HEALING THE BODY IN THE ‘CULTURE OF RISK,’ PAIN, AND INJURY: NEGOTIATIONS BETWEEN CLINICIANS AND INJURED ATHLETES IN CANADIAN COMPETITIVE INTERCOLLEGIATE SPORT

by

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A thesis submitted in conformity with the requirements for the degree of Master of Science Graduate Department of Exercise Sciences University of Toronto

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Healing the Body in the ‘Culture of Risk,’ Pain, and Injury: Negotiations between Clinicians and Injured Athletes in Canadian Competitive Intercollegiate Sport

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Master of Science, 2001

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ABSTRACT

As researchers, we must question the effect and influence of those who, in essence, are in the front lines of the sport injury/pain complex – sport medicine clinicians. Using a combination of semi-structured one-on-one interviews and focus groups with athletes, coaches, and sport medicine clinicians, this case study examined the negotiation of treatment between clinicians and athletes in an intercollegiate setting. While a number of findings were drawn from this study, they included the evidence that a ‘culture of risk’ was reinforced under certain circumstances during negotiation, but was tempered by the existence of a “culture of precaution” that worked to resist those influences. Clinicians acknowledged the benefit of working with student-athletes who recognise the importance of academics, and who tend to be cautious when injured, particularly with head injuries. Recommendations were offered to maintain and improve the negotiation of treatment, and included a greater focus on the role of coaches.
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# TABLE OF CONTENTS

ABSTRACT  

ACKNOWLEDGEMENTS  

CHAPTER 1  
INTRODUCTION  

Research Question(s)  
Assets and Limitations  

CHAPTER 2  
REVIEW OF LITERATURE  

Socio-Cultural Nature of Pain and Injury  
Injury Rates and Costs  
Pain and Injury  
Positive Deviance and The Sport Ethic  
The Construction of Gender in Competitive Sport  
The Organisational Nature of Sport Medicine  

Understanding the Clinician-Patient Relationship  
Negotiations  
Physician-Patient Negotiations  

Medico-Legal and Policy Related Issues  

Returning to the Research Question  

CHAPTER 3  
RESEARCH DESIGN  

Qualitative Research – Related Literatures and Rationale  
Qualitative Methods and Field Research  
Inductive Analysis and Grounded Theory  
Semi-structured Interviewing  
The Interview Guide  

Procedure and Data Analysis  
(1) Sport Medicine Clinicians  
(2) Intercollegiate Scholar-athletes  
i) Focus Groups  
ii) Interviews  
(3) Intercollegiate Coaches  
Data Analysis  

iv
### Methodological Experiences

- Getting In
- Learning the Ropes and Maintaining Relations
- Leaving and Keeping in Touch
- Writing Myself "Back into the Narrative"

#### CHAPTER 4

**RESULTS and DISCUSSION, I**

- Question 1 – Existence of a ‘Culture of Risk’
  - “Injury Talk” and Risk Rhetoric
  - Nature of Sport
  - Having an Athlete’s Mentality
  - Stage of Season/Varsity Career

- Question 2 – Negotiation of the ‘Culture of Risk’
  - Timing of Season
  - Type of Athlete
  - Nature of Sport

- Question 3 – Conflicting Roles

#### CHAPTER 5

**RESULTS and DISCUSSION, II**

- Interpreting Sport Medicine and a ‘Culture of Risk’
- Spheres of Influence
- Figure 1: Spheres of Influence

- Cyclical Nature of Sport Medicine within a ‘Culture of Risk’
- Figure 2: Cyclical Nature of Sport Medicine within ‘Culture of Risk’

- Making Contact
- Figure 3: Making Contact

- Sites of Negotiation
- Figure 4: Sites of Negotiation – Physician
- Figure 5: Sites of Negotiation – Therapist

- Exiting the Clinician/Patient-Athlete Relationship
- Figure 6: Exiting the Clinician/Patient-Athlete Relationship

#### CHAPTER 6

**CONCLUSIONS and RECOMMENDATIONS**

- Limitations and Recommendations
<table>
<thead>
<tr>
<th>REFERENCES and APPENDICES</th>
<th>201</th>
</tr>
</thead>
<tbody>
<tr>
<td>References</td>
<td>201</td>
</tr>
<tr>
<td>Appendix I: Faculty of Physical Education and Health, University of Toronto, Mission Statement</td>
<td>211</td>
</tr>
<tr>
<td>Appendix II: World Medical Association Declaration on Principles of Health Care for Sports Medicine</td>
<td>212</td>
</tr>
<tr>
<td>Appendix III: Code of Ethics of the Canadian Medical Association</td>
<td>215</td>
</tr>
<tr>
<td>Appendix IV: Varsity Handbook</td>
<td>219</td>
</tr>
<tr>
<td>Appendix V: A Brief History of the David L. MacIntosh Sport Medicine Clinic</td>
<td>222</td>
</tr>
<tr>
<td>Appendix VI (i): University of Toronto, Faculty of Physical Education and Health, Informed Consent</td>
<td>224</td>
</tr>
<tr>
<td>Appendix VI (ii): University of Toronto, Faculty of Physical Education and Health, Informed Consent</td>
<td>225</td>
</tr>
<tr>
<td>Appendix VII: Clinician Interview Guide</td>
<td>226</td>
</tr>
<tr>
<td>Appendix VIII: Patient-Athlete Interview Guide</td>
<td>227</td>
</tr>
<tr>
<td>Appendix IX: Focus Group General Question Areas</td>
<td>228</td>
</tr>
</tbody>
</table>
CHAPTER 1
INTRODUCTION

In a rare television moment, a former team doctor admits that during his tenure with the Toronto Argonauts, he allowed players to play professional football even though he “should have failed them on their physicals” (McIlvride, 1994). With “swollen and arthritic knees,” he allowed athletes who were at “the last stages [of their careers]” to play because they were “smart, team leaders, and [because] the coaches wanted them” (McIlvride, 1994). He notes, on camera, that the sport medicine staff would “baby their knees,” and that the players would never complain of their injuries in fear of getting cut from the team (McIlvride, 1994). While players continue to play with decimated bodies in the professional football league, another type of phenomenon is occurring on a Canadian intercollegiate sport team. At a medium-sized university in Ontario, players on a specific (contact sport) varsity team know that if their coach were to find out about an athlete having an injury, that athlete would be taken off the team roster until s/he had recuperated (P. White, personal communication, 1999). The players respond by hiding and covering-up injuries, because they also know that this particular coach will not allow them to return to the field, until they produce medical documentation that certifies them as ‘able to return to play’ (P. White, personal communication, 1999). These two anecdotes represent situations that fall along a continuum of responses to pain, injury and risk in competitive sport. A continuum that, at one extreme, includes the hiding of injury out of fear, which some times results in permanent damage, paralysis and even death (McIlvride, 1994; Tator et al., 1993).

