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HOW DO SPORTS MEDICINE DOCTORS PERCEIVE THEIR ETHICAL RESPONSIBILITIES IN PRESCRIBING LOCAL ANAESTHETIC INJECTIONS TO ATHLETES?

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ABSTRACT

Introduction: In this study, I aimed to investigate how sports medicine doctors perceive their ethical responsibilities in prescribing local anaesthetic injections (LAI) to athletes. Currently little is known about doctors’ decision-making process in this area, and the use of LAI is considered controversial. Methodology: I conducted 12 semi-structured qualitative interviews with sports medicine doctors listed on a Sports Medicine Australia website as currently practising in Victoria. The interviews were 25-50 minutes in duration with the majority of doctors (9) treating AFL athletes. Data was analysed thematically, by identifying common themes and drawing links between them.

Results and discussion: All doctors performed a risk assessment first to determine the likelihood and consequences of risk arising from LAI. From this risk assessment, doctors identified injuries they would routinely inject, injuries they would definitely not inject and a grey zone where it was not clear whether or not to use LAI. If the risk of harm was too high, doctors drew a line without considering athletes’ wishes, because of their perceived roles and responsibilities, and for litigation reasons. In the grey area of decision-making, players’ wishes and overall best interest became more important and non-medical benefits (e.g. participating in important matches and employment aspects) were factored into risk-benefit assessments. Doctors drew attention to barriers to achieving informed consent in the ‘heat of battle’ and strategies used to reduce risk of litigation in this situation. Conclusion: Most doctors’ descriptions of actual practice illustrate complexities in where they drew the line on acceptable level of risk to take in the grey-zone of decision-making, which was often moved according to doctors’ risk-benefit assessments.
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CHAPTER 1: INTRODUCTION

1.1 OVERVIEW

In this study, I aimed to investigate sports medicine doctors’ decision-making process surrounding the prescription of local anaesthetic injections (LAI) to athletes. This is considered a controversial practice, and it has been subject to litigation. The primary aim was to explore how doctors perceived their ethical responsibilities in using this treatment option. As part of this, I aimed to investigate how doctors balance their role in protecting athletes from harm associated with LAI with their role in helping athletes maximise their performance to achieve their sporting goals.

The data was gathered by carrying out individual in-depth interviews with sports medicine doctors. These doctors were listed on the Sports Medicine Australia website as currently practising in Victoria, with the majority of doctors (9) treating AFL athletes. Questions were semi-structured and open-ended which allowed doctors to reveal a number of factors they considered important in the decision-making process. Interviews were tape recorded then transcribed, and data was analysed thematically by identifying common themes and drawing links between them.

As currently little is known about how doctors decide to prescribe LAI, I will first describe how doctors place their perceived roles and responsibilities in order of importance. I will then discuss doctors’ assessments of risk and benefit, the extent to which they include non-medical benefits in this, and how they incorporated these assessments into their overall decision-making. I will also consider the role of informed consent and its implications for litigation issues, because this was raised by doctors as a significant consideration. Finally, I
will explore doctors’ emphasis on the importance of the doctor-athlete relationship, as this was an unexpected way of framing this ethical issue.

In this thesis, I will argue that although sports medicine doctors identify a clear hierarchy of ethical principles, their descriptions of actual practice illustrate complexities in the way that these ethical principles are applied in the context of sports medicine.

1.2 BACKGROUND

1.2.1 Local anaesthetic injections

LAI are used to mask pain associated with injuries. They allow an athlete to continue competing with an injury that would otherwise reduce the effectiveness of their performance, or might not allow them to compete at all.

LAI have been used to relieve pain in AFL athletes since the 1970s.\(^1\) However the issue returned to public attention after the 2003 AFL Grand Final, when it was revealed that the Brisbane Lions Football Club had used up to 18 vials of LAI on injured players.\(^2\) While LAI are currently legal in the AFL, the public debate centred on player welfare. The focus on harm is important because LAI are reported to be extensively used in the AFL, with an AFL Players’ Association Survey conducted in 2001 finding that 66% of footballers were prescribed LAI on at least one occasion, with 25% prescribed LAI on more than five occasions.\(^3\)

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Despite the widespread use of LAI in professional football, Nelson observed in 2001 that very little scientific data exists surrounding risks associated with the practice, particularly long-term effects of LAI on athletes’ soft-tissues and joints.\(^4\) In 2002, Orchard described the use of LAI as ‘one of the biggest taboos in sports medicine’ with the subject ‘not covered comprehensively in any sports medicine textbook or review article’\(^5\). However in 2004, Orchard highlighted that while no study has yet examined the long-term disability associated with local anaesthetic use, it is easy to compile an extensive list of many possible short and long-term complications from basic principles in medicine. They include the potential to rupture tendons and ligaments, fracture bones, dislocate joints and cause long-term degenerative joint conditions such as osteoarthritis.\(^6\)

As this doctor points out, the difficulty arises in assessing the likelihood of risk arising from a local anaesthetic injection, above the existing level of risk that results from injury to that area. For example, fractured fingers are associated with long-term degenerative joint arthritis, regardless of treatment method. However it is not known what is the increase in risk of osteo-arthritis in the finger if local anaesthetic is used to numb the pain from injury, above the risk that exists with no treatment at all.\(^7\)

Despite this, Orchard recently (2004) published recommendations for the safe use of LAI based on his experiences working with 3 professional football teams over a 6 year period.\(^8\) He categorises injuries for which LAI can be used under routine circumstances (as


risks are low), extreme circumstances (as risks are high) and injuries for which LAI should under most circumstances be avoided. While Orchard recognises that these lists are based on ‘sub-optimum evidence’, they represent an ‘important framework for future reference and revision’ in an area where guidance for doctors concerning the use of LAI is scarce.

Despite the potential for harm, the use of LAI is attractive to many athletes because the perceived risks for injecting particular injuries are seen to be less than the potential benefits.

The players’ perceived benefits of using LAI are tied up with reducing the number of matches missed through injury, enabling them to compete in important matches such as Grand Finals, or maximising their chance of extending their player contract to prolong their career. While the benefits of competing at the highest professional level (e.g. World Cup soccer, AFL Grand Finals) are relatively clear, the benefits at a lower level of competition can still be significant (e.g. TAC Cup football players trying to impress selectors to get drafted by an AFL team). I will discuss the players’ perceived benefits in more detail in chapter three.

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1.2.2 The controversy surrounding local anaesthetic injections

The public debate surrounding LAI has focused on the risk of harm to the athlete. Two main arguments against the use of LAI have emerged.

Firstly, some argue that LAI should be banned from sport under the current World Anti-Doping Authority (WADA) criteria. In order to be banned, drugs must meet two out of the following three WADA criteria:

1. Potential for detriment to health
2. Performance enhancement
3. Against the spirit of sport

It can be argued that all three criteria apply in this case. The WADA restrict the use of LAI to use in medical procedures, (e.g. stitches), while banning its use for painkilling purposes. However I am not looking at this as a ‘drugs in sport’ issue, as this lies outside the scope of the project. Instead, I am focusing on the second main line of reasoning against the use of LAI.

This second major argument centres on the view that doctors should never administer treatment that increases the risk of short and long-term harm to the athlete. One key stakeholder, the International Federation of Sports Medicine (FIMS) argues that the doctor should never prescribe LAI at the expense of athletes’ health. The FIMS policy statement

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asserts that ‘[the physician may not] in any way mask pain in order to enable the athlete’s return to sport if there is any risk of aggravating the injury’¹⁴.

