

Ethics in Sports Medicine

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Sports medicine physicians are not exempt from the ethical challenges of medical practice merely because their patients are robust and healthy. In fact, precisely because the patients with sports injuries are so healthy the moral issues remain subtle. Many ethical issues in sports medicine come about because the traditional relationship between doctor and patient is altered or absent. In the current review, several routine topics in biomedical ethics, including doctor and patient confidentiality, informed consent, the care of minors, medical advertising and use of innovative treatments, will be studied from the sports medicine perspective. Hypothetical case histories will be presented, along with an analysis of the underlying ethical issues. The goal of this analysis is not to offer answers to these moral questions, but to increase awareness and promote contemplation of the correct course of action.

The field of biomedical ethics addresses weighty issues. Determining when it is acceptable to withdraw life support, for example, or regulating human cloning are topics that seem appropriate for the bioethicist. Accordingly, there is a perhaps common misconception that ethical questions exist only on the cusp of life and death. But important issues in medical ethics also arise in

commonplace arenas. For instance, the simple case of a player with knee pain can be riddled with questions of informed consent, patient autonomy, and conflicts of interest.

Sports medicine physicians are not exempt from the ethical challenges of medical practice merely because their patients typically are robust and healthy. In fact, because the patients who are treated for sports injuries are so otherwise healthy (and thus do not seem to be “patients”), the moral issues remain subtle. This lack of awareness is an invitation to error: although ethical questions do not always have a universally accepted right answer, ignorance of the question easily can lead to wrong choices.

Many ethical issues in sports medicine come about because the traditional relationship between doctor and patient is altered or absent. The usual doctor and patient relationship is based on the following tenets: that the physician works exclusively on behalf of the patient; that the patient and physician have a common goal, namely, to get the patient well; and that the relationship is a private one.

All of these principles may not apply in sports medicine. Often, sports medicine physicians do not work exclusively on behalf of the patient, but also as agents of the team that hires them. (This altered nature of this doctor and patient relationship also is not always clear to players, although it should be). The typical goals of medical care also may be skewed. In the quest for money, approval, or personal satisfaction, the patient who is an athlete may trade

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an enhanced short-term performance for long-term health. Finally, encounters between sports medicine doctors and patients who are athletes rarely are private. Coaches, teammates, and agents, even if not physically present, can intrude on the privacy of doctor and patient relationship. These individuals often subject the physician to a high level of scrutiny, and may alter his or her behavior.

The lack of privacy in the doctor and patient relationship, the orientation toward short-term athletic performance, and the consideration of interests in addition to the patient's long-term well-being do not, in themselves, constitute ethical violations. Rather, they are potential problems. Cognizance of these hazards helps the practitioner act ethically and deliver appropriate care. Accordingly, the aim of the current study is to raise the levels of awareness, by presenting a collection of cases with some ethical pitfalls. The scenarios described are not necessarily a comprehensive set, nor is the critique presumed to be definitive; rather, they are to serve as a springboard to additional discussion.

Confidentiality

Respect for a patient's confidentiality is a classic and central precept of medical ethics. The reason is not only theoretical, but practical: to give good care, a physician needs complete access to all of his or her patient's medical history, and patients must be made to feel comfortable sharing this information. Assurances of confidentiality help create that environment where information is exchanged freely. The unique nature of the sports medicine doctor's relationship to his or her patients creates ethical challenges to the requirement of maintaining confidentiality.

Case History

A talented high school running back is being recruited by a major university known for the high quality of its football team and undergraduate programs. The school is considering awarding a full scholarship. Without the athletic scholarship, the player could not afford to go to this school. During an on-campus visit,

the player was examined by the university team physician. The player notifies this team doctor that he was admitted to the hospital three times for concussions he sustained while playing high school football. The player asks that the physician keep this information confidential, to avoid jeopardizing his college football career and full scholarship.

Analysis

To our view, the physician has no obligation to remain silent; to the contrary, he has an obligation to the team (and perhaps even to the player) to disclose these relevant facts. The team hired this physician to determine athletes' fitness to play, and failure to disclose a significant medical history will be dereliction of that duty. Even though the precise medical risks of a fourth major concussion are not known with certainty, the university may not want to expose itself to potential liability to using such a player and may decline to offer a scholarship to such players at risk. Because this medical information is highly material to the school's decision making process, the physician the school hired to gather such information must disclose the information.