As Sabo (1989, p. 84) writes, “my pain – each individual’s pain – reflects an outer world of people, events, and forces. The origins of our pain are rooted outside, not inside, our skins.” This idea crystallizes the core of research on the culture of pain for men and women in competitive sport. The processes surrounding pain and injury in sport are social phenomena that are pervasive, serious and dangerous to the health and wellbeing of many people. More
importantly, they occur in an environment that is cloaked in uncritical and unquestioned acceptance and idealisation. In following this idea, Young and White (1995, p. 56) suggest that "sport-related norms prescribing tolerance of pain and playing while injured call into question what it is that our culture requires of athletes who want to succeed in sport." Dominant male sport structures retain deep significance as an arena of gender verification, but the gendering of sport is never static, and continually changes as women migrate and colonise forms of sport, and their ideologies, that were traditionally the preserve of men. A dilemma for both male and female athletes is that, what has been termed the "culture of risk," (Nixon, 1992) teaches athletes to accept risk-taking in sport and to minimise or ignore pain and injuries as much as possible, but it does not protect them from the physically, socially, economically, or emotionally debilitating or disabling consequences of chronic pain and serious injuries.

As researchers, we must continually raise questions about the lived contradictions for women and men regarding the supposed healthfulness of competitive sport and the real experiences of pain and injury in sport. But, we must also acknowledge and question the effect and influence of the other key characters in the competitive sport system – particularly those individuals who, in essence, are at the front lines of the sport injury/pain complex – sport medicine clinicians. The body figures centrally in sport and physical activity as well as the need to maintain and repair it, but little research attention has been paid to how medical clinicians figure in the lives of athletes and in competitive sport. A critical examination must be made of the role of the sport medicine clinician in competitive sport settings; how their actions and behaviours affect athletes; and how they negotiate with patient-athletes regarding the maintenance of overconformity to a sport ethic that is widely believed to involve a ‘culture of risk’ and pain.
With the exception of a few occupations (see Young, 1993), there are no other activities in social life where people assume risk and injury in the same ways as they do in competitive sport. What has resulted, then, is an almost blasé acceptance of pain and injury, and an unquestioned tolerance and commitment to a ‘culture of risk’ that is most pronounced around pain and injury. Hughes and Coakley (1991) suggest that the processes that normalise risk-taking, and pain/injury tolerance are part of a larger phenomenon where many athletes overconform, what they term “positive deviance,” to a set of values. Such athletes have defined these values for themselves as the core meanings and beliefs of their sport experience, what Hughes and Coakley (1991) call “the sport ethic.” The sport ethic includes pushing ones’ limits, or being willing to take risks, or not accepting physical injury in pursuit of personal sporting excellence. These beliefs are not necessarily negative, and in many ways, they are beliefs that help individuals to push their bodies to perform amazing feats of physical, psychological and emotional strength. But, they do become problematic when individuals adopt these beliefs uncritically and to an extreme, immersing themselves unquestionably into a ‘culture of risk.’

It is important to address the terms, ‘culture,’ and ‘risk,’ in greater depth. Very broadly, culture can be interpreted at two levels. Firstly, it defines a particular way of life where certain norms, values – the ways and means of human life – are shared by a collective group of individuals. Eagleton (1991, p. 28) suggest that culture, like ideology, “denotes the whole complex of signifying practices and symbolic processes in a particular society; it would allude to the way individuals ‘lived’ their social practices, rather than to those practices themselves.” While Williams (1976, p. 91) also supports a definition of culture that makes reference to the “signifying or symbolic systems” of human life, culture can also be seen as the active re/production of norms and values by people in social contexts, thus implying the ‘making’ of
culture by humans. Risk and risk-taking can be defined in terms of the knowledge of potential loss or the encountering of harm or loss. In essence, it is knowing that something could go wrong in an activity, and still pursuing that activity. Much like the sport ethic, risk and risk-taking are not necessarily negative phenomena, and there are positive aspects to both. In terms of the human condition, certain types of risk-taking can be seen as altruistic (e.g., firefighting), while others can be and are admired and even be appropriate. In the context of this project, Nixon (1992) suggests that the normalisation of playing with pain and injury is so common in competitive sport, among athletes who are aware of the potential negative consequences of their actions, that he suggests that such competitive sport is characterised by a 'culture of risk.' Other ethnographic studies (e.g., Roderick & Waddington, 2000; Walk, 1997; Young & White, 1995; Young, White & McTeer, 1994) show that this culture is far more complex than Nixon implies. While all recognise that there is widespread acceptance and tolerance of pain and injury in competitive sport, they also recognise the complex ways in which athletes and others produce and respond to this culture. For convenience, and because this project is primarily concerned with the negative aspects of risk and risk-taking, the term ‘culture of risk’ will be used throughout the text in reference to this phenomenon. However, the complexities identified by the studies involving fieldwork are also evident here.

In addition to the issues of injury in sport and the ‘culture of risk,’ this study is also concerned with the negotiation of medical treatment in a sport ‘culture of risk.’ While there is an established literature on the negotiation of treatment in the sociology of medicine, health and illness, such negotiations have not been investigated in sport medicine. We must first ask if there is something unique about sport medicine, is it different from other forms of medicine? Do sport medicine clinicians have ‘special’ ethical responsibilities to their patients? Sport medicine may
be different from other forms of medicine since the individuals who access it are fit and healthy individuals dealing with injury or setback. They also tend to be individuals who are inclined to take risks in a culture where such risk-taking is normalised. The situation with child athletes raises even more important questions about ethical responsibility that are beyond the scope of this study. In the case of intercollegiate sport, clinicians are dealing with adult patients, who often have an overwhelming desire to compete. Given this context, it is important to reiterate that the negotiation of medical treatment in sport has not been examined, thus pointing to the relevance of this project.

