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Being a Team Physician: The How's and Why's

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Abstract: Sports medicine is a broad field that includes many different types of health care providers. A *sports medicine physician* is someone who specializes in sports medicine, but is not necessarily a team physician. A team physician is a physician who is responsible for the care of one or more organized sports teams. To be considered a true team physician, the physician must provide care at times and places separate from the usual office and surgical situation. Team physicians are often orthopaedic surgeons, but many other specialties are involved. Because the majority of problems encountered by athletes are musculoskeletal, team physicians must be knowledgeable in treating these conditions. However, the team physician must have basic skills in other fields such as cardiology, pulmonary medicine, infectious disease, and psychiatry.

Most team physicians are not paid directly for their work and, in some cases, physicians have been paying teams for the "privilege" of being a team physician. Managed care has had a major effect on team physicians and has sometimes made it difficult for doctors to care for players on teams for which they are responsible.

The legal issues affecting team physicians are similar to those affecting all physicians but can be complicated by the problem of conflicting goals between athletes, coaches, fans, media and team management. These conflicts, compounded by the question of when an athlete can return to play, add stress to the team physician's decision making.

Despite the variable financial rewards and increased pressures of being a team physician, many physicians find the ability to work directly with athletic teams rewarding. Being a team physician can help build a practice and is a good community service. Many physicians enjoy observing patients they have treated participating in sports and functioning at high levels.

What exactly does it mean to be a team physician? First, "team physician" must be distinguished from related positions such as *competition physician, team consultant*, and *sports medicine specialist*. The *competition physician* functions to organize medical coverage for a specific athletic event such as a soccer tournament or road race [62,45]. Many physicians who are interested in sports medicine become team physicians as well as competition physicians. A *team consultant* is a specialist who provides opinions or treatments when requested but does not follow the day-to-day medical matters of the team. A *sports medicine specialist* may or may not be a team physician. Some sports medicine specialists are interested in and trained in the diagnosis and treatment of sports-related injuries but are not actually team physicians.

The team physician distinguishes himself from other physicians by being available on and off the field, during practices as well as games and by working outside of the usual office hours [27,34]. According to the Committee on the Medical Aspects of Sports of the American Medical Association, a *team physician* is a physician who is given authority by a team or school to make medical judgments relating to the participation and supervision of athletes on the team or in the school [80,81]. In some instances, the title "team physician" may be misleading. Physicians have been known to claim and subsequently advertise as being a team physician for a certain team after consulting on only one patient! For some teams, the relationship is quite formal, with a written legal contract scrutinized by lawyers, that dictates the responsibilities and benefits for the team and physician [83]. Other physicians "hang out" at their child's game, begin helping the coach or athletic trainer with injured players, and grow into their role informally [79,87].

Regardless of the manner in which one becomes a team physician, there are certain factors that distinguish a team physician from a physician who simply treats athletic injuries. Most obvious is that team physicians have an interest in and develop experience with the care of injuries related to athletics. As already mentioned, a team physician spends at least some time treating athletes outside of the formal office setting, often in a training room or game or practice facility. Usually, much of this treatment is conducted without direct financial compensation or billing. Team physicians are often responsible for "covering" games and/or practice sessions [93]. Sometimes, schools or other teams will arrange "clinic" schedules where the physician will evaluate injured athletes in the training room at specified times [9,67,79]. Team physicians may spend much time corresponding by phone and mail with athletes, athletic trainers, coaches, athletic directors, and management concerning the status of injured players [34,91]. The athletic trainer is usually the primary liason between the team's medical staff and the coaching staff, and most team physicians know the athletic trainers much better than they know the coaches [29,19,49,79]. Physicians may also organize and conduct pre-participation physical examinations and sometimes provide recommendations concerning nutrition, training regimens, and medical red-shirt decisions and documentation [9,45,69,79]. More frequently, doctors are becoming involved with medical insurance issues regarding student-athletes. Team physicians may also become involved with administrative decisions, such as equipment purchases [91].

