

Client Control and the Limits of Professional Autonomy – Or why do Sports Physicians dope Athletes?

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1. Introduction

In a series of publications over the last two decades I have consistently argued that if we wish to understand patterns of drug use in sport then we need to examine the central role of sports physicians in the development and use of performance-enhancing drugs (Murphy/Waddington 1992; Waddington 1996; 2000; 2001; 2004; 2005; Waddington/Smith 2009). More precisely, I have argued that we need to understand the medicalization of sport, a process which has involved, particularly since the early 1960s, the increasing involvement of, and the increasing dependence of elite athletes upon, sports physicians in the pursuit of medal-winning or record-breaking performances. In this paper I want to draw upon research in both the sociology of sport and the sociology of medicine in an attempt to theorise the involvement of sports physicians in the doping process. More particularly I want to suggest that the involvement of sports physicians in doping should not be seen as an isolated example of unethical behaviour but that it should be seen as just one aspect of a more general pattern of unethical behaviour which is by no means uncommon in the practice of sports medicine. In this regard, I want to suggest that sports medicine is what Malcolm (2006a) has called “a very peculiar practice”, that is, it is a form of medical practice in which the constraints on medical practitioners are distinctively different from the constraints on practitioners in most other forms of medical practice and that these constraints mean that sports physicians are more likely to deviate from what are considered good standards of practice, in both a technical and an ethical sense, than are physicians in other forms of medical practice.

The systematic involvement of sports physicians in doping has been well documented elsewhere and there is no need to recite that evidence at length here. However, it may be worth reminding ourselves that there has hardly been a major drugs scandal in which sports physicians have not been central actors. Sports physicians in the Soviet Union were heavily involved in the development and use of drugs in the 1950s (Riordan 1994) and their efforts were paralleled on the American side by Dr John Ziegler, who played a major role in the development and dissemination among American weightlifters of Dianabol (Voy 1991; Todd 1987). From the 1960s, East German sports physicians were key players in the state-sponsored system of doping (Spitzer 2006). Sports physicians in the West were heavily involved in developing and refining the

technique of blood doping, which was used with such spectacular success by team doctors working with the American cycling team at the 1984 Los Angeles Olympics (Waddington 2000). Four years later, following Ben Johnson's disqualification at the Seoul Olympics, the spotlight fell on Johnson's doctor, Dr Jamie Astaphan, who had prescribed steroids to Johnson and, in the Dubin Inquiry which followed, evidence was presented of networks of physicians all over Canada and the U.S., and indeed many other countries, who were prepared to prescribe drugs to athletes (Dubin 1990). In 2004 the team doctor at Juventus Football Club in Italy was convicted of supplying players with performance-enhancing drugs, while the 1998 Tour de France provided clear evidence once again of the systematic involvement of team doctors in doping. In 2006 a major police operation in Spain revealed an extensive blood doping network run by Dr Eufemiano Fuentes in Madrid which involved perhaps as many as 200 elite athletes (Waddington/Smith 2009), while this conference is being held against a backdrop provided by the Evaluierungskommission which is investigating the involvement of sports physicians from Freiburg in the doping of cyclists in Team Telekom/Team T-Mobile. In summary, and as the British Medical Association (BMA) – not a body given to sensationalist statements – has noted, "it is clear that, at the elite level, the involvement of team doctors in doping is not uncommon and that it has not been confined to the former communist countries of eastern Europe" (BMA 2002, p. 84).

Of course, doctors who are involved in drug use are not just in breach of the rules of sport – and in some cases of the criminal law – but are also in breach of codes of medical ethics such as the World Medical Association's (WMA) declaration on principles of health care for sports medicine (WMA 1999). However, I want to suggest that this is not an isolated example of unethical conduct on the part of sports medicine practitioners; rather, it is part of a broader spectrum of unethical behaviour which is not uncommon in the practice of sports medicine. In order to understand this we need to examine the social structure of the practice of sports medicine.

