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The social management of medical ethics in sport: confidentiality in English professional football

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1 **Introduction**

2 During the 2017 IAAF World Athletics championship Botswanan runner, Isaac Makwala,
3 was prohibited from competing because he was suspected of having contracted norovirus.
4 The athlete, supported by his national governing body and medical advisers, contested the
5 decision through the media. The IAAF's head of medical services, Pam Venning, responded
6 live during the host broadcaster's (the BBC) coverage. A panel of former athletes questioned
7 the medical evidence, fairness of the decision, effectiveness of the IAAF's communication
8 and potential restraint of trade. The BBC panel were subsequently accused of bullying
9 Venning but nobody, it appears, was concerned that in justifying the ban Venning had
10 described the athlete's medical history, thus breaking a primary medical ethical principle of
11 patient confidentiality (as Makwala contested this version of events it is unlikely that he had
12 consented to this release).

13

14 There are a number of ethical challenges that arise in the practice of sports medicine, e.g. in
15 relation to doping (McNamee and Phillips 2009), substituting injured players (Anderson
16 2011) and diagnosing concussion (McNamee et al. 2016). This has led some to conclude that
17 medicine is practised differently in sports contexts compared to other medical work settings
18 (Walk, 1997; Bernstein, et. al, 2000; Devitt and McCarthy, 2010). Within this broader set of
19 challenges, confidentiality is particularly important (Testoni et al., 2013) both because it
20 involves a fundamental medical ethical principle and because it has been empirically
21 demonstrated to be amongst the ethical dilemmas most frequently encountered by sports
22 doctors (Anderson and Gerrard, 2005). Indeed, it is the mundane nature of breaches in
23 medical confidentiality, as illustrated in the Makwala case, which epitomise the more general
24 problems of the practice of sports medicine.

25

1 Many of these challenges arise from a structural dilemma facing clinicians in sports teams.

2 As the British Medical Association (BMA) noted in its handbook of medical ethics:

3

4 Doctors who are employed by sports teams and by sports clubs may find themselves
5 subject to the tension of conflicting loyalties. On the one hand they are agents of the
6 team or club with the contractual obligations of an employee, and, on the other, as
7 doctors, they are advocates for the individual athletes or players who are their
8 patients. (2003: 595)

9

10 There is a growing awareness of the competing obligations on healthcare providers and the
11 implications for clinical autonomy. For instance, Anderson and Jackson's (2013) analysis of
12 sports physicians in New Zealand reveals expectations and pressures that compromise their
13 professional standards. Other studies highlight clinicians' submission to the values of their
14 more powerful clients such as coaches, managers and players (Malcolm, 2006; Scott and
15 Malcolm, 2015). The physical environments where medical encounters take place may also
16 compromise clinicians' ability to conform to established ethical codes. In terms of
17 confidentiality, injuries frequently occur and are treated in full public view. Moreover, the
18 conventional design of sports medicine facilities often have little regard for athlete-patients'
19 privacy, leading to exposure of the injury and/or illness (Anderson and Gerard, 2005;
20 Malcolm and Scott, 2013). Potential for further compromises with ethical norms are also
21 likely to occur due to the growing complexity of multidisciplinary sports science teams
22 (MSSTs). Members of MSSTs will differ in their professional ethical codes, training rigour,
23 and compliance with the competing values of health and performance.

24

1 Organisations such as the Faculty of Sports and Exercise Medicine (FSEM, 2010) and the
2 Fédération Internationale de Médecine du Sport (FIMS) have provided ethical guidance for
3 sports physicians that explicitly state that ‘the physician’s duty to the athlete must be his/her
4 first concern and contractual and other responsibilities are of secondary importance’ (FIMS,
5 n.d.). Occupations traditionally seen as ‘allied to medicine’ (e.g. physiotherapists) have
6 tended to adopt similar ethical codes (e.g. Anderson 2009), although US Federal legislation
7 introduces notable peculiarities in relation to sharing medical information in educational
8 settings and within employee health insurance schemes (Dunn et al. 2007). Yet the literature
9 continually cites the difficulties of marrying these broader medical codes of conduct to
10 specific contexts. In order to resolve these tensions, some have argued for clearer distinctions
11 between the roles of personal and team physicians (Bernstein et al. 2000). Others have called
12 for acceptance of the impossibility of preserving confidentiality in sports medicine and a need
13 to explicitly inform athletes of the inevitability of sharing medical information with other
14 medical, coaching and institutional personnel (Johnson, 2004; McChrystal, 2014).

15

16 Attempts by sports organisations to resolve these tensions include employment contracts that
17 stipulate athletes have a duty of candour rather than a right to confidentiality (McChrystal,
18 2014) or, as highlighted by Anderson (2008), employment contracts that expressly require
19 clinicians to convey athlete health information to coaches. Academic literature recommends
20 arguments for: clearer separation of medical and sporting roles within clubs (Waddington and
21 Roderick, 2002); greater clarity of rights and duties through more robust ethical codes
22 (Anderson, 2008); withdrawal of confidentiality clauses in contracts (Anderson 2009);
23 improved and expanded education programmes incorporating all members of MSSTs
24 (Ribbans et al, 2013); and the reconfiguration of sports medicine facilities to better safeguard
25 patient privacy (Malcolm and Scott, 2013).

