athlete. Confidentiality was the most common issue related to the health information of players from the organization and from media. Privacy was also an issue in trying to provide care in a shared facility such as a training room. The next issue was the fiduciary responsibility to care for the patient and the pressure from the organization to return the athlete to the sport as soon as possible. Many reported that the source of pressure to return athletes to sports too soon came from the athlete, coaches, and other players. Responsibility to athletes, coaches, and even player unions can create conflicts. Problems related to this pressure 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 high.

In a conversation with Dr John Xerogeanes, chief of sports medicine at Emory University, Atlanta, Georgia (January 22, 2012), he identified conflict of interest as the most significant issue faced by the team physician in both the college and professional levels. He spoke about the pressure that many coaches and owners can place on a team physician to return an athlete to sport with minimal recovery time. Although some athletes desire a quick return to sport regardless of the severity of injury or the need for surgery, he said that it is not uncommon for the physician to be pressured from team management for an early return to sport. In such cases, the athlete develops mistrust in the judgment of the team physician to properly care for his best interests. As a result and at times unfairly, an athlete will choose not to see his team physician but choose instead to see a physician who is not associated with his team.

In reviewing the relationship of management to team physicians, Polsky^{11(pp4-6)} reported that, not surprisingly, management often places pressure on team physicians to return an athlete quickly to competition. Although most sports organizations have the best interest of their athletes in mind, Polsky reported some instances when an organization pressures its medical team to choose a less-than-ideal procedure to treat an athlete to promote shortened recovery time and faster return to play. Polsky reported cases of pressure from team management containing the implicit threat that the physician will be replaced if he or she does not support management policies. Likewise, management would exert significant pressure on the athletes themselves for a speedy recovery. Athletes may also have the specter of terminated employment or loss of salary due to loss of playing time. In this way, they also may place pressure on the medical team for a faster recovery via a less intense procedure. These short-term gains pose long-term risks, however.

Pressure to play early comes not only from management (and even ownership) but also, as mentioned above, from the athlete and his or her peers. McKenna et al⁹ interviewed practicing physiotherapists in the United Kingdom to explore

their experiences of rehabilitating elite athletes. In response to in-depth interviews, the therapists reported that many of the athletes during rehabilitation were somewhat fragile emotionally, with their entire focus being on their ability to return to their sport. The therapists all perceived that the athletes were impatient with rehabilitation and favored a rapid return to sport, often at the detriment of ideal rehabilitation. Significant injury often had large effects on their mental states, with effects sometimes being similar to those of individuals who had experienced a natural disaster. On the other hand, responses varied widely, with some athletes viewing injury as merely a slight setback. Rehabilitation for these individuals was viewed as a return, rather than as a gain or improvement. Additionally, their time spent while injured was viewed as “missing out” on all the positive aspects of professional athletics. Athletes were described as often being very talented and somewhat arrogant, to a fault, in that they sometimes believed that they had some knowledge of what would improve them that the physical therapist did not. The physical therapist, in contrast and as a result, typically exhibited concern about projecting one’s confidence in regard to the treatment to the athletes. Polsky¹¹ provides several examples of quotes from team physicians and athletic trainers about the tremendous pressure that athletes feel to play with pain. Those athletes who did return early were more respected and admired, and those who did not were often stigmatized and ridiculed by teammates. Because there is no real job security in the National Football League, the greatest threat that players feel if they do not play with pain is replacement.

An interesting source of pressure is the pressure that team physicians often place on themselves. There are 2 reasons, according to Polsky.¹¹ First, team physicians routinely believe that they are part of the team and therefore sacrifice a player’s health for the sake of the team. Second, a team physician may put undue pressure on himself to please management so he or she can keep one’s position because of the many benefits received from the status as a professional sports team doctor. The strong pressure creating conflicts of interest for the team physician may cause one to compromise one’s medical judgment. But as Polsky correctly reminds us, although conflicts of interest may increase risks of unethical conduct, they are not inherently unethical but rather a fact of practice reality. Physicians and other health care professionals must always act in the best interest of the patient whether she or he is an athlete or not, regardless of setting, and irrespective of incentives.