There is no countervailing duty to the player to remain silent: the doctor is not the player's personal physician, and thus does not have the typical onus for silence that typically applies. In fact, the only obligation that this doctor may have toward the player is to protect him from potential dangers, and by disclosing this medical history the physician may minimize medical risk, either by preventing him from playing, or at least ensuring that all protective steps are taken.

The physician has a special ethical duty to the patient: namely, to clarify the nature of their relationship before the examination.³ Specifically, he must remind the player that he is not the player's doctor, in the ordinary sense, but rather an agent on behalf of the team whose goal is to ensure that all of the athletes are fit to compete. He must note that his job requires him to share information from the history and physical examination with coaches

and other relevant team officials.⁶ It may not be apparent to the player that even though he is in a doctor's office, talking to a doctor about medical subjects, that the normal rules of engagement do not apply. The physician must act proactively to prevent problems that result from that ignorance.

The scenario could be made more complicated if the player were to ask for confidentiality before divulging the information. (In the case above, the player divulged the facts first and requested confidentiality later.) He may say, for example, "I have some information to tell, but will share it only if you do not repeat it". Here the physician probably should not accept the offer, but simply should report that the player noted that there was some additional, unshared, medical information.

When the player's conversation occurs not with the team doctor but with his personal physician, the ethical balance shifts. Some schools request that a student's local doctor perform a pre-season clearance physical. When being cared for by one's personal doctor, even for the purpose of a pre-season physical, the physician's loyalty is strictly to the player. The doctor is of course obliged to try to protect the player. In this case, the doctor should inform the athlete that there is a risk for neurologic dysfunction if he continues to play football and sustains a fourth concussion. It may even be reasonable for a personal physician to counsel the patient against playing another season. But there is no obligation to act as an agent of the team. The physician's duty to the school or team is limited to providing truthful information. Accordingly, if the player requests confidentiality, the doctor is duty bound to remain silent. The player's right to confidentiality does not, however, impose an obligation on his doctor to provide misleading information. The doctor should refuse to submit an incomplete and misleading clearance form. The player has a right to confidentiality, but not to deception.

In the case where the divulged information was not material to the issue of fitness to play, such as sexual orientation, the pendulum swings the other way: keeping that confidence probably

is the best course of action, even though medical ethics do not demand that. At times, the courtesy that is expected of all people, namely, that secrets are kept secret, is the guiding rule. This may become ethically challenging when the disclosed information is tangentially related to fitness to play: should a team physician report to management that a player had six drinks on the flight home?

Medical Means Toward Nonmedical Ends

Most medical care combats disease. The overriding goal is to reduce suffering and prolong healthy life. Sports medicine presents a more complicated picture. Patients who are athletes do not necessarily want to get well, or to be free of pain. For many athletes, the simple goal is to get back on the playing field able to perform. In the relatively healthy population of athletes, supporting athletic achievement (and not reducing suffering or prolonging life) becomes the physician's reason for being. The atypical aims of sports medicine practice may make the appropriate and ethical path in some cases difficult to identify. Consider the following scenario:

Case History

Six weeks before the start of the playoffs, the starting guard for a playoff-bound team suffered a twisting injury of the knee that was shown on magnetic resonance imaging (MRI) to be a torn medical meniscus. The tear was in a region that could be repaired. The team doctor identified two treatment options: meniscal repair or meniscectomy. The meniscectomy would require minimal rehabilitation and almost guarantee the player's participation in playoff games. Yet it would also substantially increase the chances that the player would suffer degenerative arthritis (Fairbank's changes) in his knee 10 years hence. A meniscal repair, however, offers the chance at pain free function in the near term and the probable avoidance of articular degeneration. But a repaired meniscus also could re-tear at an inopportune time, and could prevent the player from competing in the playoff games. The surgeon thinks that despite

the risks of short-term failure, attempted meniscal repair is the best option. However, the player wants to maximize the chances of playing in the postseason and demands a meniscectomy. What should the physician do?

Analysis

The patient's and physician's goals for medical care usually coincide, yet this case shows that they may not. The question is whether the physician can allow his or her patient to assume medical risks for nonmedical benefits. Is it appropriate for the doctor to support a medical approach promoting degenerative arthritis in the future so the player can compete in the playoffs?