In contrast, the Australian College of Sports Physicians (ACSP) recently released a position statement that ‘acknowledges there is a place for the use of LAI in professional sport’ and advocates that decisions about LAI should be left as ‘principally a matter between doctors and their patients’¹⁵.

The ACSP draws attention to the sports medicine doctor’s role in maximising athletes’ performance to help them achieve their sporting goals. It recognises that medicine has moved away from doctor-patient relationships where the doctor decides what is best for the patient, to an emphasis on patient autonomy, where the athlete decides the treatment option that reflects their overall best interests in light of their social and cultural context.¹⁶

Bunch and Dvonch set out an account of what it means to be an autonomous person as follows:

The truly autonomous person is someone who develops and chooses a life plan for him or herself, instead of living by the plans of other persons or allowing circumstances to dictate life events.¹⁷

While doctors have a duty to respect the patient’s autonomy, they also have a responsibility to protect athletes from harm. Johnson identifies the conflict as:

The physician is confronted with the concern of supporting the athlete in the setting of competition, and optimising performance or protecting the long-term health of the athlete.\(^{18}\)

Very few guidelines exist as to how doctors should resolve this conflict. Decisions about LAI are currently left at the treating doctor’s discretion. Little is known about how doctors use this discretion. I aim to shed some light on this area. In this way, this study may contribute to better practice concerning the prescription of LAI by raising awareness of the complexity of the issue and the need for good decision-making.

1.3 METHODOLOGY

The data for the project was collected using a qualitative approach. This method was chosen as the most appropriate because the phenomenon I am trying to understand is ethical thinking and decision-making. This is about complex thought-processes, and is not suitable for quantitative research methods. This study was approved by the University of Melbourne Human Research Ethics Committee, under the category of low-risk to participants.

1.3.1 Individual in-depth interviews

I chose individual interviews using semi-structured, open-ended questions for a number of reasons.

Firstly, individual interviews allow in-depth analysis of particular areas of interest. It permits greater control over the focus of the interview, enabling specific areas to be explored in great detail.

Secondly, these interviews encouraged participants to identify and discuss issues that were important to them. It allowed concepts and categories that I had not predicted to emerge, and be pursued in more detail. As the participants were free to talk about any factors they felt were important, discussions revealed a wide range of both ethical and non-ethical issues. For this reason, I have chosen to discuss a range of themes identified, rather than focus specifically on one.

Thirdly, individual interviews avoid some of the confidentiality issues associated with focus group interviews. Confidentiality is particularly important given the relatively small number of sports medicine doctors working with AFL teams or in other elite-level sport. It is likely that sports medicine doctors will be familiar with most of their colleagues practising sports medicine in Victoria. Focus group discussions were not practical as doctors may be less likely to reveal attitudes that could be considered ‘unpopular’ among their peers. Doctors might also be reluctant to share stories of unethical or unprofessional behaviour due to the risk of identifying colleagues, or reducing their own status or professional credibility in the eyes of their colleagues.
1.3.2 Participants

The participant group was determined using criterion sampling. The initial aim was to recruit participants who were sports medicine doctors currently working with AFL clubs, using the criterion of current experience in an elite-level sport where LAI are used. AFL doctors were chosen as a group likely to have interest in the issue of LAI and a range of experiences in a common setting.

I first attempted to recruit sports medicine doctors currently working with AFL athletes by mailing Plain Language Statements (PLS) and consent forms to doctors listed on a Sports Medicine Australia website as currently practising sports medicine in Victoria. However I found that doctors currently treating AFL athletes were not accessible, largely because of litigation concerns.

In particular, there is a legal case in the courts where retired AFL player Adrian Whitehead is taking action against a former Carlton club doctor for alleged medical negligence and breached duty of care. Whitehead argues that injuries sustained to his ankle were aggravated by returning to play with an ankle injection, which he claims prematurely ended his AFL career.19

In response to current litigation issues, some doctors expressed their sense of legal vulnerability if a group of AFL doctors’ decision-making process concerning the prescription of LAI was documented and published. This was an interesting insight into the sensitive nature of litigation issues surrounding the use of LAI, particularly in the AFL, but also in the broader context of sports medicine. Three doctors who responded to the initial PLS were not currently involved in prescribing LAI to AFL athletes. In response to their

feedback, I decided to widen my inclusion criteria to include doctors who had previously
prescribed LAI to athletes in any sport, at any level of competition.

I re-contacted my original sample of 40 doctors by mailing an amended PLS and
additional cover letter which addressed their litigation concerns, and asked doctors to
reconsider the expanded criteria for participation.

In the cover letter, I highlighted that the project had been designed with the current
litigation issues in mind, and my supervisor and I had taken every care to make it low-risk to
participants. I also advised doctors that a number of measures had been put in place to
protect them.  

This approach proved successful, and in total, I conducted 12 interviews with sports
medicine doctors. All doctors consulted with athletes from a number of different sports, both
in private practice and in appointments with teams or organisations at a professional or lower
level of competition. Nine doctors were members of the Australian College of Sports
Physicians, while three were members of Sports Doctors Australia. Most doctors (9) held
current or previous appointments with AFL teams in Victoria.

All interviews were audio-taped, with doctors’ permission, to ensure that the
information was accurately collected. The interviews ranged from 25-50 minutes, depending
on the amount of information that the participants wished to divulge and the amount of time

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20 In the cover letter, I informed doctors that I had put a number of strategies in place to protect them from
litigation. They included:

(1) I will ask general questions relating to what factors you consider important in deciding whether or not
to use LAI, not specific questions about your actual patterns or frequency of use.
(2) If you feel uncomfortable with any question, you don’t have to answer
(3) You are free to withdraw from the project at any stage, along with any unprocessed data collected in
the interview process. I will send you a copy of my preliminary data analysis for you to comment on
or withdraw from the project at this time.
(4) All reasonable steps will be taken to protect confidentiality by removing details from transcripts,
including references to specific injuries, events and situations.
available to them. All interviews were conducted at the doctor’s sports medicine clinic, in their consulting rooms, which ensured privacy.

The sample size for this project was determined by the scope and time limitations of the project. Instead of aiming at a statistically significant number of participants, as in quantitative research, an appropriate sample size was determined by the concept of data saturation. The sample size of 12 doctors was sufficient to identify recurring common themes and achieve data saturation, which refers to the point at which data collected reveals no new information. Further, this sample size was appropriate because this was an exploratory study which aimed at describing doctors’ decision-making process rather than drawing conclusions or testing hypotheses.

1.3.3 Data Analysis

The interviews were transcribed, then the data was analysed thematically. This involved identifying a range of factors that doctors considered important in the decision-making process. Two over-arching themes emerged:

(1) Why do doctors draw a line on what they’re prepared to inject?
(2) Where do doctors draw a line, and what makes this line move, or become blurry?

Using this framework, I was able to draw links between specific factors which evolved to become more general categories, and then organised into larger themes. Data in major themes was further analysed by comparing and contrasting this with what has already

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been written in relevant literature. This follows the standard approach to thematic analysis, as described by Britten.\textsuperscript{22}

### 1.3.4 Scope and limitations

Because of the limited sample size, this study makes no claims of comprehensiveness. This was a small study that focused on a specific group of health care professionals in metropolitan Melbourne only, and included sports medicine doctors treating predominantly AFL athletes.