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In sum, four contextual factors encapsulate the social constraints on the operationalization of ethical principles in sports medicine: 1) clinicians’ multiple and conflicting obligations; 2) the openness of the physical environment in which sports medicine is practised; 3) a policy context that routinely requires the public dissemination of normally privileged medical information; 4) a practice context that is multi-disciplinary (embracing professionals with differing ethical norms) and which may lead to considerable variability of practice (Malcolm 2016). Thus, to better understand the actions of sports healthcare professionals we must examine the cultural context of elite and professional sport and the challenges this may pose to ethical practice.

Consequently, this paper has two central objectives. First, as an empirical study of English professional football, it builds on and updates a prior study by Waddington and colleagues (Waddington, et al., 1999; Waddington and Roderick, 2002), which was carried out on behalf of the Professional Footballers Association (PFA). The initial study was particularly damning, concluding that:

The most general finding – and one that we believe is a matter of concern – is that there is among club doctors and physiotherapists no commonly held code of ethics governing the way in which confidential issues are handled, and there are considerable variations in terms of both the amount, and the kind, of information about players that doctors and physiotherapists pass on to managers (Waddington and Roderick, 2002: 115).

Partly as a response to the publication of the PFA report (Waddington *et al.* 1999), and the extensive TV, radio and press publicity which it received (for press coverage see, for example, *Daily Telegraph*, 18 November 1999; *Daily Star*, 18 November 1999; *Independent*,

1 18 November 1999; *Daily Mail*, 19 November 1999, *Guardian*, 21 November 1999), the
2 English Football Association issued a set of guidelines ‘relating to confidentiality of
3 information governing players’ (FA, 2001). These guidelines drew heavily on the British
4 Olympic Association (BOA, 2000) position statement which stated that ‘the duty of
5 confidentiality of [medical] staff to the player overrides the contractual obligations owed to
6 the employer’ and noted that while managers/coaches may want to be informed about matters
7 relating to a player’s health, such information should only be passed on with the consent of
8 the player concerned (FA, 2001). They were endorsed by the BMA (2001; 2003) but,
9 ultimately, these guidelines simply re-affirmed the applicability of traditional medical ethical
10 principles within the sports context.

11

12 The earlier study exposed major problems in relation to medical confidentiality and had a
13 significant impact on policy. However, it was written for a largely medical audience and did
14 not offer a fully detailed sociological examination of the contextual factors shaping the
15 management of medical confidentiality. As such, our second objective is to examine the
16 networks of relations that enable/constrain the implementation of ethical procedures within
17 football. We argue that the adoption of clear ethical codes is constrained by the context of
18 elite sport as a medical workplace and, in particular, the relationships clinicians continually
19 negotiate with players, coaches and managers. In the next section we discuss the theoretical
20 issues at the centre of this paper.

21

22 **Theoretical contributions to the working practices of clinicians in sport**

23 The work of Howard Nixon and Eliot Freidson provide the main theoretical principles
24 informing our analysis of the constraints of clinical practice in sport. In his pioneering work,
25 Nixon (1992, 1994, 1998) contends that ‘sportsnets’ (the ‘webs of interaction’ including

1 coaches, managers, medical staff, other athletes, spectators, administrators and investors)
2 effectively conspire to coerce athletes to compromise their health in pursuit of performance-
3 driven goals because competitive success is the priority of the most powerful actors in these
4 social contexts. Moreover, Nixon claims that sportsnets tend to be homogeneous (e.g. those
5 within the sportsnet prioritise similar values and provide similar information to athletes).
6 Thus, athletes' relations with those outside this environment are likely compromised and
7 ideologies around the acceptance of risk are continually reinforced.

8

9 Like Nixon, Freidson emphasises the significance of the 'everyday work setting' in shaping
10 clinicians' actions. In sport, this work setting may include physical proximity to others who
11 may have competing interests and/or values to those typically seen as fundamental to the
12 practice of medicine. Freidson argues that it is the clinicians' work setting which is of central
13 importance in understanding both technical and ethical variations in professional behaviour.
14 He noted several studies which provide 'very persuasive evidence' that key elements of
15 professional behaviour, including ethicality, 'do not vary so much with the individual's
16 formal professional training as with the social setting in which he (sic) works after his
17 education' (1970: 90).

18

19 However, Freidson's departure from Nixon (and the rationale for our greater reliance on his
20 thesis here) is recognition of the shifting interdependencies of those enmeshed in clinicians'
21 work settings. For Nixon, medics, like coaches and other actors in the 'sportsnet', uncritically
22 accept their ongoing role in maintaining a culture of risk. This theory thus makes two
23 assumptions: 1) that the forms of social interaction remain static and unchanged over time;
24 and 2) that medics are powerful actors in the sportsnet. However, recent research suggests
25 that, while professional behaviour is shaped by the needs of clinicians' clients, these needs

1 may shift and change over time. For example, clinicians may balance a ‘culture of
2 precaution’ with a ‘culture of risk’ (Safai, 2003) at different times. Moreover, sports
3 clinicians do not necessarily enjoy the same high status as clinicians in more traditional
4 medical contexts. As such, non-traditional medical environments such as sport may inhibit
5 medical professionalism and professional autonomy (Waddington, 2012) . In relation to
6 medical ethics, ‘in the absence of circumstances that encourage and support ethical conduct,
7 all but the most heroic will be prevented or at least discouraged from acting ethically toward
8 their patients’ (Freidson, 1999, p 132).