Research Questions

This project considered the nature of the relationship between the 'culture of risk' and the negotiation of treatment in sport medicine. The major purpose of this project is to examine, using qualitative methods, the roles of sport medicine clinicians as they interact with patient-athletes in various sports in the context of a competitive varsity season. The project is designed to investigate how clinicians interact with patient-athletes beyond the basic level of clinical diagnoses, and to determine whether clinicians in a Canadian post-secondary institution implicitly contribute to and reinforce positive deviance and overconformity to the sport ethic (Hughes & Coakley, 1991). Given that the literature – primarily from professional and National Collegiate Athletic Association (NCAA) sources – and anecdotal evidence predict that a 'culture of risk' is promoted in clinician-athlete negotiations, this project attempts to answer the following questions:
In a Faculty that promotes physical, mental and emotional wellbeing, and education regarding the social constraints and dangers of competitive sport, does a ‘culture of risk’ exist amongst the student-athletes?

If there is a ‘culture of risk’ among the athletes, how is it understood by, negotiated, and dealt with by sport medicine clinicians?

How do sport medicine clinicians respond to the dual, and potentially conflicting, roles of patient (an injured individual in need of treatment which may prevent him/her from competing) and competitive student-athlete (an injured individual who may have an overwhelming desire to return to training and/or competition)?

Furthermore, this project investigates the role of coaches and the ways in which coaches are intermediaries in the relationship between clinicians and student-athletes, as well as their influence on clinicians and athletes within the ‘culture of risk.’

Canadian intercollegiate sport provides a relatively distinct setting in which to examine the interactions between sport medicine clinicians and athletes. In highly competitive sport settings, such as professional, elite amateur or Olympic level sport, the research literature predicts a culture of risk. Such sports are often revenue-producing endeavours, and athletes, staff and medical personnel are ‘paid’ as employees of a larger organisation, either through salaries or sponsorship. Many Canadian Intercollegiate Athletic Union (CIAU) athletes are elite level athletes and play with pressure during their CIAU season. However, unlike other levels of elite sport, including the highest levels of U.S. intercollegiate sport, athletes do have to be students working toward their degrees, playing seasons are relatively short, and the pressures regarding success and revenue are less pronounced. By analysing sport clinician/athlete interactions in a Canadian university setting, two of the main issues in other forms of elite sport
are more controlled: (1) CIAU athletes do not receive substantial athletic scholarships, and are thus not in an implicit employee/employer relationship with the team, coach or university; and (2) sport medicine staff are often required to attend to numerous athletes from various teams throughout the year, and are thus not affiliated with a team as much as with the entire institution.

**Assets & Limitations**

In addition to these generalisations about intercollegiate sport settings, and given that this study focuses on the case of a single university, it is important to note the unique reconstructed nature of the new Faculty of Physical Education and Health at the University of Toronto, with its explicit emphasis on both physical education and health. The mission statement, values, and guiding principles of the Faculty, create an environment that promotes internal analysis and self-evaluation, in the hope of strengthening and improving the role of physical activity, sport and recreation within the University of Toronto and the broader community. It is therefore appropriate to append the Mission Statement, values and guiding principles of the Faculty to this project, and to acknowledge the strength of these principles as one reason for this study within this institution (see Appendix I). It is important to note that any evidence of a ‘culture of risk’ here, given the explicit organisational emphasis on positive and healthy sport participation, suggests that such a ‘culture of risk’ may exist to a greater extent at other institutions with less emphasis on health in their guiding principles.

Furthermore, it is important to point out a limitation of this case study – one which also points to the significance of the sport medicine clinic and clinicians in this environment. This project took place at a time when the clinic was undergoing transformation, both physically in the sense of renovation, and administratively. Naturally, this period of transition brought with it
change in routine, and change from an existing system into a new operating system, resulting in some (arguably, natural) frustration and tension for athletes, coaches and clinicians. When this project began, some participants saw this an opportunity to voice their complaints alongside their opinions on the ‘culture of risk.’ One could argue that a limitation of this study was the fact that some participants were ‘in the mood to gripe’ about the clinic. But, this can also been seen as evidence of the important role that the clinic and the clinicians play in the lives of patient-athletes and coaches, and in the intercollegiate sport system.
CHAPTER 2
REVIEW OF LITERATURE

A preliminary analysis of the issues surrounding clinician/patient-athlete negotiations creates the framework in which to analyse the profession of sport medicine, and its role in Canadian intercollegiate sport as seen in one institution. While this literature review cannot fully examine all the pertinent themes related to this topic, it broadly considers three specific areas including: the socio-cultural nature of pain and injury in sport, the process of negotiation as it relates to the clinician-patient relationship, and the current status of medico-legal and policy issues in the Canadian intercollegiate sport system.

Socio-Cultural Nature of Pain and Injury

By examining the headlines of sports pages in newspapers, by watching the slow motion replays on televised football, hockey, or other contact sports, or by listening to the accounts of injuries experienced by individuals in sport, it becomes evident that there is a widespread acceptance of risk, pain, and injury by athletes in competitive sport. This makes pain and injury statistically normal in sport, and at the same time, creates a widespread acceptance of what has been called by some researchers as “the culture of risk” (Coakley, 1998; Curry, 1993; Nixon, 1992; Nixon, 1993; Nixon, 1994) – a culture which normalises pain and injury experience as part of a larger overconformity to “the sport ethic” (Hughes & Coakley, 1991). Socio-cultural research has started to examine the ‘culture of risk,’ with recent analyses of the gendered and gendering nature of sport injury (Nixon, 1996a; Nixon, 1996b; Nixon, 1994; Theberge, 1997; Young, White & McTeer, 1994; Young & White, 1995; Young, 1993), and its organisational nature and production (Coakley, 1998; Curry, 1994; Hughes & Coakley, 1991; Nixon, 1994;
Nixon, 1992; Walk, 1997; Young, 1993). Researchers have asked such pertinent questions as, why are injuries such an accepted part of competitive sports (Coakley, 1998; Hughes & Coakley, 1991)? How does pain and injury correlate with the athlete’s character and psyche (Dunning, 1986; Klein, 1995; Sabo, 1989; Theberge, 1997; Young, White & McTeer, 1994; Young & White, 1995; Young, 1993)? How does the injury process in sport relate to the injury process in hazardous occupations (Young, 1993)? How is sport injury distributed across the socio-economic spectrum (McCutcheon, Curtis & White, 1997)? How do men and women react to, attribute and respond to pain and injury incurred through competitive sport, and are these responses a gendered phenomenon (Gerschick & Miller, 1995; Sabo & Gordon, 1995; Theberge, 1997; Young, White & McTeer, 1994; Young & White, 1995)? How do sport injuries and the normalisation of pain tolerance figure in the broader discussion of human rights in elite sport (Kidd & Donnelly, 2000)?