Due to time limitations, this study didn’t compare doctors’ descriptions of their practice with observations of their actual practice. Similarly, time constraints meant I wasn’t able to get athletes’ perspectives on the issue to see if they saw the doctors’ role in the same way that the doctors perceived it.

In addition, this study didn’t specifically include doctors’ actual experiences due to their concerns about litigation issues. Instead, the interview questions focused on asking doctors what factors they considered important in the decision-making process in general terms. Given that many doctors’ risk assessments were largely based on personal experiences, this knowledge would have helped to frame their comments in this way.

The study is therefore exploratory, and the findings are not necessarily relevant for other situations, nor can they be used to draw conclusions about sports medicine doctors in general. However, because of the qualitative nature of the study, it was felt that even interviewing a small number of doctors would be useful in providing insight into the decision-making process of this group.

In addition, my position as a student researcher and its effects on the qualitative research process needs to be commented on. The process of reflecting on what sorts of factors influence how data is collected and interpreted is called reflexivity.\textsuperscript{23}

As a medical student researcher, I was lower within the medical hierarchy than the doctors I interviewed. This was initially a barrier to doctors’ participation with some practice administrators openly discouraging doctors allowing time for student research projects. During the interviews, however, I was identified by some doctors as their colleague, which may have meant that they were more open with me than they would have been with others. Some doctors questioned the underlying reasons for my interest in the area, in light of the negative publicity the area had received in the past. My responses indicated my interest in pursuing sports medicine as a career, as well as my current state level tennis involvement. This helped to give me a level of insight into both doctors’ and athletes’ perspective on the issue perhaps unavailable to another, though this also means I may not have been completely objective. Doctors’ responses and my subsequent data analysis and discussions should therefore be taken in the context of these background influences.

CHAPTER 2: DOCTORS’ ROLES AND RESPONSIBILITIES

2.1 THE HIERARCHY OF ETHICAL PRINCIPLES: THE PRIMACY OF NON-HARM

All doctors approached the issue of LAI with a risk assessment first. They identified a spectrum of risk associated with LAI. At one end of the scale, there was “virtually no risk” or merely a “temporary flare up of their pain after the local anaesthetic wears off” (Dr 2). Further along the spectrum, doctors drew attention to the risk of aggravating the injury and “making the condition they already have worse, or doing extra damage to other areas that have been anaesthetised” (Dr 3). At the other end of the scale, there was the possibility of causing “irreparable harm” or a “longer-term problem that might result in joint degeneration” (Dr 2).

From this initial risk assessment, doctors identified injuries that they would routinely inject, injuries they would definitely not inject, and a grey zone where it was not clear whether or not to use LAI. These categories were similar, but not quite the same as Orchard’s categories, as described previously. Generally, doctors were not aware of Orchard’s categories, because they had only recently been published (2004). I will discuss doctors’ decision-making in the grey zone in the next chapter. Here, I focus on the ethical principles that doctors referred to in explaining how they decided against the use of LAI in the case of injuries that they definitely would not inject.
All doctors agreed that they would definitely not inject an injury if they thought the risk of harm was too high. One of the reasons for drawing this line was related to doctors’ perceived roles and responsibilities, which included:

1. Primary responsibility to not harm the athlete
2. Responsibility to put the athlete’s health above the club’s best interests

2.1.1 **Primary responsibility to not harm the athlete**

As expected, doctors saw their responsibility to protect athletes’ health as paramount. Concern about risk was what doctors talked about unprompted. The reason for this was related to the Hippocratic Oath, which asserts that doctors have a responsibility to ‘first do no harm’. Several doctors referred to the Hippocratic Oath in guiding their actions.

*Preventing injury is critical to your role. Do no harm. It's the antithesis of being a doctor if you run too many risks. So you're there to protect them.* (Dr 7)

*That's our basic oath as medicos, the Hippocratic Oath, and it's absolutely critical that we undertake a policy of harm minimisation.* (Dr 11)

As expected, doctors saw themselves as responsible for protecting athletes’ current health, as well as their future health. These considerations even over-rode athletes’ wishes for LAI.

*I think protecting the athlete would have priority over their choices. I think in the heat of the moment they might make decisions that later they regret and I think it would be my responsibility to ensure their future health.* (Dr 8)
It is important to recognise that athletes’ preferences surrounding LAI come in two sorts:

(1) Negative wishes – athletes decide NOT TO have an injection
(2) Positive wishes – athletes decide TO use an injection

All doctors agreed that athletes’ negative wishes against the use of LAI would always be respected.

The International Federation of Sports Medicine (FIMS) code of ethics outlines that the doctor should respect athletes’ negative wishes against the use of LAI to avoid harming the athlete. Its principles set out an account of the doctor’s duties:

(1) Always make the health of the athlete your priority
(2) Never do harm
(3) Never impose your authority in a way that impinges on the individual right of the athlete to make his or her own decision

In this situation, the doctor’s responsibility to protect the athlete from harm is compatible with their duty to respect athletes’ negative choices.

However the FIMS code of ethics appears not to recognise the potential conflict between athletes’ positive wishes for high-risk injections with the doctor’s duty to never do harm. In this situation, if the doctor aims to avoid harm then he or she must ‘impose their authority in a way that impinges on the individual right of the athlete to make his or her own

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An athlete’s positive wishes for a high-risk injection means that principles (1) and (2) conflict with principle (3). FIMS offers no practical advice on how to resolve this conflict.

In actual practice, doctors frequently over-rode athletes’ positive wishes for LAI in favour of their duty to not harm the athlete. All doctors interviewed drew the line on injecting injuries where the risk was too high, without considering athletes’ wishes. This may be considered a form of paternalism. Beauchamp and Childress describe paternalism as:

The intentional over-riding of one’s known preferences or actions by another person, where the person who overrides justifies the action by the goal of benefiting or avoiding harm to the person whose preferences or actions are overridden.

Paternalism is usually thought of as forcing treatment on unwilling patients, but it can also be denying treatment to willing patients.

Most doctors advocated paternalistic decisions by emphasising that they should always have the final say on whether the use of LAI was appropriate (although they did not describe their decisions as “paternalistic”).

The AFL Medical Officers’ Association advocates this stance. It asserts that the appointed team doctor’s roles and responsibilities should be outlined in a letter of

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engagement from the AFL club, and should include that the doctor is responsible for making the final decision on whether a player is fit to play with an injection.²⁷

Most doctors interviewed resolved the conflict between athletes’ wishes and doctors’ duty to non-harm in favour of non-harm. In this way, athletes’ wishes could even be an obstacle to ethical decision-making, rather than an essential component of it. Dr 8 argued that athletes often put pressure on doctors to use LAI because “athletes are notorious for wanting performance and the sacrifice they’re willing to give”. Johnson observes that:

> The athlete can also be an obstacle to ethical decision-making. From the recreational fitness runner to the professional athlete, athletes routinely pressure sports physicians into early return to training or competition because of economic motivation, ego satisfaction, coach pressure, parental pressure, peer pressure, or the sense of well-being fostered by regular exercise.²⁸

Johnson’s view is supported by the results of Mirkin’s study, in which he asked more than 100 competitive runners whether they would take a ‘magic pill’, if one existed, that would guarantee them winning an Olympic gold medal but also kill them within a year. More than fifty percent of the athletes answered that they would take the pill.²⁹

Most doctors interviewed recognised that athletes were prepared to sacrifice their own health to achieve their sporting goals. They perceived that this heightened their role to

protect athletes’ health. This was the one of the main reasons they drew the line on injecting injuries where the risks were too high, without considering athletes’ wishes.