9

10 **Method and Data Analysis**

11 The research was part of a larger study which examined other aspects of the careers of club
12 doctors and physiotherapists in English professional football. Initially questionnaires were
13 sent to a named club doctor at each of the 92 Premier and Football league clubs, of which 33
14 (35.8%) were returned, and to a named physiotherapist, of which 42 (45.6%) were returned.
15 Of the club doctors who returned the questionnaire, 9 (27.3%) worked in Premier League
16 clubs, 11 (33.3%) worked in Championship clubs, 6 (18.2%) in League One clubs and 7
17 (21.2%) in League Two clubs. Among the physiotherapists, 9 (21.4%) worked in Premier
18 League clubs, 11 (26.2%) in Championship clubs, 16 (38.1%) in League One clubs and 6
19 (14.3%) in League Two clubs.

20

21 Questionnaires addressed various aspect of clinicians’ biographies and working practice and
22 invited respondents to volunteer for interview. Subsequently (Feb-July 2014) semi-structured
23 interviews were conducted with 8 club doctors and 14 physiotherapists, representing 19 clubs
24 and it was here that issues relating to medical confidentiality were mainly probed. For
25 example, interviewees were asked about their relationships with others in their work setting

1 and the impact of these relationships on their clinical decision making, pressures of returning
2 players post injury/illness, potential conflicts between medical ethics and their employment in
3 the club and the ways in which they managed confidentiality and disclosure. Of the 22
4 interviewees, 3 worked in Premier League clubs, 7 in Championship clubs, 8 in League One
5 clubs and 4 in League Two clubs. Interviews lasted between 40 and 90 minutes and took
6 place in various locations including football clubs and GP surgeries. Interviews were
7 recorded and transcribed verbatim. Interviewees provided informed consent once the
8 objectives of the study were explained and all interviewees were given guarantees that neither
9 they nor the clubs for which they worked would be identified. Interviews were analysed using
10 thematic coding (Gibbs, 2007). Emergent themes and sub-themes were identified, classified
11 and recorded according to the degree to which they resonated with key themes in the
12 established literature. This paper draws primarily on interview data, with some
13 supplementary questionnaire data included.

14
15 In the following sections we illustrate how the physical and social environmental constraints
16 of sports medicine practice impinge upon the management of medical confidentiality, the
17 impact of the contractual constraints under which clinicians and athletes are required to work,
18 and how these constraints shape clinician behaviour relating to players' injuries and
19 lifestyles. We illustrate how medical ethical practice in elite football continues to be very
20 variable and argue that this demonstrates the need to augment existing policy approaches
21 with more structurally-oriented approaches which recognize the degree to which the actions
22 of club medical staff are constrained by their work settings (Freidson, 1970) within
23 professional football.

24 25 **Results and Discussion**

1 *Physical Environmental Constraints: the spatial location of practice*

2 Club doctors were particularly conscious of the fact that the physical constraints of their
3 working environment made it difficult to maintain confidentiality in relation to players'
4 injuries. The doctor at a League Two club said:

5 I mean the room is terrible, it's a kind of crappy little room attached to the dressing
6 room, there's very little space where I can see someone in confidence but if I do I'll
7 sometimes take them through to one of the rooms in the main building of the club or
8 the manager's office sometimes, or I'll get them to come and see me here [in his GP
9 practice].

10

11 A similar point was made by a doctor at a League One club who compared the physical
12 constraints in the club with those in general practice:

13

14 Obviously one wouldn't have six simultaneous consultations going on in general
15 practice, but you know you've got three or four physio tables and 'Oi, Doc, look at
16 my calf' ... I try to give the players the opportunity to see me confidentially if they
17 want to but I think 95% or 98% of the time they're happy to discuss things out loud in
18 front of everyone else ... that's one of the differences about sports medicine to other
19 areas of practice but clearly if players do kind of approach me ... we'll go outside and
20 discuss particularly personal concerns or whatever.

21

22 These physical constraints were not limited to lower division clubs. The doctor at a Premier
23 League club said:

24

1 Yes, it's very difficult ... a lot of the conversations you have with players that are
2 supposed to be confidential are done in the changing rooms, in the corridor, pitch
3 side, on the coach, in a hotel with a whole load of other people ... if you're working
4 in a team environment most people understand that everyone knows virtually
5 everything about everyone.