2. Sports medicine: A peculiar practice?

The sociological study of sports medicine is in its infancy, with just a few published studies. Most of these have focused on the relationship between physicians and athletes with reference to how athletes define, give meaning to, and manage pain and injury, and these studies have identified important characteristics of the web of relationships in which sports physicians are involved. The work of Howard L. Nixon is a good place to start.

Nixon has made a major contribution to our understanding of the sociology of risk, pain and injury in sport (Nixon 1992; 1993; 1994; 1996). Nixon fo-

cuses on the interrelationships within sports groups, or “sportsnets” as he calls them, and attempts to identify the links between athletes and other members of the “sportsnet” such as other athletes, coaches and – of particular relevance for us – team medical staff. Nixon suggests that a central characteristic of sporting culture is the “culture of risk” and that the structural characteristics of “sportsnets” expose athletes to what he called “biased social support” – he refers to a “conspiratorial alliance” involving sports physicians as well as coaches and administrators – that can influence and impose messages which foster the acceptance by athletes of risk, pain and injury and an associated willingness to continue training and competing even when injured and in pain; he also notes that “sportsnets” insulate athletes from, and inhibit them from seeking, regular medical care from outside the sport system. Commenting on Nixon’s work, Stephen Walk has suggested that one implication of Nixon’s work is that “medicine is practiced differently, more competently, and/or more ethically in nonsports contexts” (Walk 1997, p. 24). To what extent is this the case? Does the network of relationships in which sports physicians are involved limit their professional autonomy and constrain them to make medical compromises, in terms of both technical and ethical aspects of practice, which their colleagues in other branches of medicine are less constrained to make? And if this is the case, then is the involvement of doctors in doping simply part of a more general process in which sports physicians are less constrained than are their colleagues in other branches of medicine to behave in an ethical fashion? An examination of the day-to-day practice of the team physician, drawing on some of the studies in this area, may help to answer some of these questions.

3. The day-to-day practice of sports medicine

In his book *“You’re Okay, it’s Just a Bruise”*, in which he details his work as a team physician with the Los Angeles Raiders, Huizenga (1995) presents a revealing and disturbing picture of medical practice in the National Football League (NFL), which he describes as a system based on “the dominating owner or coach selecting and paying for the team doctor – who is then magically expected to have the player’s best interest at heart” (Huizenga 1995, p. 315). The owner’s influence, he suggests, can be all-pervasive and can impact on all aspects of the team doctor’s role, including clinical decision-making. In this context, Huizenga documents the regular occurrence of malpractice and unethical behaviour by team physicians. Examples cited by Huizenga include the following:

1. A senior Raiders’ team physician who did not use a stretcher to move a player with a possible neck injury – thereby, says Huizenga, playing “Russian roulette” with the player’s spinal system – because the club owner did not want a stretcher to be used as he held “the team gets de-

moralized and plays less aggressively when they see a teammate getting carted off the field on a stretcher” (pp.124-5).

2. The non-disclosure of information to players about their injuries and “knowingly misrepresenting vital information to the patient” because the owner wanted the players to continue playing (pp. 258-271). The title of the book refers to an incident in which a player with a potentially dangerous spinal problem was told by a team doctor: “You’re Okay, it’s just a bruise”.
3. The prescription of anabolic steroids to “bulk up” a player (pp.149-50).
4. Doctors coaching young players to feign injury, against the rules of the NFL, so that they could deliberately fail an independent medical examination and thereby be placed on the injured reserve list. This allowed young players to develop their skills at the club while “hiding” them from other clubs who might seek to sign them.