Given these research examples, one area that has received little scholarly attention in the socio-cultural study of sport is the role of the sport medicine clinicians in this ‘culture of risk’ (there are extensive academic examinations and critiques of the broader profession and social institution of medicine; see Williams & Calnan, 1996, for one such summary of some of the major theoretical perspectives to date in the sociology of medicine, health and illness). There are several studies of the paramedical staff associated with competitive sport and physical activity, such as athletic trainers (see Fisher et al., 1993; Walk, 1997), but no in-depth research of a group which has become a central figure in competitive sport today – the sport medicine team. What is the role of sport medicine clinicians? How do they deal with patient-athletes beyond the clinical diagnoses? Do their actions, behaviours and ideologies reinforce positive deviance in terms of overconformity to the sport ethic (Hughes & Coakley, 1991)? How much power and control
does the sport medicine clinician wield among those within the framework of competitive sport, (e.g., athletes, coaches, governing bodies etc.)? With so many questions left unanswered about the role and nature of the clinician, there is a clear need for this project to begin to situate the sport medicine clinician as an active negotiator in the sport-injury/pain complex. Greater understanding of the current state of research in the theory of positive deviance in the sport ethic, analysis of pain and injury as gendered phenomena, as well as the organisational nature of pain and injury, allows for further discussion of the impact of sport medicine clinicians.

Injury Rates and Costs

As noted previously, sport injuries are a reality for many individuals. According to the Institute of Social Research (ISR) (1996):

Of the 6,321 individuals who reported that they had participated in sports and physical recreation activities during the 12-month period, a total of 604 individuals sustained an injury or injuries that required treatment by a health professional. Thus the annual prevalence rate of sport and recreation injuries [was] 7.2% of the Ontario population over the age of five years. The prevalence rate of injuries for those individuals who participate in sport and physical recreation [was] 9.6%.

Using those rates, ISR (1996) calculated an estimated 750,800 injuries were sustained by the Ontario population in 1995, and that injury rates for men were almost twice that of women’s – 9.4% (estimated 471,000 injuries) vs. 5.4% (estimated 279,000 injuries), respectively. ISR (1996) continued by estimating the economic costs of injuries in sport and recreation to have been approximately 637 million dollars, about 42% of which were health care costs, including visits to health care professionals, and 46% of which were lost productivity and/or foregone earnings. The remaining 12% of the $637 million was absorbed directly by the individual (or the family) that was injured. In examining serious and catastrophic sport/recreational injuries, Tator et al. (1993) found that a total of 561 cases were reported between July 1, 1991 and June 30,
1992, of which 220 were fatalities. Approximately 85% of the cases recorded were males, with an average age just below thirty. Tator et al. (1993) also calculated an economic cost model, and estimated that (in 1988 dollars) a total of approximately $225 million was spent for direct medical costs (approximately 13% of total), related expenses (approximately less than 1%), and lost time/productivity (approximately 87%). While these figures are dated, they do provide a snapshot of the relative statistical and economic significance of sport injuries in Ontario.

Pain and Injury

A growing body of literature examines the violence inflicted on the bodies of male and female athletes through the routinisation of pain and injury in sport. Initial interest focused on male athletes (Curry, 1994; Curry, 1993; Nixon, 1993; Young, White & McTeer, 1994; Young, 1993), but more recent work has extended the discussion to women. In a ground breaking study on the experiences of elite female athletes, Young and White (1995, p. 51) identify similarities between males and females in the acceptance of physical danger and injury, and conclude that “if difference exists between the way male and female athletes appear to understand pain and injury, it is only a matter of degree.” They go on to characterise the ways in which athletes in competitive sport, both male and female, acknowledge and deal with their injuries through several different strategies. “[These] strategies are articulated as rules of conduct, or norms, but they also include various techniques of neutralisation and other linguistic justifications” (Young, White & McTeer, 1994, p. 183). These strategies are characterised as: (a) “hidden pain;” (b) “disrespected pain;” (c) “unwelcomed pain;” and (d) “depersonalised pain” (Young & White, 1995; Young, White & McTeer, 1994). It is interesting to note that when in pain, it is much easier to know and feel one’s own pain, while to know and to feel another’s pain without the
suffering is difficult and elusive. As Scarry (1985, p. 4) notes, "[t]hus pain comes unsharably into our midst as at once that which cannot be denied and that which cannot be confirmed.... Whatever pain achieves, it achieves in part through its unsharability, and it ensures this unsharability through its resistance to language." Scarry (1985) goes on to describe further the ability of pain to 'shatter' language and reduce the person in pain to sounds that imitate pre-language – such as cries or shrieks. While she builds her position on pain by focusing on the structure of torture and war, she stresses that the ability of pain to resist language, either through the inability to express what pain really feels like or by reducing language to pre-language, has tremendous political consequences (see Bendelow, 1996). In short, Scarry (1985) suggests that the inexpressibility of pain and its ability to dominate the sensory and cognitive world of only the person in pain, renders pain invisible, and in doing so, makes it difficult to locate and discuss its political nature. Scarry (1985, p. 12) states that "...ordinarily there is no language for pain, that it (more than any other phenomenon) resists verbal objectification. But the relative ease or difficulty with which any given phenomenon can be verbally represented also influences the ease or difficulty with which that phenomenon comes to be politically represented" [Italics in original]. She offers some interesting perspectives that, although in discussion of torture and war, are highly applicable to sporting contexts not only to understanding the dis/ability of athletes to express their pain, but also the political implications of their involvement in and adherence to a 'culture of risk.'