6

7 Thus, and consistent with previous research (Anderson and Gerard, 2005; Malcolm and Scott,
8 2013), the environmental constraints within which club medical staff work make it difficult to
9 maintain medical confidentiality. However, while recognising the compromises of this
10 practice setting, doctors generally tried to operate on the basis of the established ethical rules
11 governing medical confidentiality. While the physical constraints of practice were concerning
12 for some, and perhaps draw attention to the wider difficulties of implementing traditional
13 ethical conventions in particular practice environments (Dunn et al. 2007), they ultimately
14 stem from the cultural norms which predominate in the 'sportsnet' (Nixon, 1992). While
15 clinicians themselves may not recognise it, the physical geographies of their work settings are
16 fundamentally shaped by attitudes towards, and evaluations of the significance of, their
17 practice. It is to this that we now turn.

18

19 *Social Environmental Constraints: the cultural norms of practice*

20 Requests from players to be treated in private were reported to be fairly unusual and several
21 interviewees indicated that there is a general acceptance on the part of most players that
22 information about their injuries will normally be conveyed to managers/coaches. This point
23 was clearly made by a physiotherapist at a League One club who said that players 'almost ...
24 take it as a given that when it comes to an injury ... [the manager] will know all about it ...
25 the players sort of accept that'. Indicatively, one interview with a Championship

1 physiotherapist took place in an office with a whiteboard that contained a list of players who
2 were required to undergo further examinations following routine cardiac screening.

3
4 Recognition of the fact that medical information will usually be shared with the manager and
5 others (Johnson 2004; McChrystal, 2014) does not mean that such communication is
6 unproblematic. Some medical staff expressed concern that information about players' injuries
7 was often released into the public realm by the manager. A physiotherapist at a
8 Championship club described the situation as a 'free for all with information', adding 'If you
9 speak to a player or you're assessing that he's got this problem, you tell the manager, it's in
10 the press ...'. A physiotherapist at a League Two club, asked with whom he shared
11 information about players' injuries, said:

12
13 with the other physio because obviously we interchange, and with the manager. So
14 [the players] agree to that. Now they've said, 'What if the manager tells somebody?' I
15 said, 'Well, I have to give him that information, now what he chooses to do with that
16 information ... I will tell the manager pretty much all about what's wrong with you
17 and what the manager chooses to do with that information I've got no control over.'

18
19 While players may generally accept that their injury status may be common knowledge
20 within the club, there are good reasons why players may not want their injury status to be
21 known outside the club. Perhaps the most obvious reason is that this might adversely affect
22 future transfers between clubs (for an example, see Waddington and Roderick, 2002) but, as
23 in the case of cardiac screening, it could also be career ending. While it is good practice for
24 clinicians who have responsibility for a patient to share information, the sharing of

1 information with people who are *not* bound by the rules of professional confidentiality is
2 particularly problematic (Collins et al. 1999).

3

4 *Social Environmental Constraints: Contractual Arrangements*

5 Perhaps one of the most significant changes in relation to the management of confidentiality
6 since the earlier study has been that many clubs responded to the more prescriptive approach
7 to confidentiality by requiring players to sign a general confidentiality waiver (see also
8 Anderson and Gerard, 2005; Malcolm and Scott, 2013). These were mentioned by several
9 interviewees, who seemed to see these as resolving the problem of confidentiality. For
10 example, a physiotherapist at a Championship club said that when players sign for the club,
11 ‘they sign a form basically at that point which provides us with the consent required during
12 their contractual stay, that we will have to at times discuss certain issues with the club
13 manager or the coaches’. A physiotherapist at a League One club said: ‘All the new players
14 who come into the club, I’ve got a written consent form to say that they understand that at
15 times their physical state may have to be discussed with a manager or a coach’. A doctor at a
16 Championship club said, ‘When they sign a contract to play for the club they ... sign to have
17 released to the club any information that is important about their physical health and
18 wellbeing ... so they sign a consent form’.

19

20 The introduction of confidentiality waivers to athletes’ contracts can be seen as a response
21 which effectively circumvents the ‘spirit’ of recent guidelines. As Malcolm and Scott (2013)
22 note in their study of medical staff in British Olympic sports, the use of such general waivers
23 is relatively common, yet ‘the BOA’s position statement on athlete confidentiality implies
24 [that] consent should be specific, not reliant on open-ended or general permission, and the
25 exception not the norm.’ Malcolm and Scott (2013) found that some interviewees recognized

1 that such waivers were ‘legally redundant’ and Holm et al. (2011), have similarly argued that
2 ‘Consent to disclosure should be specific and the sport physicians should not rely on any
3 more general or open-ended consent given by the athlete patient (e.g. in an employment
4 contract)’. Such general consent cannot be specifically ‘informed’ and there is the clear
5 possibility of coercion to sign a general waiver, for example when a player transfers to a new
6 club.

7
8 However, most revealing is the fact that despite discussion in the literature, and explicit
9 mention in existing guidelines on confidentiality in sports medicine, these contractual
10 arrangements were both ubiquitous and viewed as almost entirely unproblematic. No
11 interviewee – doctor or physiotherapist – questioned their use. No interviewee spoke about
12 players’ or agents’ resistance to such contractual clauses. Thus, not only do the cultural
13 norms of practice shape the physical environment, but they are engrained in institutional
14 procedures.