While some doctors saw players’ wishes as an obstacle to ethical decision-making, other doctors saw the athlete’s wishes as paramount and favoured patient autonomy over their duty to non-harm. These doctors argued that the fully informed athlete assumed responsibility for the risks associated with LAI and recognised the athlete’s right to decide on their basis of their overall best interests, in light of their social and cultural context. This view is consistent with Levine’s account of the role of the doctor in the sports medicine context:

The role of the physician is examine, diagnose, and educate the patient about the risks of his or her medical condition, and recommend one or several course of treatment. The final decision and responsibility rests with the informed patient, who must synthesise this information with assistance from family and friends, in light of his or her own goals and aspirations.

Most doctors’ decision-making process moved from paternalistic decisions if the risk of harming the athlete was too high, towards allowing fully informed athletes to assume responsibility for what doctors saw to be acceptable levels of risk associated with the athlete’s chosen treatment. If the risks were acceptable to both the doctor and athlete, the athlete’s wishes and informed consent became important in the decision making process.

This was what occurred in the “grey zone” identified earlier. I will discuss the role of informed consent in the decision-making process in more detail in chapter 3.

### 2.1.2 Responsibility to put not harming the athlete above the team’s best interests

Not only did doctors put not harming the athlete ahead of autonomy, they also put it ahead of the team’s best interests. Doctors saw their responsibility to the club as secondary to their responsibility to protect athletes’ health.

*Even though I’m paid to work for a football club, basically my primary responsibility is to the players’ health.* (Dr 6)

Doctors treating non-AFL athletes adopted a similar stance, regardless of whether they were employed by a sporting team, organisation or other governing body.

*The first responsibility is to the player as an individual, and the responsibility to the team secondarily.* (Dr 9)

This view is reflected in the International Federation of Sports Medicine (FIMS) code of ethics, which states: “The physician’s duty to the athlete must be his/her first concern and contractual and other responsibilities are of secondary importance.”

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The FIMS statement has arisen in recognition of doctors’ potential conflict of interests, where doctors’ responsibility to protect athletes’ health may clash with the short-term goals of the organisation. Pipe observes that:

Our primary responsibility is to protect the athletes’ health and well-being as defined most broadly… However what is best for athlete’s long-term health may conflict with the organisation’s short-term interests in winning. As a result, we may have a problem with divided loyalty, which raises significant questions about the ethical practice of our profession.  

Some doctors interviewed also recognised that the club’s best interests included short and long-term interests. Like Pipe, these doctors saw that there was a potential conflict of interest between the club’s short-term interests in winning, and protecting the athletes’ health interests.

Within a sporting context, it’s easy to get swayed by circumstances and sort of say, what do we have to do at any cost, you know, there’s the expectation of the team, the coaching staff and the player concerned that you get them back. (Dr 1)

It’s important for the doctor to keep a reasonably clear head and not be overly influenced by other personnel who are around. There’s always pressure there, and you can’t say you’re completely devoid of the interests of the team. But you do have to keep a very clear balance. (Dr 3)

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While the organisation’s short-term interests were a potential source of conflict with athletes’ long-term health, athletes’ best health interests were often compatible with the team’s long-term interests.

*If you keep a player healthy, even if it means that they have to have a period out of the game and they recover from injury, rehabilitate, then that’s good for the long-term interests of the club.* (Dr 5)

### 2.2 HOW RISK IS INTERPRETED

As a consequence of their focus on the duty to not harm the athlete, doctors approached the issue of LAI with a risk assessment first. They saw making an accurate assessment of risk to be their major ethical obligation. The way they assessed risk indicates different underlying conceptions of what counts as benefit and harm to the athletes. In this risk assessment, doctors identified (a) the likelihood of risk arising from the use of an injection and (b) the consequences of the risk arising.

**(a) Likelihood of risk**

One doctor described the likelihood of risk arising in terms of probability. This assessment influenced whether or not to proceed with an injection.

*It’s probability… [If there was a] greater than 50% chance of actually making it a lot worse you wouldn’t do it. If you thought that it was like 5-10% then you might do it. If you thought that it was a 1% chance you probably would do it. If it was a 0% chance you definitely would.* (Dr 7)
Most doctors underlined that “the critical factors are the site of injury and the type of injury” (Dr 11) in determining the likelihood of risk of harm. For this reason, it is not surprising that doctors emphasised that “being 100% sure of the diagnosis is the most critical factor” (Dr 7).

First of all you have to have an accurate diagnosis. So the doctor is clear in his own mind about what the specific tissue damage is. That will then determine what the risks are. (Dr 3)

While current literature claims that ‘there is no study that has examined the long-term disability associated with local anaesthetic use’ and that this lack of scientific evidence represents a major dilemma for team physicians’, this did not appear to be the case for the doctors I interviewed. They asserted that “experience is probably more important than the scientific evidence” (Dr 3). Similarly, “common sense and experience are the governing factors” (Dr 1) in these treatment decisions. These doctors took the same approach as Orchard, who formulated guidelines on the basis of his own experience.

In response to the lack of scientific evidence, doctors used basic principles in sports medicine to determine the likelihood of risk of harm.

Primarily I would fall back on the joint involved and what I know about the joint, physiologically, anatomically, how it works. (Dr 4)

What you’re using here are your basic medical principles, your understanding of pathology and your understanding of how certain injuries heal. (Dr 7)

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Other factors that influenced the probability of physical risk were similarly derived from first principles and past medical history, such as the athlete’s previous and co-existing medical problems.

*What’s the natural history of injury to the joint, what’s the severity of the injury, are there existing problems with the joint…the background the player has with that anatomical location, the joint itself.* (Dr 4)

Similarly, players’ body size, shape and morphology helped doctors predict future risk of harm through their effects on the nature and amount of physical trauma that the injury was exposed to.

*A tall jumping key position player…a small running player…for a weight bearing joint, very different forces. Also their morphology…for an A-C joint, if someone’s pretty muscular, they can tend to protect it a little better…than someone who’s pretty wiry…sort of exposed.* (Dr 4)

Likewise, the nature of sport affected the likelihood of risk of harm.

*There are obviously some injuries that can be protected, and obviously the sport being involved, there’d be a difference between a body contact and non-body contact sport.* (Dr 9)
Consequences of risk arising

In addition to assessments of the probability of further harm, doctors analysed the severity of consequences if the risk eventuated. This is where knowledge of the natural history of the injury was important. Knowing the injury’s natural history determined:

*Whether that’s something that’s going to get better with time or recover anyway. Or something that’s going to lead to a permanent injury. If it’s something that’s easily treatable, then I guess you’re more inclined to allow them to continue participation as opposed to an injury that may not be treatable or curable.* (Dr 9)

Some doctors were more likely to inject injuries if “it’s not going to have an undue effect on the natural history [of the injury]” (Dr 5), provided that the natural history of the injury was not severe.

Apart from purely physical aspects of risk, doctors also took account of broader social factors. Doctors also considered the consequences of risk arising from LAI use in terms of potential to miss future games in the season. The timing of the season was important because injecting injuries later on in the season or after infrequent events reduced the likelihood of missing future games through injury.