Given their generally excellent health and "posture of physical invulnerability" (Young, White & McTeer, 1994, p. 185), pain and injury are often understood by athletes as a form of bodily betrayal. Injury and pain become physical and symbolic cues of character and identity, such that pain tolerance and disregard of bodily limits are often seen as a reflection of moral
strength and character development (Dunning, 1986; Hughes & Coakley, 1991; Sabo & Panepinto, 1990; White & Young, 1997). In addition to courage in the face of physical challenges, moral courage is implied in this normative system. As Hughes and Coakley (1991, p. 309) note, “the idea is that athletes never back down from challenges in the form of either physical risk or pressure, and that standing up to challenge involves moral courage.” The pervasiveness of this ideology extends into the lives of men and women, and becomes part of the construction of gender identity for many of these individuals. It becomes part of their “sport ethic” (Hughes & Coakley, 1991).

Positive Deviance and The Sport Ethic

In discussing the sport ethic, and its relevance to the examination of the sport medicine clinician, it is essential to understand the concept of positive deviance. In a key study, Hughes and Coakley (1991, p. 308) have characterised the acceptance of pain and injury in sport as “positive deviance,” which they suggest is “caused by an unqualified acceptance of, and unquestioned commitment to a value system framed by...the sport ethic.” Positive deviance refers to a form of overconformity that goes so far in “following commonly accepted rule or standards that it interferes with the well-being of self or others” (Hughes & Coakley, 1991, p. 310). The value system of sport encourages overconformity to a set of norms or guidelines that athletes use to evaluate themselves or others as they train and compete. Much of the positive deviance in sport involves an unquestioned and unqualified acceptance of, and conformity to the value system embodied in the sport ethic, as defined by Coakley (1998, p. 152).

The sport ethic is the cluster of beliefs that many people in [competitive] sports have come to use as the dominant criteria for defining what it really means, in their social worlds, to be an athlete; the sport ethic constitutes the core of the high-performance sport culture.
Information from and about athletes has led Hughes and Coakley (1991) to suggest four beliefs that make up the sport ethic: (a) being an athlete involves making sacrifices for 'The Game'; (b) being an athlete involves striving for distinction; (c) being an athlete involves accepting risks and playing through pain; and (d) being an athlete involves refusing to accept limits in the pursuit of possibilities. Not all athletes overconform to this ethic, but these norms make up the mindset and culture of many athletes in competitive performance sports. It is in this framework that athletes learn to expect, accept, minimise and/or ignore pain and injury as a normal part of the game, and even take pride in their pain threshold as proof of their character as athletes and their dedication to the team (Nixon, 1993). As Hughes and Coakley (1991, p. 316) stress: "...it [should be] emphasised that the norms of the sport ethic are positive norms; it is under the condition of uncritical acceptance and extreme overconformity that they are associated with dangerous and destructive behaviour." Overconformity to the sport ethic becomes part of the overall participation experience, and although it varies between sports and athletes, it appears to be both “generic across sport and specific to particular sport cultures” (White & Young, 1997, p. 1).

While Hughes and Coakley (1991) offer one interpretation for why injury and pain tolerance are accepted as part of the sport experience, Goffman (1967) also interprets why individuals turn to risk-taking and situations where risk is involved in the construction and exhibition of 'character'. He states that character: "...[on one hand] refers to what is essential and unchanging about the individual – what is characteristic of him. On the other, it refers to attributes that can be generated and destroyed during fateful moments...Thus, a paradox. Character is both unchanging and changeable. And yet that is how we conceive of it" (p. 238). Goffman suggests that it is during "moments of action" where there is a sense of risk (the amount and nature of risk being subjectively interpreted by the individual) that a person has the
opportunity to "[display] to himself and sometimes to others his style of conduct when the chips are down" (p. 237). He further notes that risk and action have appeal since these are moments when "character is gambled; a single good showing can be taken as representative, and a bad showing cannot be easily excused or re-attempted. To display or express character, weak or strong, is to generate character. The self, in brief, can be voluntarily subjected to re-creation" (p. 237). While the actor can stand to lose a great deal in this moment of action, a tremendous gain of character can also occur — "a central opportunity to show strong character is found in fateful situations, and such situations necessarily jeopardise the risk-taker and his resources" (p. 260). Goffman suggests that the qualities of character that emerge from the fateful situation tend to be "essentializing" such that "a single expression [of character in the face of risk] tends to be taken as an adequate basis for judgement" (p. 218).

Goffman identifies four key qualities of character that individuals try to convey in fateful situations (i.e., moments of action), including courage, gameness, integrity and composure (see p. 218–227). He suggests that these qualities "specify...how [an individual] will manage [him or herself] in [an] activity," and that these qualities are "an aspect of the individual’s character" (p. 217). He further suggests that, "[e]vidence of incapacity to behave effectively and correctly under the stress of fatefulness is a sign of weak character.... Evidence of marked capacity to maintain full self control when the chips are down — whether exerted in regard to moral temptation or task performance — is a sign of strong character" (p. 217; Italics in original). This is highly applicable to our exploration of athletes’ pain and injury tolerance, since injury is seen by some as a fateful moment, a moment when character can be built. Sport is an ideal venue for the establishment and perpetuation of 'character' since it is not only a social situation, but also involves risk and fate. Athletes may try to establish a sense of character in the face of risk for
themselves, and convey particular messages or signs of strength in character to their coaches and peers. One could argue though that if a single expression of character tends to be taken as definitive, “...once an individual has failed in a particular way he becomes essentially different from that moment on and might just as well give up” (Goffman, 1967, p. 235). If tolerance of injury is seen as an example of a strong character, to not tolerate it implies weakness in character and an inability to communicate courage, gameness, integrity or even composure. This is problematic since there is a political contradiction here in that praise is reserved for conformity/overconformity to an ethic, but an individual is often showing great strength of character in resisting that ethic. What is interesting to point out is Goffman’s (1985, p. 167) own view of injury since, as he writes:

Physical danger is a thin red thread connecting each of the individual’s moments to all his others. A body is subject to falls, hits, poisons, cuts, shots, crushing, drowning, burning, disease, suffocation, and electrocution. A body is a piece of consequential equipment, and its owner is always putting it on the line. Of course, he can bring other capital goods into many of his moments too, but his body is the only one he can never leave behind.