15
16 *Beyond the ‘Sportsnet’: Lifestyle issues*

17 While players ‘sort of accept’ that information about injuries will be passed on to the
18 manager, they are more likely to request confidentiality in relation to what a League One
19 physiotherapist called ‘off-field activities’, that is matters relating to players’ personal
20 lifestyles; such issues may include visiting night clubs, consumption of alcohol, the use of
21 drugs and sexual health problems.

22
23 There was a general consensus among doctors that information about players’ private lives,
24 as opposed to information about their injuries, should be treated confidentially as in other
25 medical contexts. For example:

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It's reasonable for a manager to need to know about someone's injury but I will have someone ... who might have ended up in bed with a woman and had a rash or a discharge, whatever, I've seen that on a number of occasions, three or four times a season I have to deal with that but there's no need [for] anyone else to know anything about that at all. (League Two doctor)

The doctor of a Championship club similarly said that, faced with the problem of a player who was drinking heavily, he would not inform the manager:

Doctor: Well, yes, I'd try to keep it between me and the player and try and sort it out as much as possible.

Interviewer: So you wouldn't tell the manager?

Doctor: No. I don't think so. If it's getting a real bad problem then obviously I'd have to say to the player, 'Look, do you want me to discuss this with the manager?' But I'm sure that he would say 'No'.

Interviewer: And if they said 'No'?

Doctor: Then I'd have to respect that.

However, even in relation to personal lifestyle issues, tensions between professional ethical obligations and contingencies of the work setting remained. These were clearly seen, for example, in the response of a Premier League club doctor when asked whether they would inform the manager if they discovered a player was using drugs. He said:

What I would say to the player is, 'If you come to me with a drug problem you know we need to deal with that'. I would suggest that the best way of dealing with this is to

1 go to the manager and explain that there is an issue and we need to help you ... 'If
2 you don't want me to tell the manager I won't tell him but he's going to find out
3 because everyone finds out, so you're better off fronting up' ... So I would try and
4 make players ... deal with it and probably then a few people in the club need to know
5 about it. But if they choose not to do that we can't tell them.

6

7 The club doctor thus indicated that, in this situation he would seek to persuade the player that
8 his best interests align with the subcultural norms of disclosure – indeed that maintenance of
9 confidentiality was a contextual impossibility – while also acting to dissipate future pressures
10 on his own practice. It might be suggested that, in seeking to persuade the player to inform
11 the manager, the club doctor was in effect pursuing a course of action that more clearly
12 aligned with the conventions of the work setting than with their training or ethical codes.

13

14 *Balancing ethical guidance and conflicting interests*

15 When asked about the ethical dilemmas which they faced, some doctors made explicit
16 reference to published codes of conduct. For example, the doctor at a League One club
17 stressed that 'one always needs to remind oneself that ... one's GMC [General Medical
18 Council] responsibilities are primarily to the interests of the players first and foremost and
19 their health and wellbeing'. The same point was made by a doctor at a Premier League club
20 who cited the Caldicott principles (named after a UK government report into the use of
21 patient information in health care), and said 'the medic's primary responsibility is to the
22 player and not to the football club', though he added 'in reality it's a compromise'. In a
23 comment which provides support for the conclusion of Waddington and Roderick (2002)
24 that, at the time of their earlier study, there had been no commonly held code of ethics
25 governing such matters, this doctor said that it was he who had introduced the Caldicott

1 principles at the club and that ‘When I introduced that here nobody had ever heard of it’. He
2 added ‘With the advent of the Premier League and ... when the EPPP [Elite Player
3 Performance Plan, introduced in 2011] was introduced with category one status with the
4 academy, that meant recruiting a lot of staff and they weren’t aware of any of these principles
5 so it’s been hard work policing that side of it’. These comments reflect both the tendency of
6 Premiership clubs to have larger MSSTs (Author 2017), and the traditional hierarchy of
7 healthcare professions in which doctors normally oversee the work of other healthcare
8 workers.

9

10 While the responses of doctors were relatively uniform, the responses of physiotherapists, as
11 in Waddington and Roderick’s (2002) study, were more mixed. Several physiotherapists
12 adopted an ethical position which was not very far removed from that adopted by most club
13 doctors. A physiotherapist in a League One club was very critical of the lack of
14 understanding of many managers and coaches of the ethics of confidentiality: ‘None of them
15 have got the understanding of it, the managers don’t understand, the coaches don’t
16 understand because none of it is talked about on their course’. He said:

17

18 I remember getting asked at an interview with a club previously, ‘What would you do
19 if a player came in and had been doing this, that and the other?’ And I said, ‘Well, I’d
20 speak to him about getting in touch with the PFA.’ ‘So you wouldn’t tell the
21 manager?’ ‘Well, no’. And this is the guy interviewing me for a job at a
22 Championship club. And he said, ‘Well, you have to go and tell the manager straight
23 away’. And I was like, ‘Well, no, you can’t really do that’. So you are in a really
24 tough spot but in interview I’ve been asked ‘Would you do that?’ and I said ‘No, I
25 wouldn’t, I would speak to the player and we would go down that route’.

