The Sociology of Return-to-Play Decision Making: A Clinical Perspective

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An 18 year-old female member of the national soccer team underwent an anterior cruciate ligament reconstruction 6 months previously. The university's athletic therapist cleared the athlete for training the week previous. There is an important competition for her university this weekend and the university coach wants the athlete to play and believes she is ready to compete. The athlete says she wants to play. The national team physician/surgeon becomes aware of the situation just prior to the weekend and does not feel that it is safe for the athlete to compete.

Rational decision making requires weighing the benefits and risks of different alternatives.1–3 In the sport medicine setting, making return-to-play (RTP) decisions within a team environment can be difficult and complex. In contrast to settings in which life decisions are primarily about oneself, a clinician’s role is to determine a reasonable course of action for a seemingly independent third party, the athlete, with particular attention to the risks and benefits that flow from any decision. Although clinicians are sometimes required to make decisions, within specific parameters, for patients who are incapacitated, RTP decisions are made for someone who is otherwise capable of making autonomous decisions. A clinician’s decision may conflict with the athlete’s viewpoint, and the process of dispute resolution can be complicated and jeopardize a physician–patient relationship. It is often unclear how much weight should be afforded to information provided by a coach or family who may, or may not, have an athlete’s best interests at heart. A potential conflict of interest is present if the clinician derives remuneration or nonfinancial benefit as a result of association with the team; finally, there may be unique pressures as a result of the conflicting expectations of a team, other health professionals, the public, and the media.

The above considerations relate directly to an individual clinician making a single decision. The clinical vignette above illustrates how complex the actual decision-making process can be—even when caring for an elite amateur athlete. When the full spectrum of RTP decisions are made in a “real-world” context, views from the athlete, physician, physical therapist, athletic trainer, coach, teammates, team administration, agents, and athlete’s family must be anticipated and assessed. In addition, it may not always be clear who holds the “seat of power” within the decision-making process: in some situations, the “coach is king,” whereas in others the “physician reigns supreme.” In other settings, for example, Workers’ Compensation Agencies, the opinion of another physician is usually required to override a treating physician’s opinion,4 and external pressures may be different because injured workers are generally (but not always) better protected than athletes from losing their position.

Given the complexity of these issues, it is surprising that a literature search on the sociology of decision-making processes within sport yielded only a few articles examining how athletes, coaches, and physicians view RTP decisions; no articles were identified specifically addressing the underlying processes that might guide such decisions.
The results of interviews with athletes, coaches, medical teams, and our own clinical experience permit an examination of some perspectives that are relevant to this important clinical reality and serve to highlight areas that would benefit from increased attention.

What motivates an athlete to want to RTP?… or not? Notwithstanding fear or anxiety regarding the possibility of re-injury, important internal factors impelling an athlete to return as soon as possible include (1) a perception of “body betrayal” and the “self-resentment” that may accompany injury, and (2) a strong psychological need to compete or an overriding “love of the game.”

External factors include sociocultural influences and widespread willingness of athletes to accept higher risks of injury because they are accorded greater status among peers and fans. These pressures can lead some athletes to experience an identity crisis, have feelings of guilt and shame, or experience alienation from the team when injured. All of which can lead to low self-esteem and depression.

Although some athletes would like to make RTP decisions themselves, others indicate that they have learned to trust physicians and trainers to make decisions for them and believe it is important for medical personnel to prevent them from returning to sport prematurely. Conversely, some athletes have reported being pressured into returning to sport too early by the physician, trainer, or coach.

Caught in a “risk–pain–injury paradox,” coaches believe their function is to push athletes to their limits without taking excessive risks, which may include competing while injured. Although elite coaches have reported that medical clearance was necessary before training could begin, they have also expressed the view that they possessed important and relevant information central to the RTP decision-making process.