INFORMED CONSENT, CONFIDENTIALITY, AND OTHER ETHICAL ISSUES

Because of conflict of interests, the team physician faces a unique situation related to the ethical principles of autonomy and to confidentiality and informed consent. To what extent do team management and related stakeholders have a right to medical information about the athlete? Without doubt, the team has a stake in the medical decisions affecting the care of

the athlete. As Dunn et al⁷ described, an athlete with a torn meniscus will often best be treated with a meniscal repair than with a meniscectomy based on long-term outcomes. After explaining the procedure, the risks and benefits, and alternatives, the athlete may opt for a meniscal repair, ready to sacrifice short-term playing time for longer rehabilitation and better long-term outcomes. Yet, when advised of the athlete’s decision, the coach, agent, and owner may disagree, hoping for a quicker return. Ultimately, the loyalty of the physician must be toward the wishes of the athlete, despite pressures exerted on the physician to change the athlete’s mind. In such a case, the physician must advocate for the most appropriate course of medical treatment given the evidence. If when given full disclosure and informed consent, the athlete decides for a meniscectomy, the physician must weigh the benefits and risks of doing an alternate procedure based on his or her best judgment. As mentioned above, in the final analysis the physician has the right to refuse a medical treatment that one judges to be inappropriate. We must remember that physicians should never agree to a medical procedure that is not considered standard and appropriate care. It is always the ethical obligation for health care professionals to justify their medical decisions based on sound professional judgment.

What is particularly unsettling is that sports physicians are often bombarded from the press and public with suggestions to use the latest fads in medical technology, some valid and some not. The field of sports medicine is evolving constantly due to innovative research, emerging technology, and financial investments from commercial enterprises. Certain emerging medical interventions and technologies are in the experimental stages or have little clinical evidence supporting their efficacy in long-term outcomes. Not too long ago, thermal capsular shrinking techniques developed a vocal following in orthopaedics and media hype, in lieu of the more invasive but successful surgically tightened stabilization procedures for athletes with recurrent shoulder dislocations.⁷ Orthopaedic team physicians can be placed under extreme pressure from coaches, owners, agents, media, and athletes to use current “sexy” procedures with very little evidence to support their use. With emerging technology, the physician must obtain full consent of the patient, which requires full knowledge of all aspects of the procedure, including its less proven nature. The physicians themselves must conduct a careful review of the new technology before administration to a patient.

In traditional medical settings, confidentiality about medical conditions is a general obligation that physicians and other health care professionals owe to their patients.⁴ Most health care codes of ethics support the inviolability of confidentiality except under conditions in which the health care professional judges that the withheld information may result in harm to the patient or someone else.¹² In addition to being ethically obligated to maintain patient confidentiality, health care professionals are legally bound by state laws, as well as federal law (Health Insurance Portability and Accountability Act, or HIPAA) to maintain patient medical confidentiality.^{6,7}

In sports medicine, numerous occasions arise to challenge the patient/athlete's rights to confidentiality. Bernstein et al⁶ raised an interesting hypothetical scenario and subsequent question: Say that during an on-campus medical evaluation at a major college, a recruited athlete discloses to a team physician that he experienced 3 concussions while playing high school football, each of which required hospitalization. In spite of the athlete's urgent request that the physician keep the information confidential—to avoid jeopardizing his college football career and potential scholarship—does the physician have an obligation to tell the team coaches and athletic director?

Certainly, coaches for a college team recruiting an athlete for a scholarship have a legitimate right to know about the potential athlete's fitness to compete. It is morally permissible and in fact morally required that the team physician tell the coaches about the significant past medical history of this student athlete to avoid future harm. The operative phrase in this case and in many cases of confidentiality is "significant past [or current] medical history" that is relevant to provide. Certainly, the physician should never tell a coach about a potential student athlete's personal history that has no bearing on his or her ability to perform athletically, if in fact that information was given in confidence. But a physician is under no such obligation of strict confidentiality if, for example, an athlete discloses that he is illegally taking performance-enhancing drugs. This action is directly in violation of rules controlling the use of banned substances, and it moves toward a legal issue taking precedence over any ethical concern about confidentiality. Bernstein et al⁶ suggested that prior to any examination or care of an athlete, the team physician or any health care professional has a duty to clarify the nature of the relationship with the athlete before the examination, indicating that he or she is not the patient's private health care professional and confidentiality is not guaranteed. The same should be done with team management, who should be apprised of the nature and limits of confidentiality requirements. If an athlete is seeing a private health care professional not employed directly by the team, then the limits of confidentiality are based on the type of information judged by the health care professional that affects the athlete's overall health and welfare to compete.