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He emphasized that ‘there is a lot of pressure on you’ but was insistent that he would not breach player confidentiality, citing his relative maturity, occupational experience outside of sport, and his identity as a physiotherapist first and foremost, in rationalizing this attitude.

A physiotherapist at another League One club, like some club doctors, made a clear distinction between information relating to injuries and information relating to personal matters. He said: ‘If it’s to do with a player’s injury I think you have to be very careful that the management team have all the relevant information’. However, in relation to personal issues, he would not inform the manager if the player asked him not to do so:

I think I would respect that. Yes, I think you’d have to take it for what it was, and you’d appreciate the type of information they were giving you and the reasons why ... there would definitely be a level of confidentiality ... your responsibility is to the individual player and not to the club or the manager – it’s been made very clear on several occasions on the CPD that we’ve done.

Tellingly the phrases ‘I think’ and ‘level of confidentiality’ suggest a perception that such ethical guidance constitutes a broad approach rather than absolute principles.

A physiotherapist at another Championship club said that confidentiality also extended to information about injuries if a player requested this. He pointed out that players sometimes play with injuries and they may seek to conceal the injury from the manager in order that they can continue playing. Indicative of the kinds of negotiations clinicians often initiate with players seeking to keep issues private (Malcolm and Scott, 2013), he said:

1 There are sometimes players who play with injuries and I will be careful to say to
2 them, ‘Look, you know I believe that it’s in our interests for me to let the manager
3 know that you have this or that and we must modify your training, but if you don’t
4 want that to happen then obviously that’s your prerogative’ ... I will normally say to
5 them at the beginning ... ‘We’ll keep it private for the moment’ ... but sometimes
6 you’re not comfortable with it anymore and I’ll say, ‘I should speak to the
7 management about this because I think we should modify your training. Are you
8 happy with that?’ And occasionally they’ll say, ‘No’ ... And again that’s their
9 prerogative.

10

11 He emphasized that ‘You need to cover yourself but you always must respect the
12 confidentiality of that situation’, and in this regard another Championship physiotherapist
13 emphasized that the key issue was adherence to occupational codes of practice: ‘We just
14 adhere to ... the HCPC (Health and Care Professions Council) guidelines and regulations ...
15 then we’re covered from the physiotherapy aspect’.

16

17 However, the commitment of some physiotherapists to the ethical guidelines governing
18 confidentiality was undermined by a sense that their primary responsibility was to the club or
19 manager, rather than to the player-as-patient. Asked what information about players he
20 conveyed to the manager, the physiotherapist at a League One club said:

21

22 The diagnosis really, roughly the prognosis, how long they’re going to be out for, that
23 kind of thing. This manager, he likes to know a little bit more so he wants to know
24 how they are holistically, so he wants to know how they are in their personal life, if

1 we find out anything, you know, that kind of thing. Just anything that can help them
2 really.

3
4 What this reveals is not simply that medical staff are pressured to release potentially
5 confidential information, but that they may be actively encouraged to use their position and
6 influence to search out information in the interests of their employers and managers.

7 The physiotherapist at another League One club saw the issue in very simple and
8 straightforward terms: ‘As far as drugs and alcohol [are concerned] if we suspect it we would
9 have to tell the management. There’s no point in us keeping that behind because ultimately
10 we’d get, you know, *looked at*’. The idea of getting ‘looked at’ clearly implied the possibility
11 of some kind of disciplinary action because he had not carried out what was deemed to be his
12 prime duty, which was to keep the manager informed, rather than to protect player
13 confidentiality.

14
15 But indicative of Freidson’s (1970) conceptualisation of professional learning being moulded
16 in the specific work setting, others described themselves as undertaking ‘a balancing act’.
17 This League One physiotherapist continued, ‘You have to try and, you know ... the players
18 think that you’re on their side and the managers think you’re on their side, and you just have
19 to play the game’. ‘Playing the game’ seemed to involve some duplicity. He said, ‘So if we
20 ever do release information ...we always try and make sure the manager is aware that it’s,
21 you know, confidential and that we are not divulging. And if it’s information that you need to
22 discuss with a player, then it didn’t come from us, type of thing’. The rules of the ‘game’
23 were more directly drawn by those imbued with the cultural norms of professional sport than
24 the conventions of healthcare.

25

1 This perspective was underscored by the response of a League One physiotherapists who was
2 asked what he would do if he discovered a player was drinking heavily or using drugs:

3

4 It's a tough one ... it's really hard ... I've built relationships with the players and I
5 think they trust me ... and if I go to the manager and snitch on them and then it gets
6 back and they know it's me, then I've killed that relationship straight away ...so
7 you've got to keep the players on side but again I believe that my loyalty lies with the
8 club and our performances on the pitch ... That's my first loyalty. So I will try and
9 deal with it with the player so I'll say to them, 'Listen, you shouldn't be drinking like
10 that, it's ridiculous' ... give them my opinion. If they choose to accept my opinion
11 that's fine. If not, if I hear they're still drinking, then I might go to the manager and
12 say, 'Listen, I'm hearing that he's drinking'.

