

# Ethical practice and sports physician protection: a proposal

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EDITOR'S  
CHOICE

## PREAMBLE

It is in the nature of medical practice that it is always likely to yield ethical problems because of the role that health, illness and injury play in the lives of patients.

Sports physicians can find themselves in particularly difficult (though not unique) contexts because of the role of the body in athletic performance, especially at elite and professional levels. Contrary to recent articles,<sup>1-4</sup> however, Sports Medicine should not be viewed as giving rise to distinct or unique ethical difficulties. Such difficulties as arise in Sports Medicine merely reflect the kinds of challenges and dilemmas (eg, confidentiality, conflicts of interest, consent, disclosure, working with vulnerable populations) as are found in other branches of medicine, though not necessarily in precisely in the same configurations.

One common professional response to the recognition of ethical demands and professional ambiguity is to establish codes of conduct such as those published by the American College of Sports Medicine (ACSM),<sup>5</sup> the Australasian College of Sports Physicians (ACSP),<sup>6</sup> the International Federation of Sports Medicine (FIMS)<sup>7</sup> and the Faculty of Sport and Exercise Medicine (FASEM).<sup>8</sup> Within the literature of applied ethics,<sup>9</sup> sports ethics<sup>10</sup> and sports medicine ethics,<sup>11</sup> the limitations of these codes as instruments of education, guidance and punishment have long been noted.

Most recently, within *BJSM*, the ACSP has presented and defended their new Code within the broad aim of contributing to the development of a professional community of practitioners.<sup>12</sup> One of the merits of the Code that the article

draws attention to is the articulation of standards of expectation, differentiating among other things between those actions that are, on the one hand, compulsory from exhortations to best practice on the other. (They capture the distinction in 'must' and 'should' statements.) Nevertheless, that code itself has recently been criticised<sup>13</sup> for a range of issues that it neglects or which it fails to recognise are at odds with extant practice.

One of the standard criticisms of any code of professional ethics, which has often been overlooked in discussions of sports medicine ethics, arises from the notion of scope of application. To whom do the rules apply? Sports Medicine is not unique in being professionally fractured along disciplinary and geographical lines. The idea of a universal code, an Esperanto of sports medicine ethics, is almost certainly a pipe dream. Nevertheless, what the sport physician can and should do is to achieve the greatest clarity possible about the precise boundaries of their roles before engaging their services in order, first, to identify potential conflict and, second, to agree upon a clear set of priorities with the relevant parties concerned: athlete patient, Club/Team/Federation/event organiser and so forth.

In this Editorial, we propose a model of the nature of professional relations between sports physicians, athlete patients and other institutions for whom they offer paid and unpaid services (such as Clubs, Teams and National Governing Bodies). We do not suggest that what is proposed is radically new. Scholarship and professional discussion on these issues has sporadically appeared over the last 20 years. It is hoped that adherence to the proposals might reduce many, though not all, aspects of ethically problematic practice relating to confidentiality and disclosure, conflicts of interest and insurance issues regarding fitness to practice abroad. It is further hoped that it will help to guide professional conduct in sports medicine and serve to stimulate further professional reflection on the nature and purposes of sports medicine within a defensible ethical and professional framework.

## THE ROLES OF THE SPORTS PHYSICIAN AND THEIR RELATIONS WITH ATHLETES AND THIRD PARTIES

Sports physicians occupy a specific set of roles. For example, they may carry out the role of an athlete patient's general practitioner; a team doctor for a single club; the sport physician for a national sports federation (of which their club may be one constituent) or an international sports federation; an independent consultant to an employer of the athlete patient; an event physician whose services have been engaged by event organisers; and a specialist consultant in a legal process. Each of these roles brings ethical challenges, but between them there may be conflicts of expectations or duties.<sup>14-16</sup> Although sports physicians may occupy other medical and healthcare functions beyond their sports medicine practice, the proposals below refer specifically to their interaction with any athlete patient. Where there is overlap between their role as consulting physician (ie, general practitioner) and sports physician, it is the duty of the physician clearly to distinguish these and to communicate them both to patients and other interested parties.

In all the scenarios that sports medicine presents the sports physician, it is recommended that the sport physician is focused on the care they give to their athlete patients. Best practice may be difficult to determine in a young medical specialisation, where the nature of individual care and the demands upon athlete patients may appear ambiguous. It is not always clear how to interpret the best interests of the patient.<sup>17</sup> Nevertheless, if sports physicians are to give their athlete patients the highest level of care they are able, to it is of the highest importance that they develop trusting relationships. Athlete patients who do not trust their sports physicians to act always in their best interest are unlikely to share with them such information as may help diagnosis, cure and prevention of athletic injuries and other deleterious conditions.