Huizenga also cites one other revealing practice. Under a collective bargaining agreement, the contract of a player cannot be terminated while he is “physically unable to perform the services required of him”, i.e. while he is injured and Huizenga notes: “Currently when a dispute arises, team orthopedists testify against the player – their patient. It’s unheard of for a doctor in any other situation to testify against his own patient, unless that patient has literally committed murder” (p. 316). These incidents suggest that it may not be unusual for club medical staff to breach medical ethical guidelines, the rules of the NFL and/or the law by subordinating the interests of the individual player-as-patient to those of the club. Following the stretcher incident, Huizenga was on the point of resigning, saying: “It’s not ethical for me to stay here. I can’t be associated with this kind of medicine” (p. 125). He eventually resigned in protest when the club owner supported a team doctor who deliberately withheld information from a player about a potentially serious spinal problem (pp. 266-7).

4. Managing injuries: Return to play decisions and informed consent

Many of the unethical practices identified by Huizinga were also found in a study of club doctors and physiotherapists in English professional football by Waddington and his colleagues. For example they found that, as in the NFL, relevant information about their injuries may be not conveyed to players, or may even be deliberately withheld as a matter of club policy (Roderick/Waddington/Parker 2000, pp.175-6). It is significant that in the United States there has been a good deal of litigation concerning informed consent in the field of sports medicine, with a central claim in many cases being that information was withheld – either negligently or intentionally – from athletes

about the true nature of their conditions, thereby preventing the athlete from making a properly informed choice about his/her fitness to return to play (Herbert/Herbert 1991, p. 121). Such situations clearly raise serious ethical concerns.

In relation to return-to-play decisions in English football, the need to get players playing again as quickly as possible after injury constitutes a major constraint on club doctors and physiotherapists and also has potentially important implications for the quality of care which players receive (Waddington 2006). The need, as one physiotherapist put it, to “get players fit yesterday” leads to what one doctor called the “unfortunate” need to make medical compromises in his treatment of players (Waddington 2000, pp. 75-6). In this regard, Waddington et al. (1999) found clear evidence that in some situations the professional autonomy of clinicians may be severely restricted and team doctors and physiotherapists may find themselves involved in situations in which players are regularly returned to play before they are medically fit to do so. Under these conditions, team doctors and physiotherapists appear to have two choices, both of which are problematic. They may simply adapt to and accept the situation, in which case the quality of care they are able to offer will be compromised to a greater or lesser degree. Alternatively, they may come to feel that their professional autonomy has been so compromised that they are unable to do their job in what they consider a properly professional manner. Significantly, Huizenga’s book suggests that physicians in the NFL may find themselves with a similar dilemma: either accept the constraints imposed by club owners and provide care which may be seriously compromised or, as Huizenga did, resign because it is not possible within that situation to provide what the doctor feels is an acceptable level of care.

A particularly striking example of the way in which team physicians may be constrained to make clinical compromises is provided by Malcolm’s work on rugby club doctors in England. The example relates to the diagnosis of concussion. In recent years there has been growing concern about the long-term health risks associated with concussion. In order to protect players’ health, the International Rugby Board (IRB) has adopted a precautionary policy which requires that any player sustaining any concussion must abstain from playing and training for a minimum period of three weeks “and should only resume when declared symptom free after a medical examination” (Malcolm 2009, p. 196).

However, one consequence of the IRB rule is that any diagnosis of concussion will automatically deprive the club of the player’s services for three weeks. Within this situation, the resistance of players and coaches to a diagnosis of concussion has led “to a rejection of treatment protocols”. Thus Malcolm found that most club doctors have effectively rejected the IRB guidelines and their underlying precautionary philosophy, and that many go to considera-

ble lengths to avoid offering a diagnosis of concussion, with the loss of the player's services which this would entail. Some doctors even argued that loss of consciousness – traditionally regarded in the medical literature as the most serious symptom of concussion – was not, on its own, sufficient to diagnose concussion (Malcolm 2009, p. 202).