The time required to fulfill the obligations of team physician varies and depends on the number of athletes and teams for which the physician is responsible. For example, the physician for a large university may be responsible for the care of more than 900 athletes. Some doctors in student health centers on college campuses also care for the varsity athletes and spend a large percentage of their time doing so [79]. Football coverage is notoriously time consuming because of the large number of players per team and higher injury rates. Football team doctors are usually responsible for being present at all games, including away games. Some teams require a physician to be present at all contact practices [79,82]. For basketball, the team physician usually does not go to away games, and the home physician is also responsible for covering the visiting team [30]. Sports with a higher risk of injury such as wrestling and gymnastics are more likely to require a physician's presence [79]. Although the time commitment may vary, most team physicians will devote many weekends and evenings to their team [79].

What type of specialty training does one need to become a team physician? The majority of team physicians are orthopaedic surgeons, with many of them having formal post-residency fellowship training in sports medicine [36, 93]. However, there are many other specialists who are team physicians, including internists, family practitioners, physiatrists, pediatricians, emergency physicians, and general surgeons teams often find it helpful to work with a group of obstetrician/gynecologists, rheumatologists, and osteopaths [9,10,12,14,15,18,20,27,28,30,55,58,60,71,73,79,86]. Some specialties, including family practice, internal medicine, and emergency medicine, have developed post-residency fellowship programs in sports medicine [8,85]. In a recent survey conducted in a Division I university, 88% of the medical problems reported to athletic trainers were related to the musculoskeletal system [40]. A study in high school athletes reported that more than 90% of injuries involved the musculoskeletal system [75]. Clearly, team physicians must have expertise with disorders of the musculoskeletal system, whether or not their practice is limited to non-operative management [30,34,67,86].

The team physician is often the primary care physician for all the medical needs of the athletes and must have basic knowledge in areas such as nutrition, psychology, dentistry, infectious disease, dermatology, cardiology, pulmonology, and physiology in addition to knowledge of the musculoskeletal system [17,21,34,67,68,79,51,52]. Pharmacologic knowledge is also important, and specific knowledge of what drugs are banned by organizations such as the NCAA and the USOC can be critical if drug testing is performed [67,79]. In a large city or university, the physician may have access to many sub-specialists, but these consultants may not be readily available in some locations, especially if the team is traveling out of state or abroad. When the team physician of a professional baseball team was asked why he, an internist, was the official team physician instead of the orthopaedic surgeon who was considered a consultant, he replied, "For the type of problems our guys get while on the road, you don't need an orthopaedic surgeon." Team physicians are often required to treat communicable diseases and in the case of foreign travel should be responsible for assuring that the proper vaccinations are performed [45].

Being a team physician can be an enjoyable experience. The opportunity to work with young, motivated patients and to participate in the successes (and failures) of a team can be tremendously rewarding. The variety of

supplementing one's office and operative practice with activities on the court or field is often enough reason to become a team physician. There are sometimes other "perks," such as game tickets and travel. The financial rewards are variable. Fewer and fewer physicians are on salary and most team physicians have a fee-for-service relationship with or without a formal contract [79,83]. Also, some physicians feel that their practice is enhanced by recognition in their community that they are the physician for a certain team. When choosing a doctor for a sports injury, a patient may say, "I want to go to the doctor who treats the Metropolitan Cougars."

Ironically, some teams are actually charging doctors for the "privilege" of being their physician. In some cases, the job of team physician is actually put up for bid [64,70]. For instance, Major League Soccer (MLS) set up a bidding situation where the highest bidder became the team physician in cities with teams. In the Washington, DC area, MLS officials requested a sum of $150,000 from local doctors who were interested in becoming DC United's physician. Both the Charlotte and Jacksonville teams in the National Football League reportedly put the job of team physician out for bid [37,48]. The Orlando Magic of the National Basketball Association received money from their medical providers and the Jacksonville Jaguars of the National Football League reportedly received one million dollars from the group that became their team physicians [37,42,63,64,72]. The Carolinas Medical Center committed $150,000 per year to the Carolina Panthers and described their contract as a managed care contract, with the players steered toward their hospital [90].

