Abstract
All physicians are faced at some time with fundamental challenges while striving to respect the principle canons which define a physician’s ethical code. These canons are: 1. Primacy of patient interests, 2. Patient confidentiality, 3. Informed consent, and 4. Maintenance of a high standard of care. Athletes, because of their focus on performance, often present unique situations which lead to ethical challenges not seen in the general patient population. Adherence to the four principle ethical canons guides physicians to make ethical decisions when dealing with these unique patients.

Goals of Treatment
Orthopedists encounter patients from many different walks of life; a wide diversity of socioeconomic backgrounds, occupations, and age. Athletes as patients are a unique group of individuals who test the foundation of medical ethics and deserve special consideration. A discussion of this physician-patient interaction is warranted to elucidate the sometimes less than obvious conflicts that arise.

From the outset, a difference in the core set of values changes the nature of this physician-patient relationship. Non-athletes seek reduced suffering and pain as outcomes of medical treatment. Motivated by the goal of prolonging a healthy life, they approach health care decisions by seeking treatments that maximally restore and maintain long term function.

Olympic gold medalist Vince Matthews offered insight when he proclaimed “Twenty years from now, I can look at this medal and say, ‘I was the best quarter-miler in the world on that day.’ If you don’t think that’s important, you don’t know what’s inside an athlete’s soul.” The athlete patient is driven to perform and pursues the extremes of physical capacity to compete. Long term health may take on an importance secondary to achievement. After injury, he often searches for a quick fix to overcome a situation that compromises performance. Speed of recovery becomes a main priority.

Extensive training also affords a unique knowledge of his own body, a factor that serves as an asset during medical evaluation and treatment. Respect for this awareness facilitates the decision making process. By nature, the athlete patient is usually very motivated and prepared to commit to a rehabilitation program, eager to push the limits of the healing process.
Primacy of Patient Interest: Loyalties

Primacy of patient interest, defined as adhering to what is in the best interest of the patient above all other competing interests when making treatment recommendations, must be the primary guide in dealings with the athlete patient. However, the team physician is a role encompassing many loyalties, creating the potential for conflict when these duties overlap. As an employee of the team no longer working principally for the individual patient, there is an obligation to share medical findings with management. In the arena of professional sports, failure to disclose medical findings may actually result in disciplinary action. Exposed to criticism by a raucous media, recommendations undergo extensive scrutiny and statements are twisted to feed sensationalism. Bad press can be devastating not only for professional standing in the community but also for success as a businessperson managing a private practice. Alternately, a favorable standing can help build a reputation and bring new patients to the door.

Coaches and fans are a source of pressure for both athlete and physician, particularly when victory is on the line. The contained focus on one person’s health spirals out of perspective to impact a much wider audience. A physician may be drawn into and caught up in this fan mentality or feel a sense of obligation towards the success of the team that employs him. Ultimately, he must wade through these multiple roles of team employee, businessperson, and fan to focus on the principal role as a physician who is primarily concerned for the health of the patient.

In some situations, a physician takes on the role of gatekeeper. Writing clearance notes for return to school and work as well as making recommendations about when to resume certain activities after injury or surgery is a routine part of orthopaedic practice. The National Collegiate Athletic Association Sports Medicine Handbook declares: “The team physician has the final responsibility to determine when a student-athlete is removed or withheld from participation due to an injury, an illness, or a pregnancy. In addition, clearance for that individual to return to activity is solely the responsibility of the team physician.” Legal precedent has protected this responsibility, citing college sport as a privilege and not a right. For professional sports, the team physician is appreciated as more of a medical advisor than the final say on medical fitness to play.

Confidentiality

The altered level of confidentiality in the team physician-athlete relationship merits dedicated discourse. Contained in the Hippocratic Oath is the following statement “Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private.” Recognized for centuries, trust in the physician patient relationship takes foundation in the right to keep one’s personal medical information private. Confidentiality creates an environment where information is exchanged freely and ensures the treating physician access to even the most sensitive details, ultimately necessary for accurate diagnosis.

Private physicians treating athlete-patients are bound by the strictest code of confidentiality. The Health Insurance Portability and Accountability Act (HIPAA) attempts to legislate this long-honored code in order to formally protect the communication. Critical to this conversation is the distinction that a private physician does not have a responsibility to the athlete patient to hide information or write a medical clearance note when it is not medically appropriate. The relationship involves duty only to the athlete, but not to promote non-medical interests and goals with false or misleading information, only to protect health records. The physician cannot share information without an athlete’s consent, even if it is life-threatening such as a diagnosis of a cardiac problem. These rules are slightly altered for minors or in situations involving possible harm to other people as is the case with race car drivers.