Malcolm (2009, p. 205) notes that a rule which was designed to protect players' health has actually had "the unintended consequence of leading clinicians to avoid the diagnosis of concussion" and he concludes that clinicians "come to diagnose concussion in a way that they know will be acceptable to others" (Malcolm 2009, p. 201), i.e. to coaches and players; in effect, club doctors have simply abandoned a medical definition of concussion and have substituted for it the lay understanding of coaches and players. As Malcolm notes, "Allowing sporting performance criteria to override medical guidelines [...] enables the diagnosis to become consistent with rugby players' (and coaches') own definitions of what constitutes an injury" (Malcolm 2009, p. 191). Clearly the professional autonomy of physicians is seriously undermined in a situation in which diagnosis and treatment come to be dependent on lay, rather than clinical, criteria.

Perhaps the most striking recent example of unethical medical practice in rugby was provided by the so-called "Bloodgate" scandal involving Harlequins Rugby Club in 2009. Trailing in an important match, Harlequins wanted to bring on a specialist kicker, Nick Evans, but Evans had previously been substituted and could only return to the game as a temporary substitute for a player with a blood injury. Another player, Tom Williams, had been given a sachet of fake blood which he used to produce the effect of a bleeding mouth injury. He was led off the field by the club physiotherapist – who had been a party to the plan – but the club doctor on the opposing side was suspicious and asked to examine the "injured" player. In the dressing room, the Harlequins club doctor then made a small incision in Williams' mouth to produce genuine blood. Following a disciplinary hearing at the Health Professions Council, the physiotherapist was struck off the register, while the General Medical Council held that the doctor's action had "not been in the best interests of her patient" and she was given a formal warning that her actions had been "unacceptable". (*Guardian*, 19th August 2009; *Sunday Times* 23rd August 2009; *Guardian* 24th August 2010; *Daily Mail* 6th September 2010; *Guardian.co.uk* 14th September 2010). It is clear that the medical staff allowed their commitment to the club's sporting success to override their commitment to the ethics of medical practice and the case illustrates very clearly the pressures on club medical staff to deviate from good practice.

5. Patient confidentiality

In a study of team medical staff in English professional football, Waddington and Roderick (2002) found that breaches of patient confidentiality were not unusual. More specifically, they found that there is no commonly held understanding governing the management of confidential issues and there are considerable variations in terms of both the amount, and the kind, of information about players which doctors and physiotherapists pass on to managers/coaches. Several physiotherapists emphasised that they were employed by the club and saw this as sufficient justification for passing on information which would normally be considered confidential, such as information relating to a player's drinking habits or other aspects of a player's off-the-field lifestyle.

Waddington and Roderick also identified serious breaches of medical ethics among doctors; the most flagrant breach occurred in a case in which a club doctor clearly acted as an agent for the club and used confidential medical information about a player to advance the interests of the club over and against those of the player. In this case, the club doctor threatened that he would make public medical information about a player – information which was actually incorrect and which exaggerated the extent of a player's medical problems – in order to undermine the player's desired transfer to another club (Waddington/Roderick 2002, pp. 120-1).

A study of 16 sports physicians in New Zealand revealed a similar lack of consistency in terms of how physicians deal with confidential issues. Some of the New Zealand physicians had accepted contracts which actually obliged them to share medical information with coaches and team management and five physicians said that they were prepared to disclose information, even against the wishes of the athlete, but in line with their contractual obligations; in this situation the interests of the individual athlete-as-patient were clearly subordinated to those of the club (Anderson 2009, p. 1080). Writing from an American perspective, Mellion and Walsh (1994) have similarly noted that confidentiality is "often compromised" by the doctor's relationship to the club and that "information is seldom held in the strict doctor-patient confidentiality".

Although there is clearly a need for more studies in this area, there are enough data to suggest that breaches of patient confidentiality may not be unusual within the sports medicine context. The UK General Medical Council (G.M.C.) has noted that "patients have a right to expect that [doctors] will not disclose any personal information [...] unless they give permission" (G.M.C., not dated, 2), but it seems that elite sportspeople may not infrequently be denied a right which other patients routinely enjoy.