Some physicians feel that an association with a professional team is a useful form of professional advertising, especially in sports such as football, which have high injury rates and where the injuries often receive significant attention in local newspapers [48]. As part of these financial agreements, the physician or medical group becomes a "sponsor" and is given certain advertising rights such as having their name on billboards. Additionally, their name may be mentioned by the announcer at the game or on radio or television advertisements. These advertisements are easily recognized at most professional and some collegiate athletic events. In some instances, large health care organizations are negotiating for contracts to take care of professional or college teams. These organizations become responsible for choosing the team's athletic trainers, physical therapists and physicians. The strategies of teams' choosing their medical care by the ability of the doctor or health care organization to pay the team or by large health care organizations negotiating all-inclusive contracts with the teams are becoming more common. Unfortunately, this method of choosing team physicians often relegates skill and experience to a less important position in the decision making process. Also, many physicians feel strongly that advertising, in general, is ethically questionable [33,48,95].

This new method of choosing team physicians whereby physicians pay money to the team may create additional ethical problems. In the past, the team physician was sometimes a friend of the owner or of someone in management. Gradually, a trend developed where these physicians were replaced by people with expertise and experience in sports medicine. This new trend of physician selection being influenced by financial factors creates questions as to the loyalty of the physicians: Are they loyal to the players or to the organization? Players may not like the concept that their team doctor was not chosen because of his skill alone. Although this phenomenon has been seen mostly in professional sports, there is concern that it could become more prevalent even in college sports. Some experienced physicians

feel strongly that this trend is not good for the specialty of sports medicine [33,48,95].

Managed care is an increasingly important factor for the team physician and may contribute to the unfortunate phenomenon of physician ability becoming less important in determining who becomes a team physician. In the past, if a team physician provided good service and was well liked by the players, coaches, and trainers, most referrals would obviously be directed to his office. However, many team physicians are now encountering the following situation: A player who has been followed by the team physician for many years for minor injuries (no bills generated) is examined in the training room. The athlete has now twisted her knee and has an effusion and a positive Lachman's test. The physician recommends an X-ray and possible anterior cruciate ligament reconstructive surgery. However, the athlete belongs to an HMO that requires an evaluation by a primary care doctor and referral to a different orthopaedist. This scenario and other similar ones are becoming more and more frequent with the result that many physicians are deciding that the decrease in financial compensation attributable to managed care precludes them from continuing their role as team physician. Managed care may also affect the treatment of college athletes who are unable to receive more than superficial treatment from their team physician. In a survey of two Maryland Universities, 65 out of 202 athletes were from out of state. Many of these athletes had out of state primary care physicians. If the primary care physician does not allow out of network care, treatment may be delayed, often resulting in lost playing and practice time [9]. College athletes are allowed only 4 years of participation, and any loss of playing time while they are "in season" is important. It is also unfortunate when the team physician, who usually knows the athlete well and is most experienced with the treatment of sports-related injuries, is not allowed by the insurance company to treat the patient and must stand by as the athlete is treated by someone who may not know the athlete and who may not understand the subtleties of the injury or the time factors involved with college athletics [78].

Similar legal issues affect all physicians and, in general, the principle that good medicine equals good law holds true [67]. The definitions of standard of care and medical liability are no different for the team physician [7]. However, there are some special legal considerations for the team physician. It is expected that the team physician have expertise in certain areas of sports medicine such as the treatment of potential spine injuries in football. A physician must have the skill that is expected of a *reasonably competent practitioner in the same class to which he belongs* [6]. Some team physicians have had difficulty getting malpractice coverage because of the risk of multi-million-dollar athletes incurring career-ending injuries [83]. There is often pressure on the athlete and medical staff to return the athlete to playing status as soon as possible [42]. This pressure comes from coaches, management, and sometimes the player himself. The physician may allow the player to return to his sport sooner than he would another "normal" patient. If a decision is made to allow an athlete to play "hurt," it is extremely important that informed consent is thorough and well documented [7].