In order to provide their athlete patients with the highest level of care, it will be necessary, therefore, for a clear separation of roles where possible between the sports physician, the athlete patient and the relevant third parties such as team coaches or managers; club owners, press officers; and those involved in team or squad selection. While this is not always possible, and while the sports physician may be burdened with a number of potentially conflicting roles, they should always seek to clarify and minimise such risks before

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the engagement of their services, consulting with colleagues and up-to-date sources of professional guidance.

### PRIMARY RESPONSIBILITY TO THE ATHLETE PATIENT

Promoting, securing and maintaining the health status, both short term and long term, of the athlete must be the primary responsibility and over-riding priority of the sports physician. While the sports physician may have additional contractual and non-contractual obligations to third parties, these should never take precedence over their primary duties to the athlete patient. A sports physician who can act as a complete fiduciary<sup>18</sup> (ie, an agent entrusted with the good of, and care for, another) for the patient is likely to provide better medical care because she/he is likely to give and get better information to and from the athlete patient. Clearly, not all sports physicians actions are consistent with such a norm in the face of powerful external pressures, especially within highly commercialised professional sports.<sup>19</sup> Hence, the potential for conflicting obligations should be minimised in order to provide long-term care that is best for athletes, best for club/team/NGB and best for the sports physician.

Where the sports physician is the sole treating physician (such as an event physician) she/he should be clear that their duties lie to all athlete patients irrespective of their club or team or federation affiliation(s). Before the commencement of events, the sport physician should seek to clarify the boundaries of their role with the event organisers and any issues of indemnity that would need to be understood before offering services to any athlete patient.

### CONFLICT OF INTEREST

Sports physicians often find themselves with obligations to third parties beyond the athlete patient.<sup>20 21</sup> The sport physician must seek to minimise potential conflict of interest. This will allow them to fulfil duties of care and to respect patient autonomy and confidentiality.

Before commencing employment, or agreements to provide services, the sport physician should seek to gain agreements as to their independence from any contractor of their services, preferably in writing. This agreement should specify whether their relation is one of (1) employee (eg, team doctor) or (2) as an independent consultant (eg, to perform a preparticipation fitness evaluation prior to selection or joining a new club). Clarity of expectation

must also be sought if the sport physician is fulfilling more than one role (eg, orthopaedic surgeon and team doctor) for an employer in relation to an athlete patient, which may give rise to a conflict of interests.

The agreement should, among other things, secure the above principle that the provision of healthcare to their athlete patients be their exclusive responsibility. The sport physician should never be coerced into agreeing the return to athletic competition of an athlete patient who is unfit to do so.

Wherever possible the agreement should lay out lines of communication and the responsibilities for reporting, which (where possible) should be directly to a person not involved in athletic performance, selection or management thereof. Any reporting must be within limits that respect duties of consent and confidentiality laid out below. The agreement must state with clarity what the expectations are upon the sport physician and those with whom they are to communicate. To protect the interests of all parties, the sport physician should keep appropriate records and store them securely so that access is permitted to the members of the care team only.

### CONFIDENTIALITY AND DISCLOSURE

Athlete patients should be made aware that personal or private healthcare status data may need to be shared with other members of the healthcare team in order to provide the best level of care. There should be clarity as to the persons with whom such information may be shared.<sup>22</sup>

Sports physicians should, in their work, minimise the risk that confidential information is inadvertently revealed to others, for instance during examinations in a common treatment room or when participating in a press conference.

There may be occasions where the athlete patient wishes to consent to breaches of confidentiality where they judge such a disclosure to be in their interests (eg, with regard to recovery times or injury prognosis). Such disclosure should not prejudice the interests of the patient nor should there be coercion to divulge such from interested parties such as coaches, team managers or media representatives. Consent to disclosure should be specific and the sport physicians should not normally rely on any more general or open-ended 'consent' given by the athlete patient (eg, in an employment contract). Any such information as is passed on to those involved with athlete management or selection should

be strictly on a 'need to know' basis. All parties should understand and agree that complete disclosure of records, even with athlete patient consent, should be the exception not the norm.

Moreover, there may be conflicting interests arising from the variety of roles that the sport physician may be asked to fulfil. Where an sport physician is the treating physician in cases where an evaluation for a third party arises (eg, to check fitness before a new contract, or an extension of funding, or movement to a new club or team); a clear separation of their knowledge and powers is necessary and must be communicated to all parties, especially the athlete patient. This should include information about their role(s) and any perceived potential for conflict. The sport physician must also consider other factors such as the location of the examination and who may or may not be present in order to fulfil their fiduciary obligations to the athlete patient. In some circumstances, it may be appropriate to ask not to be put in this situation if the conflict of interest is acute.