13

14 Explicit in this account was: a) recognition of the tensions between everyday practice and
15 professional ethics; b) the primary strategy of 'managing' players so that such conflicts over
16 confidentiality were removed before they arose; and c) of ultimately forsaking medical
17 ethical principles and guidance in the pursuit of either an obligation to their employer, or their
18 own career interests.

19

20 In the next section we compare and contrast the responses of doctors and physiotherapists.
21 These differences relate to the strength of ethical guidelines governing their respective
22 professions, their typical working practices and the extent to which their working practices
23 are shaped by their acceptance of medical or sporting values.

24

25 *The work settings of club doctors and physiotherapists*

1 Club medical staff are often under a great deal of pressure from managers to deviate from
2 established standards of good practice (Waddington and Roderick, 2002; Anderson and
3 Jackson, 2013). This pressure cannot be explained in terms of the manager's personality
4 characteristics but is itself socially generated (Freidson, 1970), an aspect of the network of
5 relationships in the modern football industry. Of particular importance in this context are the
6 increasingly intense commercial, media and other pressures for clubs to achieve success on
7 the field of play (Anderson and Jackson, 2013). These pressures are experienced particularly
8 acutely by the club manager, whose position within the club is a notoriously insecure one and
9 whose tenure is often very short.

10

11 But in contrast to the homogenization which Nixon (1992) suggests is characteristic of
12 'sportsnets', data from both this and the earlier study suggest that club doctors are generally
13 more able than physiotherapists to resist these pressures. Perhaps due to being members of a
14 much older, more established and higher status profession, or to differing degrees of
15 economic dependence, there were clearly observable differences in the attitudes and
16 behaviour of doctors and physiotherapists towards maintaining patient confidentiality. To
17 some extent, this could also be seen to stem from the relative pressure managers appear to
18 exert on club doctors and physiotherapists. For instance, several physiotherapists perceived
19 managers as 'quite sensitive to the fact they need us almost on the inside a little bit, in the
20 dressing room to see what goes on' (League One). A physiotherapist at another League One
21 club said there was 'a lot of pressure on you' and, asked whether he ever experienced a
22 conflict in terms of his responsibility to the player and to the club, he said 'Yes, definitely.
23 And it's a big conflict as well ... [managers] kind of want to know everything that goes on'.

24

1 But a key aspect of explaining differences in professional behaviour lies in differences in
2 professional identity, for most doctors' primary occupational identity is as health care
3 professionals rather than as employees within the football industry; this is particularly likely
4 to be the case with doctors working outside a very few of the most glamorous clubs. Their
5 primary identities as medical professionals, as well as their ability to resist pressures from
6 managers to deviate from good practice, are likely to be reinforced by their everyday work
7 setting (Freidson, 1970), which typically differs from the work setting of club
8 physiotherapists. Of particular relevance in this regard is the fact that, unlike most
9 physiotherapists, almost all of whom are full-time employees of the club, most doctors are
10 only employed on a part-time basis (Author 2017). Thus most doctors spend most of their
11 working time in, and almost certainly derive most of their income from, medical practice
12 outside the football club. The majority (61.5%) attend the club only once or twice a week,
13 with just 18.7% spending more than 20 hours per week at the club; in League Two, the mean
14 working time is just 3.8 hours per week. The everyday work situation of most club doctors
15 is, then, *not* in the football club but in general practice in the community, where the ethical
16 rules governing confidentiality are generally known and accepted by doctors and patients
17 alike, and where they are likely to be reinforced by the everyday practice of general
18 medicine.

19

20 The work setting of club physiotherapists is very different. Almost all physiotherapists
21 (97.6%) indicated their primary employment is in the football club and almost all work on
22 five non-match days per week and attend both home and away first team matches. Over half
23 (54.8%) estimated that they typically work between 50 and 60 hours per week, with almost
24 10% stating that they worked in excess of this. Thus the everyday work situation of club
25 physiotherapists, unlike that of club doctors, is actually in the football club, an organization

1 the central goal of which is to produce a successful sporting performance rather than to
2 improve health. Moreover, the convergence of the practice traditions of physiotherapy and
3 the specific patient demands within sport lead physiotherapists to occupy a particularly
4 blurred position in relation to healthcare and performance (Scott and Malcolm, 2015) and
5 medical ethical principles may become compromised. Within this context the culture of
6 medical confidentiality is less well established than in general practice and, indeed, the
7 importance of confidentiality may not be generally recognized or understood by key
8 personnel, most notably managers; one physiotherapist, it will be recalled, complained that
9 managers and coaches 'don't understand' confidentiality. Thus it may be argued that, both in
10 terms of the everyday network of relationships within which they practise their profession
11 and in terms of the amount of time they spend within the club, it is physiotherapists, much
12 more than doctors, who bear the brunt of the day-to-day pressure from managers. As a
13 Premier League club said:

14

15 We're not full-time so we're not dependent on the club, so if I get the sack it's no big
16 deal, which probably means that we're probably a bit more into, you know, we'll give
17 a proper independent opinion, and I sometimes think in football if you're told what to
18 do by the manager because that's your job, your full-time job, if you get the sack it's a
19 disaster. So I think sometimes we can give a slightly more independent opinion for
20 the good of the player and the good of the club, which may not necessarily be what
21 the manager wants to hear.