This discussion of positive deviance in the sport ethic leads us to the paradox of competitive sport, and implicates the need for and role of the sport medicine clinician. While competitive sport is generally seen by many people to build, enhance, and even improve the body and psyche, creating fuller, more well-rounded individuals, it also creates a body and psyche that is destroyed and/or damaged, and which destroys and damages others (Messner, 1989). This interpretation lays bare a tragic irony in the dominant sport culture – that the powerful athlete, a symbol of strength and health, sacrifices his or her health in pursuit of idealised athleticism, and even idealised masculinities and femininities (see Curry, 1994; Curry, 1993; Hughes & Coakley, 1991; Sabo & Gordon, 1991; Theberge, 1997; White & Young, 1991; Young, White & McTeer, 1994; Young & White, 1995; Young, 1993). Athletes are often held
up as symbols of health or vitality in sport and fitness subcultures, but descriptions of athletes’ experiences show how the pursuit of athletic excellence and personal success entail the development of a disregard for the body (Klein, 1995). Paradoxically, as the body is built up to move through the competitive hierarchies of modern athletics, the body is increasingly worn down – in essence, an athletic career also becomes a “pain career” (Bendelow, 1996, p. 171). Many athletes are thus embroiled in a larger set of power relations inside and outside of sport that is often exploitative and leads to “physical entropy rather than health” (as cited in Sabo & Gordon, 1995, p. 12). This interpretation also implicates the role of the clinician in this paradox. As athletes work on and wear down their bodies to excel in their sports, there is an ever-present need for the specialised knowledge and abilities of sport medicine clinicians, trained in the types, mechanisms and treatments of sport injuries. In many ways, overconformity to the sport ethic creates a supply-demand scenario, where the commodity being exchanged is the health and well being of the human body. With an understanding of positive deviance and the sport ethic as a form of ‘character-builder,’ we must now ask how this relates to the construction of gender in competitive sport? How does tolerance and disregard of injury translate into how men and women see themselves as athletes? Subsequently, the focus turns to the place of the sport medicine clinician in this subculture, and whether s/he is complicit in maintaining positive deviance to the sport ethic.

The Construction of Gender in Competitive Sport

As Theberge (1997, p. 69) states, “competitive sport is one of the most important arenas for the production and expression of gender.” Young boys are often taught that sports help turn a “boy into a man”, and that to endure and survive pain is courageous and manly (Sabo, 1989;
White & Young, 1997; Young, White & McTeer, 1994). This alludes to a socio-cultural process of creating a dominant/hegemonic masculine hierarchically out of many masculinities that exist (see Dunning, 1986; Sabo & Gordon, 1995; White & Young, 1997). Even though hegemonic masculinity is an ideological construct, modern sport is an institution where male hegemony is tangibly constructed and reconstructed, and where “physical strength and force become important symbolic and cultural cues” (White & Young, 1997). The use of violence and force, as well as the practice of tolerating pain, become part of a masculinizing process. Young, White and McTeer (1994, p. 178) argue that male physicality in sport is “a form of symbolic domination which contributes to the reproduction and reinforcement of power relations inherent in the existing gender order.” In short, men have championed the physical basis of gender difference through the paradoxical identification of the male body as a weapon to cause harm and to be harmed. The values of the pain principle (Klein, 1995) are thus incorporated, through a complex social, psychological, cultural and political process into gender identities. Symbolic and cultural significance lies in the association of strength, body size, and aggression with male success – therefore injury both threatens that success, and is re-interpreted as part of masculine validation. This affects the lives and psyches of many male athletes in a fundamental way, since the presumed benefits of dangerous behaviour outweigh the health risks. This posture is not limited to ‘jocks’, and is evident in the lives of many non-athletic men who, as ‘workaholics’ or ‘tough guys’, deny their physical and emotional needs, and develop health problems as a result (Young, 1993). As Young (1993, p. 390) and others have pointed out, men prove themselves by achieving success in the society's dominant institutions, or “at the very least through the ideologies and icons that suggest this power,” such as dangerous professions like the military, construction, mining, and even sports. As Goffman (1967, p. 171-4) suggests, the choice of
being involved in such occupations is indicative of the need to create and ‘prove’ a particular type of character where “self-determination is central. Instead of awaiting fate, you meet it at the door. Danger is recast into taken risk; favorable possibilities, into grasped opportunity. Fateful situations become chancy undertakings, and exposure to uncertainty is construed as willfully taking a practical gamble.” Goffman (1967) himself suggests such occupations include professional spectator sports, such as football, boxing, and bullfighting, which place money, reputation, and physical safety in jeopardy all at the same time for performers, as well as recreational non-spectator sports, such as mountain climbing, big game hunting, parachuting, and surfing. In regards to the latter, Goffman (1967, p. 196) states that:

No payment is received for this effort; no publicly relevant identity is consolidated by it; and it incurs no obligations in the serious world or work. In the absence of the usual pressures to engage in an activity, it is presumably easy to assume that self-determination is involved and that the chances...are brought on solely because of the challenge...

Hegemonic masculinity has a tremendous power in the lives of men in competitive sport, but recent research is suggesting that women are beginning to adopt similar patterns of behaviour in regards to positive deviance, the sport ethic, pain and injury.

Although the history of women in sport is beyond the scope of this literature review, sport has been a setting in which gender differences were established and celebrated (Dunning, 1986; Theberge, 1997; Young & White, 1995). Historically, there has been an understanding that education or socialisation through sport was consciously understood to be masculinizing. As Kidd (1987, p. 253; see also Dunning, 1986) notes, the men who developed or promoted sports in the nineteenth and twentieth centuries were careful to ensure that only males were masculinized this way: “[t]hey kept sports as male preserves by actively discouraging females from participating; they denied them adequate facilities and programs, ridiculed their attempts, and threatened them with the spectre of ill health and reproductive death.” When women were
admitted, it was on restricted terms and according to an adapted model – events were adjusted to conform to a view of women as fragile and weak.