The sport physician should be clear as to their responsibilities with respect to their knowledge of banned products, disclosure guidelines relating to athletes who are doping,<sup>23</sup> and the reporting thereof, along with the proper advice on and filing of therapeutic exemption certificates on behalf of their athlete patients. They should also be clear about potential conflicts between professional and World Anti-Doping Agency guidelines regarding disclosure of doping practices.<sup>24</sup> They should also be aware of their commitment to doping-free sport as members of their relevant national sports medicine federation and FIMS membership.

Where sports physicians may be called upon to discuss athlete patients healthcare data in public spaces such as the media, as is the case with celebrity sportspersons, sports physicians should seek the clear and specific authorisation of the athlete patient as to what may be said to whom, when and how. Such agreements should be revisited and revised, as appropriate, on regular occasions in order to protect both parties.

### INSURANCE

It is of the highest importance that sports physicians at all times have appropriate indemnity for their services. It is the responsibility of sport physician to have such insurance in place as is necessary for them to underwrite the various services they provide. Where relevant, such as in

the team doctor role, it will be their responsibility to assure that the club or team or National Governing Body or International Sports Federation has provision for such. It should be understood in their terms of agreement that no sports physician can be asked to provide services that they are not insured to perform. This has become increasingly difficult for physicians working in highly lucrative fields such as the English Premiership football and when travelling abroad to sports competitions.<sup>25</sup> The sport physician should not be asked to provide treatments that cannot legally be provided or underwritten. This should be recognised in their agreement with the employing or contracting institution. It is advisable to agree this before the commencement of every competitive season. Employers should agree not to request services that cannot be legally provided. It should be made clear that it is the employer's responsibility to facilitate contact and, where appropriate, authorisation with the relevant local healthcare provider.

### SUPPORT FOR SPORTS PHYSICIANS

Sports physicians should be aware of professional and ethical codes of conduct as related to their professional practice. Sports physicians should frequently update their knowledge and competency base in line with best practice guidelines relevant to their national healthcare and sporting contexts and be familiar with relevant national and international codes. They should also be mindful of the potential conflicts and tension that may exist among different codes pertaining to different constituencies whom they may serve or belong to.

A final point relates to scope of practice of the sport physician in relation to the field of Sports Medicine, which must be understood in the broader contexts of medicine. It should be noted that the nature and goals of medicine are a highly contentious issue within the philosophy of medicine.<sup>26–29</sup> While traditionally, the family of medical professions shared therapeutic and preventive goals, the place of enhancement (taking individuals beyond the species norm or their own previous health norms) is centre stage in an era of personalised, technologically driven, medicine. In this vein, we must also ask what, precisely, the ultimate goal of sports medicine is<sup>30</sup>; what, if any, is the goal of performance enhancement within sports medicine, and whether the sport physician ought to embrace the performance goals of individuals or teams of professional franchises. There is ample evidence

in the literature on ethics and professionalisation cited above, in relevant Codes of Conduct, that sports physicians find themselves caught between a rock and a hard place in their healthcare provision. While exhortations to best practice as we have developed above are important, the individual physician may find themselves in a weakened position if all they can do is point to models of best practice that they feel they should be allowed to emulate. It is therefore incumbent on leading bodies such as ACSM, ACSF, FASEM and FIMS to create professional spaces in which the very self-definition of Sports Medicine can be rigorously disputed and models of best practice negotiated with the variety of powerful sports franchises and institutions. The outcomes of these discussions, however temporary, will have profound effects for our understanding of ethical frameworks in sports medicine.

### CONCLUDING REMARKS

Sports medicine has developed at a dramatic pace over recent decades.<sup>31</sup> Though its roots are in ancient Greek and Roman athletics,<sup>32</sup> it is nevertheless in its early phases of professionalisation. In the proposals above, we have avoided reference to the broader configuration of sports and exercise medicine. Our justification for this focus is that the ethics of exercise medicine draws upon, and is more closely related to, the ethics of public health. It should, therefore, come as no surprise that sports physicians are still, and will continue for some time to be, working in contexts where it is far from clear how they are best to proceed in ethical terms for the good of their patients. It is to be expected that medical practice is always likely to yield ethical problems because of the nature of medicine and role that health, illness and injury play in the lives of their patients. Sports medicine finds itself in particularly challenging, though not unique, contexts because of the role of the body in athletic performance, especially at elite and professional levels. The positions set out here, we hope, should serve to challenge and stimulate national and international sports medicine organisations to reflect publicly on what is admirable, permissible and impermissible in sports medicine, and to help to support individuals striving for the highest levels of professional conduct in sports medicine.

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