6. Sports medicine, client control and medical practice

In a classic essay Eliot Freidson (1960; 1966) pointed out that medical professionals cannot exist without clients but that clients “often have ideas about what they want that differ markedly from those held by the professionals they consult” (1966, p. 260). As a result, consultations between practitioners and clients often involve a clash between “two different, sometimes conflicting, sets of values”, based on differing understandings of health and illness. Freidson noted that there may be more or less congruence between the lay cultural understanding of the client and the professional understanding of the physician and that, to understand what takes place in medical practice, it is necessary to examine the relative sources of power of doctor and patient. This led Freidson to propose two polar types of medical practice: (i) colleague-dependent practice, in which interaction is primarily dependent on the professional evaluations and decisions of the doctor and his/her professional colleagues and (ii) client-dependent practice, in which interaction between doctor and client is largely dependent on the lay evaluations and decisions of clients.

A critical determinant of the type of practice, suggests Freidson, is the setting within which the practice is located. In this regard, the “authoritative source of professional culture” is located in professionally controlled organizations such as hospitals and medical schools (Freidson 1966, p. 267). Of critical importance is the fact that the further this professional system is penetrated, the more free it is of the lay influence of patients. Thus, a “layman seeking help finds that, the further within it he goes, the fewer choices can he make and the less can he control what is done to him. Indeed, it is not unknown for the ‘client’ to be a petitioner, asking to be chosen: the organizations and practitioners [...] within the professional referral system may or may not ‘take the case’, according to their judgement of its interest”. As a result: “Choice, and therefore positive control, is now taken out of the hands of the client and comes to rest in the hands of the practitioner, and the use of professional services is no longer predicated on the client’s lay understandings – indeed, the client may be given services for which he did not ask, whose rationale is beyond him” (Freidson 1966, pp. 267-8).

At the other extreme, suggests Freidson, is the position of practitioners located in the local community. Unlike hospital doctors, who receive their patients by referrals from other professionals, doctors who practise in the community are dependent on attracting their own lay clientele and, in order to do so, are constrained to behave in ways which are in closer accord with lay expectations. As Freidson notes in relation to community-based practice, to “survive without colleagues, it must be located within a lay referral system and, as such, is *least* able to resist control by clients, and *most* able to resist control by colleagues” (Freidson 1966, p. 268, italics in original). Thus whereas the hospital-based doctor is surrounded by professional colleagues, is subject to their

evaluation and is expected to be responsive to the clinical and ethical standards which they share, the community-based practitioner (especially the isolated solo practitioner) is not surrounded by or subject to evaluation by professional colleagues but is much more subject to evaluation by, and is therefore required to be more responsive to, the lay demands of his/her clients for it is they, rather than professional colleagues, who will determine the success or otherwise of the community-based practice. And as Freidson notes, lay influence may more or less control not only the practitioner's success in attracting clients, "but, to some extent, also his professional technique and manner" (Freidson 1966, p. 266).