The underlying moral question is complex, touching on abstract concepts such as the nature of free will, but the practical question has an accepted answer in American medicine: patient autonomy trumps physician preference. The consensus is that informed patients should be allowed to choose the medical approach that they see fit.² Because people have unique beliefs and values, the best treatment often will vary from patient to patient. It is inappropriate for the physician to impose his or her own bias toward deferred gratification on the player. In other areas of medicine, patients may refuse blood transfusions that can save their lives; they can assume a risk of dying during liposuction for the dubious goal of more slender hips. Comparatively, the player's decision to subordinate the long-term health of his knee to his immediate professional needs is reasonable. The physician's responsibility is limited to making sure that the player is fully informed about the risks and benefits of the two procedures. In the end, the patient must decide what treatment he or she desires.

The patient's values must drive the decision making process. We do not use the values that the physician may wish to impose on the patient and we definitely should not consider the doctor's personal costs and benefits, although they may be significant. In this case, the player's physician will no doubt encounter much public and private pressure to ensure that the player can compete. Performing a partial

meniscectomy offers lower risks to the doctor. The procedure is far less likely to fail in the short-term and therefore reflect favorably on the surgeon. Although it is not unreasonable for the doctor to worry about how his or her care will be perceived, it is inappropriate for such considerations to influence the recommendation for treatment. The physician's personal needs must not enter the ethical calculus.

Informed Consent

The case of the basketball player with the meniscal tear (above) highlights the importance of respecting a patient's autonomy. Autonomy can be assured only if the patient is fully informed: if the player is not told about the risks and benefits, he or she can not possibly apply his or her preferences to the possible outcomes and choose what he or she really wants. Autonomy in the face of ignorance is meaningless. Accordingly, ethical medical care rests on informed consent. Informed consent requires that patients receive and comprehend information about a proposed medical intervention, and then freely agree to undergo the treatment. Both components must be satisfied to achieve true informed consent. Although providing patients with sports injuries with information is relatively straightforward, ensuring that they comprehend it, and assessing their comprehension, often proves challenging. In addition, one may ask if consent is given freely, because there may be external and internal pressures placed on the athlete.

Case History

An offensive lineman for a college football team complains of knee pain for the past year. He started every game, but was in pain when he assumed his stance. At the end of the season, he underwent arthroscopy. Patellar arthropathy and a small meniscal tear were found, and they were debrided. Postoperatively the player did well, and had a pain free off-season. When he returned for spring practice, the pain returned too, and he played poorly in scrimmage. The coach expressed his displeasure. The player presented to the team physician before the presea-

son camp, requesting a steroid injection. He says he heard about this option from some friends, and wants to do “anything” that will allow him to play football for one more season. The team physician thinks that steroid injections in the knee may be harmful, and explains this to the player. Nevertheless, the player insists he wants the injection despite the risks they may carry.

Analysis

The doctor can be rightly concerned that the player’s decision to receive the injection is not truly an informed and voluntary decision. Even after presenting the player with a list of potential harms from the injection, obtaining the player’s genuine informed consent remains elusive. Many athletes may not be receptive to informed discussion and consideration of their treatment options—including no treatment. This problem is particularly acute when the proposed intervention and associated discussion occur during a game. In such a setting, it is likely that short-term competitive considerations will overwhelm significant long-term and remote risks.

Even when discussing proposed interventions with a receptive athlete, it often will prove difficult to accurately convey the important considerations in a readily accessible form. The player’s perspective may be overwhelmed by the potential short-term benefits of the injections: they will allow him to play football for one more season. A 20-year-old individual may have a difficult time understanding long-term costs. Even a mature student could have trouble assessing the risks of arthritis later in life, or a more immediate but less likely complication, such as infection. In addition to barriers to comprehension, the player faces difficulties in making a truly voluntary decision. External pressure (from coaches and teammates, for example) may exert a significant influence, as may his own internal drives or fantasies. Because of this, we can legitimately wonder whether his choice is made voluntarily.