It is important that the physician clearly discusses the risks and benefits of surgery or sports participation with the athlete and that both the doctor and athlete are comfortable with the decision. The importance of communication and disclosure is true for all patients and really should not differ depending on the patient's athletic status, despite the sometimes competing interests of

coaches, fans, management, and the athlete [7,91]. Athletes have sued their doctors complaining that they were never completely informed of their condition or the risks of their continued participation [32,70]. Athletes, because of their extreme competitiveness, may be particularly susceptible to "selective listening" when their situation is explained to them by the team physician and therefore may not fully grasp the risks of their continued playing. Sports may be so important to the athlete's self-esteem that he is willing to risk injury or even death. Athletes' goals are usually short-term and there is often a milieu of machismo and indestructibility that influences their decisions [3,23,35,36,92]. Team physicians have also been sued by athletes who claimed that the doctor put the needs of the team above what was best for the athlete [63,70]. For most conditions that affect the extremities, the worst risk of continued participation is persistent pain or re-injury. However, for injuries to the head and neck, or for cardiac problems, re-injury can result in permanent neurologic damage and even death. Therefore, there should never be compromise in the treatment of these conditions, regardless of the skill of the athlete or the importance of the particular contest.

In making decisions regarding an athlete's participation, physicians have competing goals. It is most important that the athlete's future in athletics and in life not be unreasonably jeopardized by allowing him to compete. (A physician must never guarantee to a patient that it is entirely safe to compete because there is always some risk inherent in sports; it is better to say that a player does not have significantly increased risk compared to his peers or that there is no medical reason that he should not participate.) Conversely, an athlete should not be held back from participation unnecessarily [81,91]. Physicians have been sued for not allowing a player to participate. Recent legal cases have used the Americans with Disabilities Act to support the athlete's assertion that they should be allowed to play despite potential risk [7,54,66]. Team physicians have sometimes been sued by athletes who have claimed that the doctor wrongfully allowed the athlete to play and the team did not allow for second opinions [31,44].

In some cases, an athlete or parent tries to override a physician's restriction on athletic participation by signing a release or waiver. These releases are problematic, however, and the physician should still not allow the athlete to participate. A parent generally has no authority to release future claims on behalf of a child, and the statute of limitations does not begin until the child reaches legal age. Moreover, "selective listening" problems, referred to above, may also affect the validity of a release. In a case where an athlete continues to participate despite the physician's recommendation against participation, the physician should write a letter reaffirming his belief that the athlete should not participate. Physicians are liable for inaction as well as action, and failure to try to prevent unsafe activity can be considered negligent [43,54,81,89].

Are physicians legally liable, even when they are working in a voluntary capacity? The answer to this question has been effected by the problem that some areas of the country have had in attracting doctors to become team physicians. To reduce physicians' legal concerns, thereby encouraging physicians to work with teams, some states, such as Maryland, Arizona, Arkansas, Georgia, Florida, Kansas, Missouri, Ohio, Oregon, and Tennessee, have passed laws that provide immunity to team physicians who provide care in an emergency, in good faith and without compensation [27,30]. However, even a volunteer physician can be liable under some circumstances, especially when it is determined that gross negligence has

occurred [7,43,53].

