Ethical Dilemmas for the Team Physician

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On examination, you have diagnosed a 17-year-old high school starting offensive tackle with an anterior cruciate ligament tear. The problem is that his parents do not speak English and they do not attend the games. The athlete wants to play and his coaches want him on the field, but he refuses magnetic resonance imaging. You discuss this with the trainers and coaches. You decide to hold him out for fear of further injury to his knee that could have long-standing effects. Would your decision be different if he was 18? What if he was a college athlete trying to impress professional scouts? What if he was a National Football League athlete who knew his window of opportunity was narrow?

Serving as a team physician is both rewarding and challenging. Although some sports medicine decisions can be intuitive, others can be more difficult. The art of sports medicine is painted with the understanding of the pressures applied to not only the medical team but also the athlete, coaches, family, agents, and other vested entities. Each individual involved in the process brings his or her own goals and bias. Sometimes, figuring out what is best for the athlete is more complicated than just mastering the medical aspects of treatment. Personal, family, and financial pressures may affect the situation and cloud the decision-making process.

The role of the team physician is further complicated by potential contractual obligations to the team if the physician serves as a consultant or an employee of the team. Although a physician treating an athlete for a "second opinion" is only beholden to the patient, a team physician may have an obligation to also protect the interests of the team. The traditional doctor–patient dyad is challenged by the doctor–athlete–team triad.[1] A second opinion physician is freed from obligations to the team, but still has the challenges of balancing the athlete's wishes with careful medical care. For full patient autonomy to be effective, the athlete needs to understand the relationships between the physician, the athlete, and the team.

The concept of beneficence relates to physicians' obligation to protect patients' welfare above other goals, despite an inconvenience or cost to themselves.[2] When treating athletes, the team physician's efforts toward beneficence are often under public scrutiny. Public perception of the physician's treatment may be based on how fast the athlete returns to play or even how well the athlete performs. For example, consider the case of a professional baseball player with a medial meniscus tear. Treatment with meniscus repair involves a prolonged recovery with the potential for failure and subsequent additional surgery, but may have the benefit of meniscal preservation. There may be external pressure to repair the meniscus, even if the meniscus is nonrepairable. On the other hand, partial meniscectomy may allow a faster return to play, but may risk progression to arthritis. The physician is challenged to balance the wishes of the player and the team with the "best" medical care, knowing full well what the public perceptions of that treatment might be.

Swisher et al[3] surveyed a group of athletic trainers to determine the ethical issues that they face. Their most common issues were interdisciplinary conflicts, miscommunication about decision-making roles, conflicts of interest, and pressure to return to play from coaches, parents, supervisors, administrators, or the athletes themselves.

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Concussion treatment has garnered much media attention recently, which has spurred continually evolving National Football League guidelines for concussion treatment. Treatment of musculoskeletal injuries is even more difficult to streamline. In-game decisions regarding orthopedic injuries are still at the discretion of the medical team and should continue to be so. Although patient autonomy is paramount, is an athlete injured during an intense game really in a position to give informed consent? It can be argued that in these situations, education of the athlete and informed consent are meaningless.[4] It is therefore incumbent on the medical team to take responsibility for protecting the best interests of the athlete.

The International Federation of Sports Medicine has published a code of ethics that details the obligations of the sports medicine physician. According to the International Federation of Sports Medicine, "the physician's duty to the athlete must be his/her first concern and contractual and other responsibilities are of secondary importance."[5] Team physicians must take the time to understand the many pressures that are applied to athletes to help them make the most informed decisions.

As physicians, we are fortunate to hold a position of respect in the community. We must use that respect responsibly to help guide our athletes to make the best decisions. Although athletes, particularly elite-level athletes, can sometimes seem intimidating, remember that by virtue of them sitting in front of physicians, they are apprehensive and possibly intimidated as well. Physicians should not be afraid to guide and direct shared decision-making. Resist the urge to treat the star athlete differently from any other patient, but acknowledge the many confounding factors at play. Sometimes, the "heroic" medical treatment is appropriate; other times, it may actually be harmful. We have been blessed with an opportunity to guide our patients and positively affect their lives. Although as humans we are often tempted to allow conflicting influences to affect our medical decisions, we must always remember to follow the same principles that we use in our daily patient care in the treatment of elite athletes.

References

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