Obtaining the player’s genuine informed consent for an intraarticular injection can prove to be a complicated endeavor, but it is not impossible. The physician must work to ensure

the patient really understands. Sometimes this may mean spending additional time eliciting the patient’s comprehension through a discussion, or even recommending that the patient speak to former players who had undergone injections. Similarly, ensuring the voluntary nature of the patient’s decision also may require additional time and patience. The requirement for informed consent is not met until information is fully exchanged—not recited. Nonetheless, once that information has been exchanged, the patient is allowed to make an autonomous decision. Even when a patient’s choice disagrees with the physician’s preference, it still can be an informed and autonomous choice worthy of respect.

Enabling Dangerous Behavior

Sports can be physically risky and the lure of danger may be part of the sport’s appeal. Managing that risk is one of the main jobs of the team physician. Still, at times, the presence of high risk places the physician in a bind: by attending events the physician may decrease the likelihood of a bad injury (compared with the risk of the sport without a physician present), but by attending (and thus endorsing) the sport, the physician may encourage some to play, thereby increasing the risk of a serious injury (compared with the risk if the sport was not played at all).

Case History

A neurologist specializing in head trauma was asked to serve as a ringside physician for a major boxing match. He is concerned that by attending he will be seen as condoning (if not endorsing) a necessarily harmful activity. However, he is convinced that his skills, judgment and willingness to end the bout promptly if one of the fighters is injured will minimize the chances that either of the combatants will be hurt. He is uncertain how to respond to the invitation.

Analysis

The neurologist faces a difficult decision. If a sport is dangerous, the physician must strive to

make it less dangerous; but if he or she becomes involved with a dangerous sport, his or her involvement may encourage participants to play, thereby increasing the number of injuries. This paradox is not unique to boxing. Many sports, especially at the professional and Olympic levels, carry a high degree of danger. Sports such as downhill skiing or football are associated with high rates of injury.

Close physician involvement with hazardous sports have been shown to decrease the incidence of some serious injuries.⁵ For example, doctors' efforts to reduce spear tackling in football demonstrably decreased the rate of catastrophic injury in that sport. The benefits are real, not theoretical. However, given that the stated goal of boxing is to batter the opponent's brain into unconsciousness, one could easily argue that the physician has no place at ringside.

If an activity exists only to create severe injuries, associating with them is completely inconsistent with the doctor's mission of promoting health. The prospect of suturing lion wounds in the coliseum was not why Galen moved to Rome in the second century and patching modern gladiators is no more a part of the physician's mission today. The question, then, is whether boxing is a sport with associated risk, or rather it is an activity that exists only to create severe injuries, that just so happens to take place in sports arenas. This question is not resolved. Without more firm data, we think that participation in boxing remains a personal decision: a doctor should not be faulted for going, but likewise a conscientious objector should not be viewed as abdication his medical responsibilities.

Both of these approaches have additional responsibilities. The doctor who serves as a ringside physician cannot simply abide the status quo; it is incumbent on him to work from within to improve the safety of the sport. Likewise, the doctor who thinks that boxing should not receive medical sanction not only has the privilege to decline to serve, but also has the moral responsibility to lobby for changing the sport.

Advertising

One of the pressures the neurologist (in the case above) may have felt in the case above is the need and desire for publicity. As healthcare becomes increasingly competitive, physicians have been forced to be more aggressive about building and maintaining their practices. Thus, the neurologist may not want to be at the boxing match, but his practice manager, accountant, and partners all would encourage it. Pressures in medical economics also have spurred many doctors to advertise aggressively.

At its best, medical advertising informs individuals of their options. At its worst, medical advertising misleads patients and encourages inappropriate use of resources. Sports medicine doctors may be particularly susceptible to using this latter type of advertising because of the nature of their patients: these patients typically require care in nonemergency situations where they can choose a provider, and they have medical problems for which precise outcomes measures are difficult to obtain and critically evaluate. Patients with sports injuries often are avid "comparison shoppers" who base their decisions on the need for treatment and choice of providers on perhaps irrational criteria. Practitioners must be wary that they do not abet this irrationality, especially with misleading information.

Case History

A middle-aged executive comes to a sports medicine doctor for a knee arthroscopy. The executive tells the doctor, "I went and saw another doctor, and he obtained an MRI and it showed a torn meniscus. He wanted to operate on me, and I like him, but I'm coming to you because I know you are the best. After all, you take care of the local professional basketball team. I saw your ad during the game last night." Unbeknownst to the executive, the doctor he now is visiting is in fact a general practice orthopaedist with no fellowship training, and was designated as team physician because his practice purchased blocks of tickets and advertising. Most of the players actually obtain their orthopaedic care from other physicians. What are this doctor's duties to disclose?