Another difference between routine office practice and team physician practice that may have legal ramifications for the team physician is that some of the treatment rendered by team physicians is done in informal settings. Therefore, documentation is not as rigorous. A team physician may not dictate or write a note every time he evaluates a blister or rash in the training room or evaluates a concussion or "burner" on the sideline. Sometimes, medications such as anti-inflammatory medications are dispensed without a formal prescription. These medications are sometimes dispensed by the athletic trainers, using "standing orders" from the physician. The team physician must understand that he assumes legal risk even when he treats players informally or when medicine is dispensed via "standing orders" by the athletic trainer [32]. The physician may get a sense of security thinking that the players appreciate his helping the team and would therefore never take legal action against him. Although most team physicians would agree that athletes are generally less litigious, unfortunately, this is not always true and the team physician must be careful with every medical decision. In a survey of high school football teams in California, 6.6% of the schools had been involved in football injury litigation within the past 5 years. (93) Legally, a physician/patient relationship or contract is assumed any time a physician renders care to a patient, even without verbal or written expression [27]. Many sports medicine groups such as the American College of Sports Medicine are developing written standards of care that may become an important risk-management response to the increase in litigation throughout all of medicine [32].

Guidelines to help the team physician to function efficiently from a legal standpoint include the importance of good documentation of opinions, especially those relating to the ability of an athlete to continue sports participation. The physician should learn the intricacies and the common injuries of the sports for which he is responsible. The team physician should try to be objective about his decisions, and avoid being influenced by the coach, media, fans, or management [56,84]. It is important, but sometimes difficult, to be firm about one's decisions, especially if the decision is to keep a star athlete out of play [79]. It is helpful to have objective tests and the opinions of consultants to back up one's decisions. If there is any doubt about an athlete's ability to re-enter a game, the decision should usually fall on the side of safety. Additionally, appropriate malpractice coverage specifically for your activities as a team physician is essential. Some experts recommend that team physicians have a high limit on their plans [27,34,67,81,96]. Although team physicians have a tendency to render treatment in more informal settings, it is wise to get written consent for any procedure or medication that is dispensed. Failure to prove that proper consent was obtained before a procedure, even a minor one such as an injection, can result in a charge of assault and battery in addition to malpractice. Some experts recommend obtaining a formal written contract with the advice of lawyers before agreeing to become a team physician. However, the best way to avoid legal difficulties is to practice good medicine, which includes developing good rapport with one's patients, being careful and thorough, following through, keeping good records, and consulting or getting second opinions when necessary [81,96].

There are certain stresses and pressures that are unique to the team physician. As discussed earlier, there is the pressure to get the player back in the game as soon as possible [42]. Many team physicians believe that they may lose their job if they keep players out too long. The decision

whether to allow an athlete to play can be difficult, but must be made often by a team physician [79]. Unnecessary restrictions on an athlete can be harmful and frustrating for the athlete [33]. Decisions to restrict an athlete are more likely to be made by physicians not experienced in sports medicine who tend to be more conservative [79]. Another unique pressure on the team physician is the degree of attention his decisions or treatment may receive. When a player is treated surgically or non-surgically, the player's progress is scrutinized by teammates, trainers, coaches, management, fans, and media. The physician's responsibility is primarily to the patient, despite pressures from the coach, management, or fans [33,56,95]. Because of the publicity that some athletes' injuries receive, the team physician may be inundated with suggestions or advice from general managers, coaches, trainers and even fans. The team physician may have to deal with second guessing and criticism [18,22,23,26,83,41,50,57,76]. In extreme circumstances, physicians have received death threats because of decisions they have made concerning high-profile athletes [77]. Depending on the relationship between the physician and the team management, the physician's position may be vulnerable. Sports injuries are rarely life threatening, but there are high standards of precision for both diagnosis and treatment [75]. A poor outcome or prolonged recovery can damage the physician's ego as well as his reputation. The team physician may be forced to make instantaneous decisions about how long an athlete will be disabled because of the need for teams to fill their rosters while an injured player is relegated to a "disabled list" [83]. Potential conflicts between coaches and team physicians can be avoided by a clear understanding that the physician has absolute authority concerning medical decisions [86]. Usually, good coaches and physicians come to realize that what is best for the individual player is what is best for the team.