In recent times, increasing numbers of women are challenging the myths of the female body as frail and weak. A particularly significant challenge to gender ideologies is the increased involvement of women in sports seen as the “flag carriers of masculinity” (Theberge, 1997, p. 70), such as hockey, rugby and wrestling. As Theberge (1997, p. 70) points out, “these are sports that quintessentially promote hegemonic masculinity and to which a majority of individuals are regularly exposed.” Ethnographic research reveals that with this increased involvement in competitive sport, there has come a general sense of empowerment by many female athletes – a physical, social, psychological, and even emotional sense of empowerment (Theberge, 1997; Young & White, 1995) What has also come, as women “colonise ‘new’ sport territory” (Young & White, 1995, p. 56), has been a lack of reflexivity by many female athletes about their adoption of the competitive sport system, and its underlying values, thus resulting in a reproduction of the masculinist meaning of sport structures. As Young and White (1995, p. 53) show, some of the very strategies that women use in discussing the tolerance of pain and injury represent “the cornerstones of the dominant male model of sport, and are adopted for a number of reasons: to show courage or character; to consolidate membership or kudos in a group; to avoid being benched; to help make sense of compromised health in a lifestyle that reveres health and fitness.” Many women are participating in and colonising traditionally male-exclusive spaces in sport, but instead of contributing to “a deliberate and organised reconstruction of the meaning of pain and injury in sport, women appear to be contributing to an already defined sport process replete with violence, excessive and compromising health behaviour” (Young & White, 1995, p. 56). Much like the discussion of men in the culture of pain, for women, playing through
pain is an indication of a player's ability and an affirmation of her commitment to her team and her sport. Research shows a lack of critical awareness of the physical dangers of competitive sport participation, and provides evidence that women athletes are readily accepting of violence inflicted on their bodies in competitive sport (Young & White, 1995). This suggests an incorporation of, rather than resistance to, the dominant model of men's sport. In terms of the construction of femininity, it becomes clear that for many women in competitive sport, qualities such as physical strength and aggression, and injury experiences, do not inherently or objectively compromise the femininity of women. Rather the discourse of women in studies such as Theberge (1997) and Young and White (1995), demonstrate that sport may contain key emancipatory possibilities. These include a range of opportunities for extending physical limitations, developing a positive sense of physical self, and of co-operating with or competing against others (Young & White, 1995). It is quite safe to say that there is a sense of accomplishment and satisfaction that many women derive from their sport participation – a sense of strength that is oftentimes directly linked to the “physicality of sport and the possibility for the exercise of skill and force in athletic competition” (Theberge, 1997, p. 84), and which results in the expression of an “empowered femininity” (Young & White, 1995, p. 57).

The findings raise possible ambiguities in sports-related emancipation for women. As Young and White (1995, p. 56) note, “women's increasing participation in aggressive sport is interpreted as a dialectic, in which resistance to male dominance in sport is tempered by a degree of hegemonic incorporation.” The sense of empowerment is critical in the creation of gendered identities since, as Klein (1995, p. 115) notes, “in our culture, masculinity and femininity are inscribed upon the body through power.” But while some female athletes experience this empowerment through sport participation, their challenge to masculine hegemony is diminished
through their uncritical adoption of a sport ethic that celebrates toughness in the face of physical violence (Hughes & Coakley, 1991; Theberge, 1997; Young & White, 1995). The images of women in competitive sport, in and of itself, emit powerful political symbolism, but we must question whether this uncritical acceptance of injury is bodily empowerment or endangerment.

The Organisational Nature of Sport Medicine

Given this preliminary understanding of the nature of pain and injury in competitive sport as experienced by women and men, it is appropriate now to examine the broader implications for this issue on the organisational nature of sport medicine. Although past work in medical sociology has questioned the progress and state of modern medicine (see Bolaria, 1988; Crawford, 1980; Frankel, 1988; Haas & Shaffir, 1991; Jokl, 1964; Navarro, 1986; Waddington, 1996), very little research by both medical and sport sociologists, has looked at the practice of sport medicine, and its effects on individuals. Few have questioned whether sport medicine clinicians are aiding injured athletes by offering specialised treatment, or are reinforcing overconformity to the sport ethic?

One of the few studies to ponder these issues was carried out by Nixon (1992) who, through social network analysis, investigated the "conspiratorial alliance of coaches, athletic administrators, sport medicine personnel, and others whose activities perpetuate the acceptance by athletes of risk, pain, and injury in sport" (Walk, 1997, p. 23). In fact, Nixon (1992) terms these alliances amongst individuals in sport organisations "sportsnets," and suggests that these interactions, among and including sport medicine professionals, reinforce the standardised ideology of overconformity to the sport ethic, which "encourages players to play with pain and take unreasonable health risks" (Walk, 1997, p. 23). Nixon (1992) argues that what normalises
these ideologies is the very fact that there is a medical support system in place for athletes that is immersed in the rhetoric of producing winning teams and athletes — repair the athlete's injury and send them out to win more games.

Nixon (1992) suggests that the insulation and immersion of these medical systems within the larger framework of overconformity to the sport ethic as seen by the coaches, administrators, athletic directors, etc., is detrimental to the health and safety of athletes due to the undue tolerance of pain and injury. As Roderick and Waddington (2000) interpret, "[Nixon] suggests that sportsnets are more likely to 'trap' athletes in a 'culture of risk' when the sportsnet is large, dense, centralised, closed, undifferentiated and stable, and where athletes are very reachable by coaches and others with authority or control within the sporting context." Nixon proposes the establishment of independent networks of medical personnel who are not so intimately connected to the sportsnets, and urges athletes to look to these independent networks of medical personnel to assess and diagnose persistent injury. Such ideas are reinforced by other sport sociologists, such as Hughes and Coakley (1991, p. 322), who suggest that:

Athletes who are injured should not be allowed to play until certified, not simply "able to compete," by a physician outside the athletic program, since team physicians may be vulnerable to overconformity to the sport ethic with sport organisations.

Although one must acknowledge that Nixon's study was done within the NCAA intercollegiate sport system, which is, in part, a revenue-producing system, his call for greater accountability, the ethical and holistic treatment of the athlete, and more research into this area can also be applied to the Canadian intercollegiate sport system.

While Nixon's discussion of sportsnets offers a theoretical critique of sport medicine systems within intercollegiate sport, Walk's (1997) look at the experiences of student athletic trainers is the precedent study in the sociology of sport literature that questions and 'tests' this
theory empirically. Walic writes of the experiences of student athletic trainers (SATs) in a large, Midwest, NCAA Division I institution as gathered through numerous semi-structured interviews. In an analysis of the concept of sportsnets, Walk (1997, p. 50) contends that Nixon’s notion of a sportsnet is both “intuitively suspect and without empirical support,” in that “even a sportsnet may be characterised by flaws in its systems of control, related negotiation and conflict, and some measures of freedom for its members, even those with the least amount of power – in the present case, student athletes and student athletic trainers.” He argues that while sport and sport medicine were insulated from the rest of the institution, the sportsnet was not as homogenous and all encompassing as Nixon suggests, particularly in the relationships between SATs and student-athletes that “worked to undermine some of the totalizing and exploitative tendencies the [institutional] sportsnet may have had” (p. 50).