Analysis

Medical advertising is legal and it is not inherently unethical. It certainly is prevalent. To level the field, even elite physicians feel compelled to advertise. It also is not reasonable to ask a physician who has paid for the advertising and now is reaping its rewards to give the patient a speech on how advertising is misleading. However, false advertisements are illegal and unethical.

The correct ethical approach here, we think, is to not purchase any label of excellence that is not deserved. A doctor is permitted to buy advertising with the team, but he is not allowed to buy an unmerited mark of quality. Because an association with a team may be an implicit stamp of skill, the doctor has an obligation to make sure that the patient is choosing rationally. He might say "Yes, I am the team doctor, but that's only glitter. You should choose me as your doctor because I have done hundreds of the these surgeries—not because I hang out in the locker room." If this doctor had in fact only done only several of these surgeries and is no expert, it is wrong for him to buy a designation that implies otherwise.

Medical advertising based on a professional team affiliation is not necessarily inappropriate. Such advertising is entirely acceptable, even without explanations, when it does not attempt to mislead. For example, a commercial that a medical practice supports the local team (similar to an advertisement run by a local restaurant or car dealership) is appropriate. Alternatively, if a doctor truly operated on a famous player with good results, that doctor, with the player's consent, should be allowed to publicize his success.

Drugs in Sports

There is no moral dilemma about whether sports medicine doctors should discourage the use of anabolic steroids by athletes. Clearly, they should discourage it. The argument is not medical nor moral, simply legal: Sports governing bodies and various state legislatures have outlawed such practices and physicians are bound by these decisions.

The moral questions arise more subtly. For instance, is it permissible for doctors to overstate the medical case against banned substances in hopes of encouraging compliance? To what extent can physicians involve themselves in legal performance enhancement? Both of these questions revolve around the same theme: that what is allowed is not necessarily proper, and what is banned is not necessarily evil. Plainly, the legal line is not necessarily the moral line.

Case History

A team physician at a major university is, in addition, an accomplished basic science researcher. An athlete sends him a note saying "I am a tenth of a second too slow to make the Olympics. Can you suggest a legal performance enhancing substance that will make me faster; or if you can't, how about one that they cannot detect when I get tested?" Before the physician responds, he reads his next email from a local high school coach, asking him to come and address the team. The coach writes "these kids have to be told by someone they trust that steroids can really hurt them." How should the physician reply to these requests?

Analysis

Sports medicine physicians are appropriately relied on for expert opinions on various exercise and sporting activities. Individuals sometimes attempt to use the physician's position of respect and expertise to promote social policies. These aims do not necessarily accord with the physician's scientific knowledge, and ultimately may compromise the doctor's authority. In fact, as best as we can tell, steroids are not going to kill their users. They may cause some physical harm, but then again so may some of the training regimens that physicians not only countenance but encourage. It is wrong for a team physician to lecture on the evils of certain drugs beyond the scope of the medical evidence.

There are numerous legitimate reasons why students should not use steroids. These include the known medical risks, and sense of

fairness to the opposing players, who may feel compelled to use them likewise to avoid an unfair disadvantage. The physician does not have to stoop to hyperbole and go beyond the known evidence. Deceiving the high school students, even for a laudable goal, is inappropriate and self-defeating. It undercuts the very credibility on which the physician depends.

Physicians have a special place in society not only because of that credibility, but because physicians honor a code of ethics. Physicians are bound ethically to shun regimens that violate even the spirit of the rules because of their implicit obligation (especially to their fellow physicians) to maintain the dignity of the profession. Public disclosure of such a rule-bending scheme could undercut the stature medicine, with practical consequence. This undermining of prestige may hamper a doctor's power to persuade, which is a necessary function in the practice of medicine. A patient may be less likely to take the advice of a physician if he or she suspects that the physician is not always honest.

The issue of a legal performance enhancer is more ethically subtle. Even legal substances may enable dangerous behavior.⁴ Also, one may argue, that the very phrase "substance enhancer" implies that this goes beyond the spirit of competition. We think that it is ethically permissible, and in fact laudable, to plumb the secrets of biology and medicine to improve human performance. Of course the imperative of science prevails: this work must be published and shared with all, not kept as a proprietary secret for one team. Certainly the act of searching for performance enhancers is not unethical. Their use, however, depends on their safety. We think that a legal substance enhancer belongs in the same class as a quirky diet or strange training routine: a physician can recommend it provided it is not dangerous.