Team physicians are not bound in the same sense by HIPAA regulations or the underlying ethical code of privacy. Health information is considered part of the employment record of professional athletes, and as such does not fall under the same regulations. At the college level, the Federal Educational Rights and Privacy Act (FERPA) permits team physicians employed by a college or student health clinic to disclose medical information without a patient’s consent to school officials who have an educational interest in the information. How is trust salvageable when confidentiality is altered in such a way? To answer this, we may draw from the philosophy of Immanuel Kant who asserts that trust is key for all interpersonal relations and relies on honesty. The team physician has a responsibility to reveal the level of confidentiality of a physician-patient encounter at the outset, particularly in a situation where medical findings will be shared with a wider audience. The natural assumption based on experience is that personal medical information is privileged, and clarification of a change in this usual practice merits specific disclosure. Akin to revealing a conflict of interest, openness of this kind serves to foster trust.

Autonomy and Informed Consent

When commenting about individual rights, John Stuart Mill remarked “The sole end for which mankind are warranted…in interfering with the liberty of action of any of their number, is self-protection…the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others.” The concept of autonomy stands out as a revolution in the practice of medicine during the 20th century. Gone are the days of paternalism. Placing absolute trust in a physician to determine treatment rarely occurs now. Whether this transition is secondary to the availability of information, the
embracing of self-determination, or skepticism for authority figures and their motivations is debatable, elements of each are probably responsible. A product of this newfound patient autonomy is a requirement for the free and informed consent of a competent patient to medical procedures to be performed. Physicians bring to the table the benefit of medical training, knowledge, and expertise while patients must filter this information through their own goals and values to arrive at the treatment option that is right for their own lives. The importance of treating patients in the context of their lives is the underlying ideal.

The concept of informed consent has particular relevance for physicians who involve themselves with sports medicine. At the center of this practice is the belief that competent individuals are the best judges of their own good. Athlete patients may be prepared to accept greater risks for greater gains. They are often more concerned with achievement in the short-term rather than long-term health. When commenting on an injury that was plaguing him at the time, Patrick Rafter explained, “Last year, I tried not to do as much kicking on my serve. Then I just said, ‘To heck with it, I’m going hard with it.’ That’s what’s best for my game.” The physician must be careful to not project his own values when guiding treatment by remembering to respect that athletes are driven to succeed and thus acutely aware of the limited time they may have to take advantage of peak physical form and the shelf life of any opportunities presented. In an area of medicine, where options are plentiful, the decision making process needs to incorporate personal goals and values of the patient.

One major prerequisite of informed consent is that it must be given freely. For all patients, the decision to proceed with medical treatment cannot be made under duress. An athlete’s physician has a responsibility to recognize and help separate out pressures of the moment that may compromise the freedom of a patient’s choices. These pressures come from coaches, teammates, and the media or are also self-imposed. This crowded environment contributes to clouded judgment and the development of a bias towards the short-term consequences of actions. An athlete, or for that matter any patient, needs space and time to assess options with perspective, to consider the impact that the injury and any treatment will have on quality of life.

The luxury of time is not always a possibility for competitive sport. Minimizing other voices during the informed consent process by having the discourse take place in as private an environment as possible can be helpful. One solution suggested is to discuss common possible injuries and treatments available with each individual beforehand. Conversation of this kind allows the physician a window into an athlete’s set of values and priorities at a time when other pressures are not present. Both parties may then take this knowledge into game time management of medical issues that arise. As is the case with most youth, athletes as a group regard themselves as invincible because they enjoy the epitome of good health. Therefore, they may not reflect on the possibilities of future injury unless asked to do so specifically.