Another source of stress relates to difficult confidentiality issues that may arise in cases where the team physician of a high-profile professional or collegiate team has to deal with the media. It is important to remember that the same standards of confidentiality apply to all patients, even a celebrity athlete [33]. Although team physicians have benefited from publicity that they have received, many experienced team physicians believe it is most ethical for physicians to discourage references to themselves in the media and should not use the media for personal gain [83].

Another consideration for the team physician is that a player's response to injury is sometimes influenced by contractual matters and the team physician may not be informed of the specific details. For example, a collegiate athlete on scholarship may exaggerate an injury to be declared medically unfit, thereby continuing to receive a scholarship without continuing to play. Conversely, a physician may be influenced by the athletic department or management to declare a poorly performing athlete medically unfit to clear a space for another scholarship athlete or another player on the roster for that team [35]. In professional sports, there may be incentives in contracts that could influence a player to hide or exaggerate an injury. A team physician may decide to operate on an athlete without having received an honest history [83]. As athletes progress to the collegiate and professional level, they often develop medical habits that are difficult for a physician to change, and they may distrust medical advice that does not correlate with what they already believe [36].

Despite the time involved and the possible financial, legal, and political drawbacks, many physicians still find the experience of being a team physician rewarding. The average length of time that team physicians

remain on the job is 11 years according to a survey conducted by the American College Health Association. This is an indication of the physicians' satisfaction with their role. Many physicians report that their personal relationships with the players and the ability to see their patients perform are especially enjoyable [79]. However, some physicians may find the stress of covering a game while worrying or hoping that no player gets hurt unpleasant [11]. There may be little or no direct financial benefit, but becoming a team physician may help to build one's practice and is a good community service [34,60,86,79]. A true sports medicine physician should not be concerned with the level of competition of the teams for which he cares---Michael Jordan gets the same injuries as a mediocre high school basketball player. Always remember that it is the athlete that is competing and not the physician. The skill of the athlete is no reflection on the skill of the physician. The athlete, not the physician, is the one who wins the medals [46]. And never forget that sport is "only a game" [47].

Conclusions

Team physicians must develop good relationships with all people connected with the teams with which they work, especially the athletic trainers. These trainers are the "front-line" caregivers and are the physician's eyes and ears. Ideally, the physician should also have a good relationship with the coach, and the coach should understand that usually what is best for the health of an individual player is also best for the team.

The team physician should relate to players similarly to the way he relates to all patients, with the exception that doctor--patient interactions may be more frequent with athletes. The same issues of documentation, informed consent, confidentiality, and professionalism apply to all patients, regardless of whether they are athletes, and regardless of their ability or fame. In today's legal environment, team physicians should be more diligent with documentation of most or all interactions with athletes, even in more informal situations such as training-room or side-line consults and for minor injuries.

It is imperative that team physicians establish a system for treating on-field emergencies. Ideally, both the doctor and athletic trainer should be certified in BLS and possibly in ACLS. There should be quick and reliable telephone access to arrange ambulance transport, and for some high-risk sporting events it may be prudent to have an ambulance on-site. It is also important to assure that appropriate medical and emergency equipment is available and easily accessible.

From both ethical and legal standpoints, a physician must have expertise in treating the problem that he is likely to encounter. Therefore, an orthopaedic surgeon team physician cannot simply be a good operative surgeon. Orthopaedic surgeons who become team physicians must develop experience and expertise in diagnosing and treating non-orthopaedic athletic problems. Conversely, non-orthopaedic surgeons who become team physicians must deveop expertise in problems of the musculoskeletal system. This expertise may be developed through courses, reading, or by working with more experienced team physicians. There are also formal team physician courses sponsored by organizations such as the American Orthopaedic Society for Sports Medicine, the American College of Sports Medicine, and the American Academy of Orthopaedic Surgeons.

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