Special Pediatric Concerns

Children are limited in their ability to express and implement their wishes. They sometimes require special protections against their own poor choices or those who would take advan-

tage of them. In most cases, parents and guardians provide this special protection as surrogate decision makers. Physicians and others reasonably assume that parents will know their children well and can best support their interests. Such an assumption is not always accurate and suggests numerous ethical conflicts.

Case History

A 15-year-old star basketball player on her high school team injures her arm in a water skiing accident during the off-season and seeks medical treatment. Physical examination suggests shoulder subluxation and instability. An MRI reveals a labral tear with a small Bankart lesion. The doctor presents the treatment options: surgical repair or intensive physical therapy. Capsular repair would offer some hope of returning to top form and would significantly reduce her risk of subsequent injury. Alternatively, physical therapy avoids surgery and should allow good use of the arm. The doctor notes, however, that if she were to decline surgery, he would recommend that she retire from competitive play. The player, who also is an excellent student and captain of the debate team, sees a life after basketball. She views this current accident to be a sign that she should give up her basketball career. Her father, who played in European leagues for 12 years, objects. He insists that she have the surgery in hopes of competing in college and beyond. The player's mother defers all medical decisions to her husband.

Analysis

The ethical questions associated with treating someone who values short-term competitive achievement over long-term physical, mental, and social health have been discussed above. In general, informed and autonomous adults may choose to behave as they desire. The situation differs with children. Legally and ethically, children's decisions require additional scrutiny. Limits to a child's understanding and decision making capability require that parents and others help ensure appropriate treatment choices.

This player's situation is especially troubling because she is old enough to understand her treatment options fairly well and seems to have addressed the question of treatment with maturity. Her father does not reject her logic, but only the utility values she ascribes to the possible outcomes.

It seems reasonable that children's input into their medical decisions should be based on their level of understanding and not an arbitrary age. Operating against the will of a thoughtful, competent child in a nonemergency situation is unconscionable. The issue is the degree of cognitive and emotional maturity that the child brings to bear on the situation. For instance, if the athlete were to refuse surgery because she is "afraid of needles", we may be more inclined to side with the father. Likewise, if the situation were reversed, and it was the father who opposed surgery ("let her concentrate on school work for a change!") we may feel compelled to help change his mind. In both of those cases, the role of the physician is to provide leadership; to educate all of the participants about the consequences of their actions. A good physician in this case, moreover, must transcend his or her role as 'shoulder doctor' and treat all of the disorders that are present. It may be that there are some unhealthy family dynamics at work here, and the sports medicine physician would be remiss if a referral to a social worker or other counselor were not made, if such help were needed.

Resource Allocation

Financial considerations have assumed an increasingly prominent role in healthcare decisions. From at least one perspective, healthcare is always in a crisis, because there is an unavoidable tension among quality, access and cost⁶: improvement in any one domain occurs at the expense of a commensurate loss in one or both of the other two. Accordingly, a physician must be mindful of how resources are spent, because money spent on one patient is money that cannot be spent on another (perhaps more needy and deserving) patient. Numerous factors influence the allocation of fi-

nite healthcare dollars. Practices of sports medicine physicians often raise meaningful ethical concerns involving the allocation of healthcare resources.

Case History

A professional football player injures his knee during a game one Sunday. A radiograph obtained during the game is unrevealing and he immediately undergoes an urgent MRI. The MRI reveals a repairable meniscal tear. The player is taken for arthroscopic surgery that evening.

Analysis

At a time when many Americans lack access to even the most basic levels of medical attention, this player receives prompt, state-of-the-art care. Is this fair? If not, who should do something about it? Perhaps the public does not mind if the player gets some special treatment—nobody seems to be harmed by it. If his doctors are willing to operate on the weekends (perhaps in return for seeing their name in Monday's paper) that is their decision, or so it seems. But at some level, there is a victim. Resources are finite, and what the player consumes, others with more pressing concerns cannot.