*If it’s a Grand Final the boundary might be moved a little bit and I might be inclined to take a little bit more risk because there is no game the following week.* (Dr 10)

*The potential for missing chunks of the season is lessened.* (Dr 8)
Similarly, these doctors assessed the consequences of risk arising on a player’s future career.

*I would deal with things differently early in their career than if they’re just trying to play the last half of the season, and they’ll probably retire at the end of the season. They’re going to have a different attitude; they’re probably prepared to take more risks. (Dr 4)*

For amateur athletes, the consequences of risk were measured in terms of its impact on life outside sport, including work.

*What if you’re one of the unlucky ones who gets a complication and you’re affected with work? (Dr 5)*
2.3 THE IMPACT OF LITIGATION FEARS ON DECISION-MAKING

Many doctors drew the line on injecting injuries where the risks were too high for litigation reasons. This reflected their responsibility to exercise reasonable care in the use of LAI, where standards of reasonable care are determined on the evidence of professional peers.

The AFL set up a Medical Legal Working Party to perform a risk management analysis in response to these litigation issues. For the purpose of AFL doctors’ reference, it categorised likelihood of risk arising from ‘unlikely’ to ‘very likely’, and consequences of risk from ‘low’ to ‘extreme’. For example, risk assessment of injecting a particular injury may be characterised as:

<table>
<thead>
<tr>
<th>Likelihood of risk</th>
<th>Unlikely</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequence of risk</td>
<td>Severe</td>
</tr>
<tr>
<td>Risk assessment (therefore)</td>
<td>Moderate to High</td>
</tr>
</tbody>
</table>

This risk management analysis also relates to issues surrounding doctors’ duty of care. The AFL recommends that doctors exercise reasonable care in their medical treatment of athletes. Expectations of reasonable care are determined by reference to the standard of care provided by a hypothetical reasonable doctor with the same qualifications and training. These standards of care are set largely on the evidence of professional peers, especially for diagnosis of injuries and treatment, for example in the use of LAI.

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There is currently very little medical literature concerning standards of reasonable care associated with LAI. This may be one of the reasons that doctors were initially reluctant to support the project. In court, doctors are held up against the standards of their professional peers. In light of this, one doctor called me and said he opposed the project’s focus because he didn’t think it was a good idea to have a group of sports medicine doctors’ decision-making process documented and published in this area. He was worried that if a group of sports medicine doctors were seen to hold this collective opinion about when to use local anaesthetic injections, then this could be used against doctors in a court of law.

While many doctors saw the project as less threatening from a litigation point of view, it was clear that litigation was a sensitive issue with all doctors aware that they were working in a litigious environment.

This is one of the issues people are concerned about, that you might have a player 20 years down the track, retired, and then say, my knee needs replacing as a consequence of... on a couple of occasions they had injections in it, never mind the 200 other games they played with a sore knee. (Dr 2)

Some doctors perceived that the threat of litigation in medicine had increased over the past 10 years. This view is confirmed by the 2003 Medical Defence Australia fact files, which state that over the past ten years the number of negligence claims against doctors in Australia has doubled and damages payouts have tripled. It reports that on the current

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average, all doctors will have at least one claim brought out against them at some stage in their career.\(^\text{39}\)

As one doctor interviewed argued:

\begin{displayquote}
I just think the whole environment is more litigious. Managers are going to be chomping on their players' ears. If you have an adverse outcome, and you're always going to get them eventually, once you've been in practice for long enough, there's always a high risk that someone's going to say, hey you might be able to get compensated. Whereas ten years ago there wasn't the same risk of that. (Dr 4)
\end{displayquote}

As mentioned earlier, there is currently a case in the courts where a sports medicine doctor is being sued for negligence and failed duty of care concerning the use of a LAI. Prior to this legal action, only one other negligence claim against a sports medicine doctor has proceeded to trial in Australia – and the doctor won.\(^\text{40}\) However this does not reflect the actual incidence of claims against doctors. According to the MDA fact files, more than two thirds of all claims against doctors in Australia do not proceed to court.\(^\text{41}\) The majority of claims are either settled at mediation or the patient withdraws the complaint.

Studies have shown that fear of litigation alters the practice of medicine, with doctors practising ‘defensive medicine’. In one study, 76% of doctors said that the quality of their patient care had suffered in recent years in response to their fear of liability.\(^\text{42}\) Some doctors


interviewed highlighted that fear of litigation affected the nature of the doctor-patient relationships and impacted on clinical decision-making.

_There’s no doubt that litigation erodes some of the trust especially in the last few years because it just puts people on the back foot a little more. No matter how much you hate to admit it, every now and then it will sort of creep into the back of your mind. Not in a major way, but you’re just sort of aware of it. It just affects your clinical decisions. It’s a less pleasant environment to make clinical decisions in. (Dr 4)_

This doctor also highlighted that his own personal level of acceptable risk had decreased in response to litigation issues. He was now more likely to refuse requests for LAI, arguing that “We inject less, definitely…Litigation. Number one reason. Without a doubt. Period” (Dr 4).

In contrast to medical literature on defensive medicine, a few doctors interpreted their response to litigation issues to mean improved desire to get informed consent. This served to increase the level of involvement that the player had in the decision-making process. Some doctors’ saw this as a positive influence on decision-making within the doctor-patient relationship.

_I think that it’s healthy that we’re now more under the pump medico-legally because it probably improves our awareness and probably improves our desires to get informed consent. (Dr 11)_
CHAPTER 3: DECISION-MAKING IN THE ‘GREY ZONE’

The problem with medicine is there’s always a grey zone. And there’s a point where you’ll do it and there’s a point where you won’t do it and it’s rare that those two points are so close together that the situation is clear-cut. So usually there’s a bit of a spot where you’re not 100% sure if what you’re doing is right or wrong. (Dr 7)

In this section I will discuss the grey zone of decision-making. Entry into the grey zone occurred only if the LAI passed the doctor’s threshold of acceptable risk. Once in the grey zone, doctors performed a risk-benefit assessment in which they defined level of acceptable risk in terms of a balance between risks and benefits, as opposed to absolute level of risk. If the doctor perceived that the benefits outweighed the risks, the doctor let the athlete make the final decision about whether to proceed with an injection, once fully informed of the risks. In this way, doctors saw their interpretation of acceptable level of risk to be more important than the athlete’s. Two separate issues arose from doctors’ descriptions of decision-making in the grey zone:

(a) Doctors adjusted the level of acceptable risk on the basis of their own assessment of non-medical benefits.

(b) Once in the zone of acceptable risk, doctors then put decisions about risks and benefits in the athlete’s hands through the process of informed consent.