Another key aspect of medical decision-making necessitates that the patient is informed regarding treatment options. Fulfillment of this requirement does not only involve the dissemination of facts which may in and of itself be a challenging task in time limited settings, but also demonstration of understanding of those facts. Competency, the final major component, comes into play here. The classic situation of questionable decision making capacity arises when medical or psychiatric conditions interfere with the ability to comprehend information presented and engage in discussions regarding the consequences of various courses of action. For sports medicine, the capability to employ reasoning and deliberation may be compromised due to situational issues. While suggesting athletes are at times incompetent to make decisions is a stretch, recognition that achievement of understanding is essential to the attainment of informed consent applies much more broadly to include all physician patient interactions. As a community, medicine needs to continue to appreciate the complexity of treatments rendered. Many people rely solely on their doctors to translate the complicated and voluminous body of scientific knowledge in a relatable way so that they may make enlightened choices. Honoring the autonomy of a patient by empowering him to realize the right to self-determination involves educating him to the extent possible. Only then does he truly exercise free will in making choices.

Special Situations: Ethics of Performing Enhancement Substances (PES)

The advent of the widespread use and abuse of Performance Enhancement Substances (PES) has resulted in unique ethical challenges for physician and athlete. Advancements in medicine have produced chemical compounds capable of boosting physical performance. When disparities in talent are minimal, an intervention that provides an edge can mean the difference between victory and defeat. Much attention has been paid to drug use by athletes, and the list of banned substances in competitive sport is lengthy and growing. At first glance, the very notion of banning drug use appears to violate respect for autonomy. After all, the risks of using chemical enhancements are assumed entirely by the individual. Greater risks for greater gains is a philosophy familiar to competitive sport whether referring to individuals or game management decisions made by a coach.

There is no doubt that scientific progress plays an important role in the ongoing evolution of sport. Light graphite composite tennis rackets with large heads replaced classic wooden versions, injecting greater power and speed into the game. Development of slick, friction resistant fabric has been credited with cutting down drag for competitive swimmers. Resisting this type of change and the conferred capacity for improved performance would be arguably illogical, yet the
advent of anabolic steroids, blood doping, and human growth hormone is surrounded by a firestorm of controversy. What is the underlying difference that incites such a reaction? Rules of sport are arbitrary but together combine to define the activity itself. There are regulations about what constitutes a dribble and a pivot foot in basketball and about how long a player can stand in the key. Passing behind the last defender on the soccer field is prohibited and corking bats is illegal in baseball. These lines in the sand are seemingly random but serve to define the game. Performance enhancing drugs do not fall within the borders we have determined as the court of play.

While an argument made in this way is sufficient to justify the stance, it is somewhat unsatisfying. Adding substance to the dialogue is a philosophical perspective. The nature of sport is not only in the final performance but in the means to the capacity for such a performance. A view from the vista is all that more amazing after the long climb, and the inherent values of the climb and the summit are distinct. A new means of reaching the same vista, such as a train or helicopter, cheat us of the values of the old and in a way, bypass them completely. Athletic achievement should not be an end in and of itself, as the true value is contained in the path to such success. As such, it is an ethical obligation to educate and advise the athlete patient regarding detrimental effects of PES both for the athlete and for the purity of the sport.

Maintenance of Clinical Excellence

Maintenance of clinical excellence applies to the treatment of athletes as it does to the treatment of non-athletes. There are certain situations unique to athletes which can, if allowed, pressure the clinician to deviate from this canon. These situations revolve around the fact that athletes are often celebrities, either locally or nationally. Their celebrity can sway physicians to treat high profile athletes rather than refer them to more qualified clinicians. The public relations (PR) benefits and media exposure associated with treating athletes can influence physician decision making. Clinicians may be tempted to perform procedures beyond the scope of their usual practice, rather than refer the patient to more appropriate providers and risk losing potential PR benefits associated with treating athletes. Again, there is an ethical obligation to perform procedures for which clinical excellence is maintained and to refer out those patients who require procedures for which proficiency has not been established, no matter how famous the patient.

Those who have the privilege of providing orthopaedic care to athletes are often faced with unique situations that present difficult ethical choices. Should athletes be allowed to sacrifice long-term health for short-term performance and the economic benefits which follow, or should there be an insistence on the more classic approach of focusing on long term health? With adherence to the over 2000 year old ethical canons, the ethical choices are clearer. Properly informed and educated athletes should be able to choose the treatment which is most beneficial to them. The physician’s ethical obligation is also to recommend treatments which are most beneficial to the athlete, not the team or the physician. In retrospect, referring to the classic ethical canons often makes what seem to be difficult decisions more straightforward.

Disclosure Statement
None of the authors have a financial or proprietary interest in the subject matter or materials discussed, including, but not limited to, employment, consultancies, stock ownership, honoraria, and paid expert testimony.

References