The argument that the player or his team will pay extra for his special treatment is disingenuous: the fees charged to a patient represent only a small fraction of the costs of delivering that care. Substantial societal resources helped create and now maintain the American medical system. Government funding has supported medical research, physician training, and even hospital construction. Even when athletes pay more than the full price for the care they receive, such care still is delivered by doctors trained at taxpayer expense, often using technological breakthroughs developed with government support: purchased healthcare always is, by definition, subsidized.

It would seem, then, that it is wrong for the player to get any special treatment when so many other individuals lack even basic care, because the treatment the player receives is being taken from others. The remedy for this

would require nothing less than a complete restructuring of the healthcare marketplace. This, of course, is beyond the responsibility of an individual physician. Still, sports medicine doctors must recognize the importance of these issues and actively contribute to the societal discussion on resource allocation. Physicians, we contend, should speak out to ensure that all people in the United States have access to at least basic care.

The special responsibilities for physicians go beyond the demand for discussion, and include a requirement to fight for greater social justice. In practical terms, this means that sports medicine physicians should voluntarily care for an indigent patient who needs them, at least on occasional basis. Doctors have a right to decide the recipients and the setting of their charity efforts—as anything less than that is not charity but a tax—but we think they must decide to give somewhere. Although most sports injuries are not true emergencies, a strong moral argument can be made that all citizens (and not just those with medical insurance) deserve high quality sports medicine care.

Innovative Versus Evidence-Based Treatment

Medical advancements require continuing experimentation and development. By definition, for every treatment, there must be a first time that the therapy has been tried. Such innovative treatments necessarily lack evidence proving their efficacy and superiority over preexisting treatments. Hence the paradox of medical progress: how dare we try the new if it is not supported by evidence? Yet how can we ever hope to obtain evidence in support of the new if we do not try it?

The paradox of medical progress is a deep-seated conflict within the practice of medicine. Moreover, because athletes often try to push the limits of current treatments, without being “sick” enough to deserve truly experimental approaches, the tension between evidence-based treatments and innovative treatments may create unique ethical difficulties for the sports medicine doctor.

Case History

A professional basketball player subluxates his shoulder while playing during the last game of the season. After all of the studies are done and a trial of therapy ends unsuccessfully, the team doctor recommends a capsular shift. Members of the media ask why the doctor does not want to perform the newer, less invasive heat shrinkage operation. According to a national news magazine article they cite, this shrinkage operation accomplishes the same goals with a shorter recuperative period, and none of the complications associated with cutting and sewing. The team doctor is reluctant because there have not been any published peer reviewed long-term studies.

Analysis

Despite a recent emphasis on practicing evidence-based medicine, definitive data on the best treatment for most conditions often remain elusive: much of contemporary medical practice lacks a firm, empirical foundation. Still, it is not the case that one can say “Well, because most of the evidence in medicine is not irrefutable, I do not have to base my treatments on evidence at all.”

The demands of ethics are that the physician use his or her talents to evaluate the basic science and clinical evidence to come to a reasonable conclusion. Sports medicine doctors, similar to all physicians, frequently must make treatment recommendations based on incomplete information. The key to providing ethical care in such situations is honest and open communication with patients. Physicians must tell their patients about all reasonable, available treatment options and then explain why they recommend a specific modality. They also must listen to their patients, to understand their preferences.

There is nothing wrong with using innovative (experimental) approaches, as long as the patient knows this and accepts the risks. When the known treatment meets all of the therapeutic goals it is reasonable to not even consider experimental treatments. However, because all of the patient’s goals (such as the

desire for small scars or the avoidance of any implant) may not be known to the surgeon, a complete discussion is required. Choosing an innovative modality instead of a standard treatment must ultimately be patients' decisions, as long as they know everything they can and should know.

Conclusion

The sports medicine doctor confronts a unique array of ethical issues. Many of these issues result from the sports medicine doctor's nontraditional relationship with his or her patients. Ethical issues in sports medicine are particularly challenging, because they frequently are subtle. Yet there often is a positive side. In questions of sports medicine ethics (unlike many other areas in medical ethics) a good answer usually can be found, or at least a good rule can be established for finding a good answer. For us, that rule is "full disclosure": tell the patient about medical risks, tell the patient about potential conflicts of

interest, tell the patient everything that he or she needs to know to make autonomous informed choices. The sports medicine physician must be vigilant. Although there are not always right answers to ethical difficulties, ignorance of them often leads to wrong choices.

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