3.1 THE RISK-BENEFIT ASSESSMENT

Much of the debate surrounding LAI focuses on the extent to which doctors should let athletes take on risks for non-medical benefit. The International Federation of Sports Medicine (FIMS) code of ethics makes it clear that considerations of medical risk should be
paramount, with ‘solely the possible risks and consequences to the health of the athlete’ governing doctors’ decisions.\(^{43}\)

In actual practice, most doctors’ risk-benefit assessments did not follow the FIMS code of ethics. Instead, these doctors’ actions were consistent with the Australian College of Sports Physicians guidelines, which emphasised ‘discussion between doctors and their patients and informed formal consent’ to decide on appropriate levels of risk to take, in light of potential benefits.\(^{44}\) However, doctors’ interpretations of benefits associated with LAI came in two sorts:

(1) A wider notion of benefits: non-medical benefits

(2) A narrow notion of benefits: medical benefits

### 3.1.1 A WIDER NOTION OF BENEFITS: NON-MEDICAL BENEFITS

Most doctors saw a wider notion of benefits which included non-medical benefits to incorporate into the assessment athletes’ overall best interests in the decision-making process. In another study, Nelson found that collegiate and professional team doctors in the United States similarly took into account non-medical factors, especially player earning capacity, in decisions to prescribe LAI.\(^{45}\) In my interviews, the majority of doctors saw the non-medical benefits of LAI use to include:

(a) Participation in important events

(b) Employment aspects


(a) **Participation in important events**

*The importance of the sport, the importance of the game, the importance of the career do impact on decision-making. Even though these are not purely medical decisions, they certainly have a significant impact on the decisions whether to use local anaesthetic injections. And obviously lower the threshold for use.* (Dr 11)

Many doctors considered the benefits of LAI in terms of participation in important matches. In their risk-benefit assessments, doctors were prepared to elevate the level of acceptable risk as the level of perceived non-medical benefit increased.

*The higher the stakes for the event and the uniqueness of the event you’re more likely to compromise in medical injury, because it is a compromise.* (Dr 7)

In addition to the objective benefits of participating in important matches such as Grand Finals, doctors also acknowledged the role of subjective benefits to the player, “where the athlete would never forgive themselves if they didn’t participate. Where they would have some regrets” (Dr 2). Even at a lower level of competition, players’ motivations and perceived benefits from participation in important matches were still very high.

*The benefits are…that you might help them achieve a goal of playing in a Grand Final that has eluded them for ten years.* (Dr 12)

*The passion that people have for playing, and all the team aspects are probably as great. At suburban football, that’s what they’re playing for. They’re not playing for the dollars. They’re actually playing for the game and commitment and the bonding and their mates.* (Dr 5)
Despite the subjective benefits of participating in important matches, doctors were still less likely to inject recreational athletes, because the stakes of the event were objectively less significant.

I'd still have a much higher threshold for doing it in a sub-elite person where there are not other stakes that are quite unique and significant. (Dr 7)

This shows that doctors are still making their own risk-benefit assessment the one that matters, not the athlete’s.

(b) The role of employment

Many doctors perceived that their role as team doctor was to maximise athletes’ performance to enable them to do their job to the best of their ability, without causing further harm. The role of employment in many doctors’ decision-making process is reflected in one doctor’s perception of the ethical dilemma; Brukner, as cited in The Age, observed that:

On one hand the players are professionals, and therefore doctors should do (almost) anything to enable them to do their job. On the other hand, they are our patients and we have a genuine concern for their health – both in the short and long-term.46

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46 Brukner, P. (2003, Sept. 30). Lions’ use of local anaesthetic injections leads to pointed questions. The Age, p. 79
In this example, the sports medicine doctor describes the athlete as a professional who should be allowed to do their job, rather than as a patient who should be allowed to autonomously choose their own treatment.\footnote{Brukner, P. (2003, Sept. 30). Lions' use of local anaesthetic injections leads to pointed questions. The Age, p. 79}

Most doctors interviewed held a similar view. They saw a potential conflict between doctors’ duty to non-harm with their role in helping professional athletes do their job to the best of their ability.

\textit{I think it's still my primary role to protect them from harm, and treat them medically, but as a close second it's to let them get the best performance they can during their career... the player's health also involves their longevity in the game... it's wider than just stopping injury because they've actually got to have a career as well. (Dr 6)}

Doctors saw financial issues such as player earning capacity associated with employment to be important in the decision-making process.

\textit{I think the whole financial thing makes a big difference. I think if it's their workplace it's a different ball game. That's a dividing line I have in my own mind... So if you've got a recreational athlete whose income and life are not sport-based then I'd have a higher threshold for using local anaesthetic. (Dr 4)}

This was similar to findings in Nelson’s study, where one foot and ankle specialist was quoted as saying that injecting a particular ankle injury was justified in a professional athlete, but injecting the same injury in a high school or college athlete could be considered...
Some doctors I interviewed argued that because financial issues associated with employment were important, they “might be more inclined to see it from his point of view” (Dr 10) if the athlete’s career was under threat through contract or selection issues.

*It might be a person who is on the fringe of selection and he might be really desperate to retain his spot. And either his options are that he doesn’t play because he’s injured or he plays with a local anaesthetic injection.* (Dr 4)

### 3.1.2 A NARROW NOTION OF BENEFITS: MEDICAL BENEFITS

While most doctors saw a wider notion of benefits which included non-medical benefits, one doctor saw medical considerations to be the only important issue in the decision-making process. In his risk-benefit assessments, benefits of LAI included only athletes’ medical best interests in terms of reducing pain and allowing the player to return to normal function in order to achieve his or her potential.

*So when I’m doing risk-benefits, the benefit is will I help this player play better if we do it, not will they win the game. I can’t make them win the game, but I can make sure the player is playing at their best potential. That’s what I mean when I say benefits.* (Dr 8)

This doctor had no grey area of decision-making because “there’s only a few really specific conditions where I’ll use it and they’re pretty clear-cut for me” (Dr 8).

According to Mitten, this outlook is less controversial from a litigation point of view, because ‘the team physician would bear substantial responsibility for harm caused by

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permitting non-medical factors such as the team’s needs, players’ stature, or economic considerations to impair the exercise of his professional judgment. 49

In the interviews, this same doctor argued that there was no difference in medical benefits to athletes at a higher or lower level of competition. This doctor was thus equally likely to inject recreational athletes if the risks were acceptable to the doctor and athlete.

So higher-level, lower-level doesn't change benefits, you're still talking about an individual player and whether this injection will help them play better. Again, as I said, that's secondary to risk. (Dr 8)

This doctor only considered participation in Grand Finals to be important in terms of the period of rehabilitation and rest it allowed for recovery from injury after the event.

I think it’s really dangerous to be doing different things in finals than you would in other games. The only way that should impact on your decisions is that often after finals they have a long lay-off period to recover. (Dr 8)

3.2 INFORMED CONSENT

Even though all doctors endorsed the importance of informed consent in theory, they identified difficulties in putting it into practice. In this section, I will discuss the complexities surrounding informed consent in the context of the ‘heat of battle’, because doctors emphasised this as a major issue. I will then describe strategies of AFL doctors to deal with this consent problem especially in terms of reducing the threat of litigation.

3.2.1 INFORMED CONSENT IN THE ‘HEAT OF BATTLE’

In the interviews, doctors recognised that achieving informed consent in the ‘heat of battle’ was “one of the really major problems facing sports medicine” (Dr 8). They considered the use of LAI during the ‘heat of battle’ to be more controversial than pre-game injections, because a number of factors impacted on the decision-making process. McCrory observes that:

> In a game situation, when there is big match pressure, financial rewards, coaching demands and the player’s desire to return to the game outweighs common sense, informed consent has no real meaning.⁵⁰

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In response to these influences, Johnson argues that the quality of informed consent was reduced in the ‘heat of battle’:

The athlete cannot really be expected to make a truly informed and unbiased assessment of the options, especially if the injury occurs during a game and the physician and player have to decide whether to proceed with an injection in the “heat of battle”.51

Beauchamp and Childress defined the components of informed consent as follows:

1 Full disclosure of information
2 Voluntary choice
3 Understanding and acceptance of information
4 Competence of patient52

Many doctors highlighted that full disclosure of information was a particular problem in the ‘heat of battle’, compared with pre-game injections, which enabled more time to “discuss with the player what’s been suggested, what are the pros and cons, then they’re able to make an informed choice” (Dr 1).