22

23 **Conclusion**

24 This study indicates that there are still considerable variations (Anderson and Gerrard, 2005;
25 Waddington and Roderick, 2002), from one club to another and from one member of the

1 medical team to another, in terms of the amount and kind of information about players which
2 is communicated to the manager. This indicates that change requires more than simply
3 creating guidelines governing confidentiality (Anderson 2009). Indeed, data from the
4 questionnaire suggest that the creation of the FA guidelines, on its own, has had little
5 significant impact. The questionnaire asked whether club medical staff had received written
6 guidance – and if so, from which source – about dealing with medical confidentiality within
7 football. Of the 33 doctors only 7 indicated that they had received written guidance, of whom
8 3 mentioned FA guidance. Among physiotherapists, of the 40 who answered this question (2
9 non-responses), 14 indicated they had received written guidance, of whom just one (2.5% of
10 the total) mentioned the FA guidelines. In addition to the FA guidelines, other sources of
11 information listed by doctors included ‘courses’, ‘colleagues’ and the FSEM, while
12 physiotherapists listed postgraduate courses, the club’s legal and human resources
13 departments, and a medico-legal newsletter.

14
15 It has been argued that the work situation of club medical staff is one in which they are likely
16 to face considerable pressures to deviate from established standards of good practice
17 (Anderson and Jackson, 2013). As outlined in the introduction, Waddington and Roderick’s
18 (2002) research led to attempts to deal with these problems by the provision of ethical
19 guidance to club medical staff, but this seems to have had little impact. This is despite
20 significant changes to the organisation of professional football in the intervening years and
21 the growing value placed on the role of sports science and medicine within it.

22
23 While the development and publication of such codes is, of course, not unimportant, it may
24 be argued that what is required now is not simply a renewed call for more ethical behaviour,
25 or the further elaboration of ethical codes, but, rather, a more substantive or structural change.

1 For instance, following Ribbans et al. (2013), there is a clear need for national governing
2 bodies (NGBs) of sport to ensure appropriate medical ethical training is provided and to
3 monitor attendance to ensure widespread uptake, and to provide guidelines regarding not just
4 the minimum requirements for medical personnel but also the medical facilities in which they
5 practise. NGBs, players unions and especially players' agents should be more proactive in
6 policing employment contracts to ensure that athletes are not cajoled to waive a fundamental
7 ethical right. It is time to move from the relatively narrow focus of prescribing the behaviour
8 of clinicians to a more holistic approach that recognises that a primary 'source' of medical-
9 ethical breaches in sport is the coaching and management staff and, consequently, they also
10 need educating about their role and responsibilities in enabling their employees to conform to
11 the ethical standards of their profession. Currently, for instance, the League Managers'
12 Association provides a number of training courses and resources for aspiring football
13 managers yet none address issues such as medical management and the professions'
14 respective ethical obligations ([http://www.leaguemanagers.com/leadership-wellbeing/about-
15 institute/](http://www.leaguemanagers.com/leadership-wellbeing/about-institute/)).

16

17 More fundamentally – and this is a central implication of Freidson's approach – it may be
18 argued that what is required now is a change in the structural location – that is in the work
19 setting – of club medical staff vis-à-vis other people. One aspect of this is that there needs to
20 be a clear role differentiation between team and personal physicians, and between those with
21 responsibility for medical care within the club and those with responsibility for football
22 decisions. Huizenga, a former team doctor in American football, proposed one such structural
23 remedy; that team doctors be appointed 'to a set term not unlike a judge, perhaps by
24 consensus of owners and players, but then supervised solely by an impartial medical board or
25 state commission', as happens for doctors who supervise boxing in California (Huizenga,

1 1995: 316). Adapting this suggestion to the context of English football, one might consider
2 moving towards a system in which club medical staff were appointed by an independent body
3 (possibly the FA, Football League or FSEM, perhaps with the agreement of the club and the
4 PFA) for a fixed period. The thinking behind these policy recommendations is to increase the
5 professional autonomy of clinicians working in sports clubs and to exclude non-clinicians,
6 such as managers and coaches, from involvement in medical issues.

7

8 The need to increase the professional autonomy of sports physicians was also one key
9 recommendation of the PFA study by Waddington *et al.* They wrote:

10 urgent consideration needs to be given to defining the respective rights and
11 responsibilities of the club doctor, physiotherapist and manager in relation to the
12 management of injuries and other health-related issues. A central object of this exercise
13 should be to define the roles of the respective parties in such a way as to maximise the
14 clinical autonomy of doctors and physiotherapists, and to minimise the day-to-day
15 involvement of managers in the management of injuries (Waddington *et al.*, 1999: 68).

16 It remains the case that this will ‘make a major contribution towards creating the conditions
17 conducive to good clinical practice, and to protecting the health of players’.

18

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