SUGGESTIONS FOR ETHICAL CONDUCT

Having brought forward the issues of ethics in sports medicine, we turn now to suggestions to improve the ethical decision-making abilities of health care professionals working with sports teams. First, we advocate that sports medicine fellowship programs include an ethics component dealing with the conflict-of-interest issues presented by high-level athletics. We examined the webpage offerings of several high-profile sports medicine fellowships in the United States. While we were unable to view their curriculum in any sort of depth, none made any mention of ethics in any part of the publicly available information about their fellowships. One

did indicate that among its core values were patient care and professionalism, but it did not go into detail about whether there was an ethical component or not.

We suggest that the fellowship train physicians in ethical reasoning and present cases that involve ethical content. Current research in expert practice, a goal of fellowship training, clearly indicates that expert practitioners use multiple sources of reasoning, including technical, narrative, and ethical reasoning as part of patient care.

Second, there should be clear rules governing relationships between medical practitioners/facilities and athletic teams/organizations. There is evidence that in cases where physicians are employed directly by the sports team or where a physician or facility pays a premium to treat a team's athletes, a conflict of interest may arise in which the ultimate well-being of the patient athlete may be compromised in favor of short-term gains for the sporting organization. The problem herein lies when physicians are beholden to the interests of someone other than the patient. These physician-team relationships should function under clear rules to prevent the alteration of medical treatment based on nonmedical concerns. This should tie in with the American Medical Association's oversight committee.

We also suggest that health care professionals entertaining thoughts of working with sports teams be trained in basic principles and concepts of applied ethics.⁵ Codes of ethics provide a moral template for professional conduct.^{1,2,10} The principles and rules contained in professional codes can help health care professionals clarify their obligations toward the patient and to other stakeholders. The American Medical Association's code of ethics¹ contains a subsection on sports medicine. For example, opinion 3.06 (sports medicine) states,

The professional responsibility of the physician who serves in a medical capacity at an athletic contest or sporting event is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even the injured athlete that he or she not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations.

Similarly, the National Athletic Trainers' Association's code of ethics states the principles of ethical behaviors that should be followed in the practice of athletic training.¹⁰ Physical therapists working with athletes in sports teams should be guided by the principles and rules in the American Physical Therapy Association's code of ethics.² In addition, state practice acts can further clarify legal commitments.

Yet, it should be remembered that codes of ethics have limits applied to ethical decision making to solve ethical dilemmas because they do not provide any particular hierarchy of principles that govern in all situations. Simply put, codes of ethics are not designed as a framework of ethical decision making. Most health care professionals balance ethical principles of the patient's right to autonomy, with fairness, and their obligations to avoid doing harm (nonmaleficence) and doing good (beneficence).⁵ To balance these principles for a favorable

outcome, health care professionals turn to utilitarianism, balancing potential benefits versus risks and judging a decision based on maximizing positive outcomes. Before acting on a decision, the health care professional should confer with trusted colleagues, preferably those who are not directly associated with the case. A helpful approach is to present the case to a colleague and brainstorm possible alternatives. It is helpful to compare alternative suggestions to what is decided to do. Make certain that the actions are ethically justifiable (based on ethical and legal principles and rules and consistent with the threshold of using sound professional judgment), while at the same time addressing the needs of the major stakeholders in the best way possible. Once an action is taken, it is important that the health care professional judge the consequences of the action and reflect on the results. The health care professional should ask herself if the best action was taken; given the results, might a different action be called for in the future? Self-reflection is important in ethical decision making and an excellent way to learn how to navigate similar problems in the future.

A basic framework of ethical decision making should be integrated into continuing education certification courses in sports medicine. At the very least, sports medicine practices should be encouraged to integrate in-services that provide opportunities for health care professionals to discuss and reflect on ethical issues they encounter in practice. The use of narrative is particularly effective. Health care professionals can be encouraged to write stories about difficult ethical situations. These stories can be shared with colleagues as points of discussion to help clarify the issues and to work through solutions for the future. As pointed out, experienced clinicians are well versed in practice skills and knowledge, as well as technical reasoning and ethical reasoning. Part of best practice is being able to not only navigate ethical issues but effectively address ethical concerns of the athlete and other stakeholders in sports.

CONCLUSIONS

It is clear that sports medicine presents unique challenges for health care professionals because of the organizational

pressures involved in returning an athlete to competitions as quickly and as safely as possible. Physicians, like all health professionals who work with sports teams (particularly at a high level), need to be prepared to deal with ethical issues as they arise. The successful practice of sports medicine depends not only on the knowledge and skills in differential diagnoses of medical conditions and the assessment of impairments and functional losses but also on skills in ethical decision making. Given that ethical issues are ubiquitous in sports medicine, health care professionals must be properly trained and adequately well versed in the ethical issues they will face.

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