[During the match] there is less ability for the player to comprehend informed consent, and less time to deliver informed consent…therefore a higher risk of adverse outcome from the local anaesthetic use. Both injury wise and legally. (Dr 5)

All doctors recognised their legal duty to provide full information about the athlete’s medical condition, proposed treatment and alternatives, probability of re-injury, severity of harm and potential long-term health effects. They expressed concern that time pressures in the ‘heat of battle’ prevented full disclosure of information and this increased their perceived vulnerability to litigation. I will discuss strategies that doctors used to protect themselves against litigation in section 3.3.

In addition to concerns surrounding full disclosure of information, some doctors questioned players’ competence and understanding of information in the ‘heat of battle’, where “they’re often pumped up, they’ve got battle fever, and they just want to get back out there” (Dr 8).

This doctor drew comparisons between the ‘heat of battle’ with other emotional extremes that may compromise rational decision-making and therefore quality of informed consent.

_Whether or not emotionally they’re able to give informed consent... I tend to think they are. Because if you start to say the athlete in the heat of the moment can’t give consent then you start talking about women in childbirth and soldiers in battle and anyone else in emotional extremes and it’s a can of worms._ (Dr 8)
3.3 STRATEGIES TO REDUCE RISK OF LITIGATION

In response to concerns about quality of informed consent in the context of the ‘heat of battle’ and in general, doctors drew attention to a number of strategies they used to reduce the risk of litigation, many of which were endorsed by the AFL Medical Officers’ Association (AFL MOA). They can be summarised as follows:

(1) Pre-season information sessions
(2) Documentation and signed consent forms
(3) Colleague for second opinion and witness
(4) Letting the athlete initiate discussion about LAI

3.3.1 Pre-season information sessions

The AFL MOA produced a CD that enables club doctors to conduct annual information sessions to advise and educate AFL players on issues surrounding risk of injury in professional football, risk of playing with a LAI to mask pain from injury (both short and long-term risks), as well as informed consent.

As one AFL doctor explained, this information is provided “as a prelude to the rapid decision-making that needs to happen during the game” (Dr 10).

These pre-season information session also served to address issues of consent which one doctor emphasised “need to be discussed with athletes in the pre-season coldly and in the light of day before anything happens” (Dr 7). Doctors raised athletes’ awareness that: “club doctors might need to inject you, without much notice, and without time to give you fully informed consent” (Dr 4).

3.3.2 Signed consent forms

In addition to disclosing full information, most doctors interviewed emphasised the importance of getting athletes to sign consent forms, because they recognised documentation was, in general, important. This focus on documentation is reflected in the medico-legal literature, which recommends that for each informed consent process undertaken, there should be documentation of the specifics of the discussion about risks, benefits, and alternative treatments.55

However in the past, doctors have drawn attention to the pragmatic difficulties of documenting the informed consent process during the match.

From practical experience, I know that I might be faced with 20 injuries during a match – how can I keep contemporaneous notes on all such situations?56

In addition to time constraints, doctors recognised problems with signed consent forms related to the quality of informed consent. Doctors asserted that players’ reduced

understanding of information in the ‘heat of battle’ compromised the quality of informed
consent and increased their sense of legal liability.

Later on, if something went wrong and they weren’t happy about what had occurred, you wouldn’t have a leg to stand on. I mean, how can you give informed consent in that situation, even if you got them to sign? You’d have sweat through the ink and the hand wouldn’t be signing too well and it would all be an indication that they’re saying…I just want to get back on. (Dr 6)

Even though signed consent forms did not indicate high quality of informed consent, doctors still got players to sign consent forms because they believed that bad documentation was better than no documentation. McCrory drew attention to the medico-legal adage; ‘good notes = good defence, bad notes = bad defence, and no notes = no defence’.

### 3.3.3 Colleague for second opinion and witness

In addition, the AFL MOA recommends that two medical practitioners attend all AFL games. One doctor interviewed highlighted the value of two doctors in providing athletes with a second opinion on this issue:

Both the two doctors might be present at the time this issue is discussed so the player has the opportunity to hear two different opinions, if necessary, or hear the same opinion but expressed in different ways by different people. (Dr 3)

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Additionally, doctors were prepared to raise the level of acceptable risk to the athlete if there was a third party present to witness that the discussion about risks had taken place. This served to protect doctors against litigation if an adverse outcome arose.

_There are circumstances where you'd elevate the level of consent, which in those circumstances I'd probably get a colleague to stand beside me while I talked about it in front of the athlete so they could hear and we could have an open discussion about it to see where I thought I was wrong to be so strong, for instance. And for that athlete to see, and also to protect me because I've got a third party there who could then later come and say, [this doctor] said, no, you shouldn't do this and he was quite strong about it. He said this, this and this so I had some protection if there was any litigation._ (Dr 7)

### 3.3.4 Letting the athlete initiate the discussion about LAI

Some doctors endorsed letting the athlete initiate the discussion about LAI because they considered this to be less controversial from a litigation point of view. Athlete-initiated discussion ensured that the athlete’s choice was voluntary, which is important because, as explained earlier, quality of informed consent has implications on litigation issues. Furthermore, it indicated that the athlete was “positive about seeking intervention, rather than negative or potentially ambivalent about it” (Dr 5), which reduced the likelihood of litigation after an adverse outcome, assuming that the athlete was fully informed of the risks.

_Ninety-five percent of the time, I let them suggest it. I don’t actually offer it or suggest it first. It’s usually them asking me then I have the opportunity to explain the risks and assess it._ (Dr 7)
In addition, one doctor called me with regards to the preliminary data analysis I had sent all participants to invite their feedback. This doctor emphasised the importance of letting the athlete initiate the discussion about LAI in terms of protection from litigation. He explained that athlete-initiated discussion about LAI ensured that the athlete’s choice was free from the doctor’s coercion, reducing risk of litigation in this way.

As a counter-example, some doctors perceived that it was their legal duty to disclose all the options available to the athlete, rather than wait until the athlete initiated the discussion about LAI.

*I think it’s important to give the players all the options that are available to them. And local anaesthetic is always one [option] that’s going to be there if there’s an injury that’s amenable to it. I feel it’s my duty to give that as an option. (Dr 12)*

However, regardless of who initiated the discussion, the emphasis remained on the athlete’s voluntary choice for litigation reasons.

*If I mentioned local anaesthetic injection and I got the feeling the player is not keen, I wouldn’t really push it. I’d never be comfortable giving a player local anaesthetic under duress. (Dr 12)*
In the interviews, all doctors emphasised the importance of their relationship with the athlete in terms of decisions surrounding LAI. However, none actually articulated why the relationship was important. In this chapter, I attempt to interpret the significance doctors attach to the relationship. There are several possible interpretations of why this is important. They can be summarised as follows:

2. How well doctors know the athlete helps to determine how accurately they can predict the level of physical risk of injecting an injury in that particular person.
3. Rapport and trust in the doctor-patient relationship affects the likelihood of litigation after an adverse outcome.