Some felt, for example, that medical personnel did not always appreciate the necessity of an individualized approach and that delaying return to training or play may sometimes harm the athlete: “We believe that [the athlete] has too much time where they do nothing and while they’re doing nothing, everything is degenerating. We believe they shouldn’t do nothing (sic), they should do something, even if it’s a little something.” In addition, many elite coaches consider themselves responsible for managing unrealistic athlete expectations about progress after an injury and return to sport.

When several health professionals are involved in caring for an athlete, the lines of communication and authority must be clearly defined or what is already a complex situation for RTP is likely to become even more problematic. According to one consensus document, the essential elements for RTP decisions are the safety of the injured athlete and other athletes, as well as compliance with any rules or regulations. Although some have mentioned that social and economic factors may create pressure for the clinician, an explicit statement of the role such factors play has not been proffered. Because of the absence of clear recommendations, individual treating clinicians have been described as using their own value and belief systems, which often include issues other than safety.

Although power relationships within society are commonly studied in medical sociology, this has not occurred within the context of RTP decisions and the interaction between the multiple individuals and institutions involved. Family, friends, agents, coaches, clinicians, and institutional or corporate managers have interests in RTP decisions, and their interactions are often complex and confusing. Although “negotiation” of approaches to treatment between clinicians and athletes occurs frequently, the clinician usually has ultimate decision-making power. But when athletes avoid interaction with clinicians, they retain power over the decision-making process by default. Coaches may prefer to interact directly with clinicians because they fear athletes will “put their own spin” on any recommendation. Some coaches believe that clinicians who are ex-athletes have a better understanding of the psychosocial factors involved. It is also possible that coaches, like athletes, sometimes prefer to avoid approaching clinicians altogether.

Because determining prognosis is difficult and frequently subjective, some disagreements regarding RTP will always occur. But differing sociocultural and clinical perspectives of the physician, coach, athlete, and others lead to a high potential for conflict. Two important factors may minimize development of such conflict: a formal structure or process outlining how an actual RTP decision should be made and a formal process to guide the interactions between individuals who contribute in any way to the RTP process.

We recently described a 3-step decision-based RTP model that provides a structure for how the decision can be made. It includes an evaluation of health status, an assessment of injury risk, and an examination of other advantages and disadvantages of RTP. It is important, in considering RTP issues, to identify areas for traditional sport medicine research (eg, what factors contribute most to injury risk) and to consider how the input of others (eg, epidemiologists, sociologists, ethicists) might improve our decisions. For example, because there is always risk associated with activity, the most relevant question for RTP decisions is whether there is an unacceptable risk. Is it acceptable to prevent a female softball player from RTP if her risk is twice normal [normal risk = 4.3 injuries per 1000 athlete exposures (AE)]? When it is still only 25% the risk of playing men’s football (normal risk = 35.9 per 1000 AE)? Furthermore, in a rational decision-making model, decisions are based on an assessment of all the benefits and harms surrounding alternative choices; injury risk is only 1 potential harm. Other factors such as social (eg, athlete self-identity), economic (eg, Olympic athlete with sponsorship potential), political, and legal issues broaden the context for defining what is considered an acceptable injury risk or an appropriate RTP decision.

The complexity surrounding RTP decision-making processes offers interesting opportunities for future research. Who should be responsible for creating the supportive psychosocial environment required to help regain pre-injury physical and mental status? Are potentials for conflict of interest transparent? How does trust develop among the coach, athlete, and clinician? What is the power hierarchy within a multidisciplinary health care team? Should the clinician be reporting risk separately and then allow others to help determine if this risk is acceptable?

In summary, the current decision-making process is embedded within a social context reflected principally by the
values, beliefs, and attitudes of the ultimate decision maker. The steps in the process are not always transparent; this can lead to confusion and unnecessary conflict. Given that RTP decisions represent a fundamental element of sport medicine practice (every athlete/patient who is injured is given advice on when it is appropriate to resume activities), it is time that we learn more about how, when, where, why, and by whom these decisions are made in different sport settings and how such processes can be improved.

REFERENCES