The peculiar features of the situation of the team physician in professional sport mean that this type of practice is characterized by an even higher degree of client control than is normally the case in community-based practice. In this regard, the contrasts between the position of the hospital-based doctor and the team physician are striking. The team doctor works within an organization in which the key values are not professional values relating to health, but lay values relating to sporting success. And if hospital doctors are the highest status workers – the "stars", as it were – within the hospital, the "stars" within sports clubs are the players and coaches, while the doctors are reduced to the role of lower status, "bit part" players, mere "service workers", whose job it is to look after the stars. Significantly, their remuneration and status within the clubs is often consistent with their position as service workers. Huizenga, for example, records that he "apologetically" raised the issue of his salary with the owner of the Los Angeles Raiders, who offered him, in a "take it or leave it" manner, an annual salary which was less than many players received for a single game (Huizenga 1995, p. 63). A similar point was made by a doctor at an English football club, who said that the club quibbled about his bill, even though it was "peanuts", while another club doctor indicated that he received just £5,200 per year for his services, even though he had calculated that, applying the BMA's recommended scale of charges to the number of hours he worked, he should have been receiving £25,000 (Waddington et al. 1999, pp. 9-10, 13-4). And if their remuneration is often commensurate with their role as service workers, so too is their non-financial status. In his study of rugby club doctors, Malcolm (2006a, pp. 176-7) recorded "a number of incidents where medical staff were demeaned by the behaviour of others within the rugby club setting" and he noted that the "level of respect afforded to some medical staff in some rugby club contexts [...] marks out sports medicine as being [...] characterized by social rules quite different from those of other, 'normal', forms of medical practice, where great respect is usually accorded to medical practitioners". And far from respecting their status as medical experts, some managers in English football simply disregarded the advice of their own club doctors and physiotherapists (Waddington 2000, pp. 71-9).

Not only do team doctors work in a situation which is dominated by lay sporting values but this is also a situation in which, unlike doctors in many other settings, they are frequently professionally isolated. Thus Malcolm (2006b, p. 383) noted that rugby club doctors “tend to work in isolation from other professional colleagues” while, in professional football, Waddington (2000, p. 77) found that not only were club doctors professionally isolated within the club, but there were also few opportunities for them to meet professionally with doctors from other clubs (Waddington et al. 1999, p. 14). As Freidson has noted: “All else being equal in this situation of minimal observability by colleagues and maximum dependence on the lay referral system, we should expect to find the least sensitivity to formal professional standards and the greatest sensitivity to the local lay standards” (Freidson 1966, p. 269). This is, it is suggested, what we frequently find in the case of sports medicine.

One final point needs to be addressed. If club doctors are constrained on a day-to-day basis to make medical compromises, and also to accept what they would, in other circumstances, certainly regard as unacceptable rates of pay as well as relatively low status, then we need to ask: why do doctors accept such forms of employment? On this issue the evidence relating to job motivation is clear.

7. Job motivation

By far the most common motivation which leads doctors to accept employment as team doctors relates not to professional goals, such as improving clinical expertise or qualifications, or moving into sports medicine as a full-time career – most club doctors continue to work in another area of medicine which constitutes their main source of income – but rather, derives from their longstanding love of sport and, in many cases, their commitment to a particular team. One English football club doctor, whose father had been the previous club doctor, explained: “I did medicine so that I could be the team doctor – I wasn’t interested in any other team”. Another club doctor said: “Basically although I’m 46, there’s a ten year old boy inside saying ‘Fantastic! Fantastic! It’s great’”, while another doctor said that he did the job because he had always enjoyed playing football and being a club doctor was “the next best thing to playing” (Waddington et al. 1999, p. 10). In rugby, Malcolm noted that the most commonly cited motivations for acting as club doctor were “support for the team” (82.4 per cent) and a “general interest in sport” (67.6 per cent) with just 5.5 per cent indicating that their interest in sports medicine was a major motivational factor (Malcolm 2006a, p. 170). In the American context, Huizenga describes a visit to the office of Dr Rosenfeld, who was a senior doctor with the Los Angeles Raiders. Huizenga says that Rosenfeld had “one of the largest Beverly Hills practices and took care of a veritable Who’s Who of Hol-

lywood stars. But once I stepped into his office, I could see what made him really proud. His walls were plastered with Raider memorabilia and multiple shots of Dr Rosenfeld assisting dazed athletes off the field with thousands of spectators serving as a blurry backdrop” (Huizenga 1995, p. 8).

Most club doctors have a strong and prior commitment to sport before they enter club medical practice. As Freidson has noted, there may be a marked discrepancy between the professional culture of doctors and the lay culture of their patients; however, in the case of team medical practice, it might be suggested that this gap is bridged, not by the fact that the patients share the professional culture of the doctor but, on the contrary, by the fact that the team doctor shares the sporting culture of his/her clientele. What are the key elements of this sport ethic?