4.1 INFORMED CONSENT

One possible interpretation of why doctors attach significance to their relationship with the player is related to considerations of informed consent. Knowing the player well enabled elucidation of the players’ values and preferences in relation to their treatment.

However rather than just interpreting the players’ wishes and helping them select the treatment option that best meets these values, doctors entered into discussions with players to help the athlete examine the worthiness of their preferences. This is best described in the
literature as the deliberative model of doctor-patient relationship.\textsuperscript{59} In this model, the doctors educate and advise athletes about what their priorities should be. In particular, the doctor encourages the athlete to consider health-related values and choose the treatment option that best meets these values. As one doctor argues, "that's my role, to educate them. So really, what you really should be thinking about and considering" (Dr 3).

\textit{And sometimes players need help to put things into perspective. And there are situations, lots of situations, where you would discourage the player, even though he’s very keen to take the risk… I think it’s essential that you do protect them from doing anything that’s foolish. And that the risks they’ve got to take are very carefully considered. (Dr 3)}

In this model of doctor-patient relationship, the emphasis is on assisting the athlete to articulate and analyse the merit of their own values in light of the various influences on their decision-making.\textsuperscript{60}

\textit{They have pressures from work…sponsors, managers, coaches, all these commitments. They’ve got to prioritise and manage their time. They’ve got to take on board pressures from the coach, from the team to play, and they’ve got to look at their health, they’ve got to look at their long-term future. (Dr 2)}


If doctors really do see their role as described in the deliberative model, this is a good explanation for why they place so much importance on their relationship with the athlete. This is because having that sort of deliberative interaction really only works if there is trust and rapport already established in the doctor-athlete relationship.

While doctors recommend treatment options that realise athletes’ own preferences, in this model doctors do not coerce or dictate what the athlete should do. That is, doctors didn’t spill over into the paternalistic model of the doctor-athlete relationship. Doctors emphasised that the final decision rests with the athlete.

*I don’t make decisions for people. We just present them with the facts. And what are the pros and cons. [We ask] how important is this game to you? Are you prepared to risk the downside for the chance of being able to play? (Dr 2)*

In the deliberative model of doctor-patient relationship, doctors recognised that their own values will influence their judgments of the worthiness of the patients’ values. “The player is the one who finally decides what the best then is. Now, it would be foolish to say that this can’t be influenced by the doctor’s opinion and the way he presents the information.” (Dr 3)
4.2 PREDICTIONS OF PHYSICAL RISK

Some doctors seemed to suggest that their relationship with athletes was important for full disclosure of information that might influence predictions of physical risk. In an established relationship where rapport had developed over time, the patient was more likely to reveal factors that influenced assessments of risk of further injury. As one doctor said, “it’s too dangerous in someone you don’t know, you have no relationship with, no rapport, no time to assess the injury” (Dr 5). Full disclosure of important information enabled the doctor to achieve an accurate diagnosis, which, as I noted earlier, was crucial in accurately predicting risk.

Personal interaction with the player was needed to get knowledge about the person that would influence the accuracy of predictions of physical risk. For example, knowing a person’s pain tolerance was an important factor in predicting risk.

You need to know the sort of person in terms of what their level of pain tolerance is, or their motivation to play is, I mean, some people will very much crash through at any cost. You would be concerned that they would run the risk of doing further damage to themselves. (Dr 1)

Knowing the player’s level of common sense was another important consideration.

I’d have a relationship with that particular player and know them reasonably well and have a pretty good feel whether or not they know what they’re doing. So there’s some common sense about it and I have some confidence that they know what they’re doing. Some individuals are stupid about it and some individuals are very thoughtful about it. (Dr 7)
A third reason that relationship with the player seemed to be important was related to the likelihood of litigation after an adverse outcome.

*If you haven't got the player on your side and totally committed then a) it may not work and b) they're much more likely to complain and sue if there are complications afterwards. So you really have to get that rapport and feeling with the player that this is something they're comfortable with, that they're happy to do. And if you're not getting the right vibes then I'd steer clear of it. (Dr 12)*

This view makes sense, considering some studies on medical litigation. Hickson investigated patients’ motivations to sue their doctor after an adverse event. Most patients cited reasons related to dissatisfaction with doctor-patient communication. Specifically, these patients argued that their doctor refused to listen or speak openly with them, tried to mislead them, and failed to warn them about long-term medical problems. In another study, Beckman reviewed transcripts in which patients revealed their reasons for filing lawsuits against their doctors. Four key themes were identified from the review: patients sued because they felt abandoned, that the doctor did not value their views, that information was delivered poorly, and that doctors did not understand their perspective.

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CONCLUSION

Overall, this study has shown that while doctors held a clear hierarchy of ethical principles in theory, in practice things seem to be much less clear-cut. In particular, doctors’ descriptions of actual practice illustrate complexities in where they drew the line on acceptable level of risk to take in the grey zone of decision-making, which was often moved according to doctors’ risk-benefit assessments.

Although I identified the notion of the grey zone in the interview data, my overall impression from the interview was that many doctors were reluctant to say explicitly that they sometimes operated in the grey zone. This may have been in response to the negative media publicity following the Brisbane Lions’ use of LAI in the 2003 AFL Grand Final, which condemned doctors for their role in seemingly compromising athletes’ health in favour of non-medical best interests.

Another possible reason why doctors were reluctant to discuss the grey zone of decision-making surrounds informed consent and its effects on litigation issues. In the case of the ‘heat of battle’, doctors themselves identified a discrepancy between the theory and practice of informed consent. Many doctors expressed concern at this, as they perceived that reduced quality of informed consent increased their vulnerability to litigation in the event of an adverse outcome. In response to concerns about informed consent, doctors drew attention to several strategies, many endorsed by the AFL MOA, to reduce the risk of litigation in this situation.

This report paves the way for future studies by identifying issues that can be examined in more depth, using larger sample groups. As discussed earlier, further research should investigate athletes’ perspectives on the doctor’s role in prescribing LAI.
Additionally, studies could compare doctors’ descriptions of their practice with observations of their actual practice, as well as incorporating doctors’ actual experiences in the use of LAI, since this wasn’t a specific focus in this project due to doctors’ litigation concerns.

From a broader perspective, this study adds to the body of knowledge on how sports medicine doctors perceive their ethical responsibilities in prescribing LAI to athletes. In this study, doctors’ responses differed in one significant way to similar research on doctors’ ethical responsibilities conducted elsewhere. Unlike in other studies, many doctors interviewed emphasised the importance of the doctor-patient relationship in the decision-making process. As discussed in chapter 4, the reasons for this focus were neither obvious nor clear-cut; however, further research may reveal why doctors framed the ethical issues in this way.

The findings of this report have several implications for the practice of sports medicine. First, it points to an increased need for discussion about doctors’ decision-making process in prescribing LAI to athletes. This is important because the Australian College of Sports Physicians ‘recommends that education and training of medical practitioners in their use of local anaesthetic agents in sport is appropriate’\(^\text{63}\). Findings from this exploratory study shed light on doctors’ risk-benefit assessments concerning the prescription of LAI; further research is needed to assess whether current education and training underlying these decisions is appropriate. In this way, this information may be used to directly address, rather than side-step, the complexities in doctors’ decision-making process surrounding the prescription of LAI to athletes.

REFERENCE LIST