Coakley (2007, pp. 161-3) has noted that the key aspects of the sport ethic are a dedication to “the game” above all else; a relentless striving for improved performance; an acceptance of risk and a willingness to play through pain and injury; and an unwillingness to accept obstacles in the pursuit of sporting success. He also suggests that many forms of deviance within sport, such as drug use and violence, may be understood as arising not from a rejection of these norms of sport but as a result of over-conformity – that is an unquestioned acceptance of and extreme conformity to these norms in the pursuit of sporting success. This type of “overdoing-it deviance”, he suggests, involves an over-commitment to the goal of sporting success which may lead, for example, to the willingness to risk serious injury in order to continue competing and to an acceptance of drug use or other unfair means if these enhance the likelihood of sporting success.

Coakley’s concept of over-conformity is also helpful in understanding those aspects of the behaviour of sports physicians which deviate from what is generally considered good medical practice. Many club doctors, it is clear, have a longstanding and real commitment to the sport ethic. However, key aspects of the sport ethic sit uncomfortably alongside the key values of medical ethics. And just as some athletes develop an over-conformity to the sport ethic so too, it is suggested, do some team doctors. Thus while team doctors will have a dual allegiance to medical ethics and to the sport ethic, their work situation constrains them to pay greater attention to the latter at the expense of the former; in short, the work situation of team doctors constrains them to “buy into” the sport ethic and to the key goal of sporting success and, at least to some degree, to “buy out of” medical ethics. The clearest example of this process of over-conformity to the sport ethic and the associated “buying out of” medical ethics is provided by the widespread involvement of sports physicians in the development and use of performance-enhancing drugs.

8. Conclusion: Physician behaviour and deviant medical careers

Jörg Jaksche, a professional cyclist who admitted using drugs while at Team Telekom, said of the two team doctors who were involved in doping riders that: “I think they were most of all concerned about being close to the athletes and sharing in their success. A kind of love, a sick sort of affection” (Hacke 2011). Detlef Hacke, a journalist of *Der Spiegel* who investigated the doping scandal at Team Telekom, had met one of the team doctors, Lothar Heinrich, on several occasions and he says that Heinrich “did not view his work as just some job that had to be done. He enjoyed being part of a winning team; he relished the attention, the interviews. He loved to sit on a racing bike” (Hacke 2011). These comments hint very strongly at an over-identification with the riders and teams and with the over-commitment to their success suggested by Coakley’s concept of “overdoing-it deviance”.

We know a good deal about the constraints faced by elite level sportspeople and the ways in which these constraints – particularly the greatly increased importance which has come to be attached to winning – may be associated with the decision to use performance enhancing drugs. What has been much less studied are the constraints on team physicians to deviate from conventionally accepted standards of professional behaviour. In this regard a research agenda might usefully consider the following questions. Given their involvement in “sportsnets” and their often strong personal interest in sport, to what extent are team physicians themselves constrained by the greatly increased importance which has come to be attached to winning and by a sporting agenda in which “second place doesn’t count”? To what extent do they experience pressure, perhaps not just from athletes but also from the coaches, managers and others, to supply athletes with performance-enhancing drugs? How easy is it to resist such pressures where the prescription of such drugs may mean the difference between winning and losing an important competition which may involve considerable international prestige? To what extent do doctors themselves understandably wish to be part of a medal-winning or record-breaking team? Is not such participation in a winning team in itself testimony to their professional skill, even if this is used in a way which might generally be considered deviant? In much the same way that it is important not to see the drug-using athlete as an isolated individual, so it is equally important not to see drug-prescribing doctors as isolated individuals, but to examine the everyday constraints on their behaviour and the ways in which these constraints might open up deviant careers within medicine.

9. References

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