Documented in the study were the often conflicted and contradictory views held by SATs towards the ‘culture of risk’ – concern for the health and welfare of the student-athlete as well as the reproduction of injury-legitimating norms – yet this was significantly affected by the role that SATs often assumed in this sport/sport medicine system. SATs were often seen occupying the ‘middle’ position – a liaison position – between patient-athletes and ‘higher’ authorities, such as coaches, administrators, and other health professionals. Walk argues that this positioning of the SATs forces them into a paradoxical role where they form close bonds with athletes, empathise and sympathise with the patient-athlete, at times reproduce and reinforce the ‘culture of risk’ as desired by the athletes, at times reproduce and reinforce the ‘culture of risk’ as desired by the coaches, while also occupying the role of the guardian of the athlete against external pressures to play. This is further exacerbated by the fact that SATs are often exploited student workers – “40
to 70 hour per week internships added to the schedules of full-time university students is *prima facie* [Italics in original] exploitation” (p. 54).

While Walk's study offers a great deal of material relevant to this project, it is important to note two themes generated throughout the article. First is Walk’s acknowledgement that while student-athletes often have the least amount of power in the sport, they should not also be viewed as “‘dupes’ by minimising the roles and responsibilities they may play in exercising sovereignty over the treatment of their own bodies” (p. 54). This reinforces the importance of agency, not just of athletes but for all individuals involved in the negotiation process, and its impact on the negotiation process. Secondly, Walk reiterates that “future studies of sport should... study how the processes of injury-related negotiation and conflict among coaches, athletes, and sports medicine personnel take place” (p. 51).

This discussion of the nature of sport injury leads to the need to understand the unique nature of sport medicine, and its potential for greater harm than good. It is a specialised field of medical practice and, as such, treats specific medical phenomena at the cost of treating the whole person – in other words, dehumanising the athlete (Hobberman, 1990). As Navarro (1986) notes, the specialisation in medical knowledge and practice tends to focus on specific parts of the body. In a generalised discussion on medicine, Sabo and Gordon (1995, p. 13) suggest, “though modern medicine acknowledges the integrity of the whole person, the emotional and intellectual uniqueness of the individual is sometimes lost amid highly bureaucratised, technological, and sterile environments of contemporary medicine.” In essence, this is an indication of the dehumanisation of the athlete. In a more sport-specific context, Young, White and McTeer (1994, p. 186) argue that, although “the structure of competitive sport contains a medical infrastructure designed to accommodate the physiological and medical aspects of injury (sport
medicine clinics, rehabilitation centres, physiotherapy), athletes seldom receive assistance in working through [socio-emotional] side effects” (see Roderick & Waddington, 2000; Scarry, 1985). How are sport medicine clinicians implicated in this concept? Do they contribute to a “lack” of treatment for competitive athletes in Canadian interuniversity sport? What measures do sport medicine clinicians take to deal with the socio-emotional side effects of sport injury for their patients? While these sport-related questions form the context of this project, it is important to begin our exploration of this topic by examining the broader sociological literature on the physician-patient relationship.

Understanding the Clinician-Patient Relationship

This study revolves around the relationship between the clinician and patient in a setting that intersects between medicine and sport participation. There are three main ways that a patient may respond to a clinician: (i) to do everything a clinician recommends; (ii) to ignore everything a clinician recommends; and (iii) to discuss and negotiate the form of treatment that the clinician recommends. In cases where the interests of the patient and clinician may conflict, as can potentially be the case in sport where an injured athlete may want to train and compete and the clinician would like the patient to heal doing so, the final two options are most often used, as indicated by the evidence. The aspect that lends itself the most to sociological analysis is the third option, and there is an established literature on this subject in the sociology of medicine and health, particularly that of the physician-patient relationship (e.g., see Calnan & Williams, 1996 for a discussion of ‘lay’ evaluation and critique of medicine and medical care). This project represents innovative research in the sociology of sport, and since this thesis is
concerned with negotiation between clinicians and patient-athletes, it is valuable to begin our discussion with an examination of the broader theories of the concept of negotiation.

**Negotiations**

Strauss (1978, p. ix) suggests that negotiation can be conceptualised simply as the process of “getting things done” when individuals, groups, or organizations of any size work together. The process can include such activities as persuading, educating, manipulating, appealing to the rules or authority, coercion, bargaining, and influencing which Druckman (1977, p. 24) suggests “[are]...cuts on negotiation [and that] each process is a paradigm for the analysis of negotiation. However, the fact that all...processes operate in any particular negotiation renders incomplete an analysis that does not document the interplay among them.”

It is important to emphasize here that such terms as negotiation, bargaining, debate imply opposition, thus making conflict the very basis of negotiation (Thompson, Peterson & Kray, 1995; Polzer, Mannix, & Neale, 1995). However, it is equally important to point out that negotiation also implies a certain desire to resolve conflict and to find compromise. To look at the negotiation process between clinicians and patient-athletes is, by necessity, to look at this situation, arguably, through the lens of conflict and opposition. This does not mean that clinicians and patient-athletes are always on the opposite ends of the spectrum, but rather, that their relationship holds the potential for conflict. While the source of conflict is unique to the particular situation at hand, Walcott, Hopmann, and King (1977, p. 194-195) suggest that:

…conflict is often grounded in misunderstanding. Such misunderstanding is not (or is not limited to) merely factual disagreement, nor is it simply a result of ambiguous communication. It stems from basically different images of reality held by the parties to a dispute or negotiation. These images may have their sources in cultural differences, in different individual or collective learning experiences, or in different ideologies, and as
[suggested], they are reinforced by the 'blindness of involvement' in one's own particular experiences or point of view.

The different ideologies and "blindness of involvement" held by the actors regarding the tolerance of injury and pain, as implied by existing 'culture of risk' literature, suggest the potential for disharmony and misunderstanding of motives. Communication of differing values and ideologies become integral to the negotiation process, but even so, is affected by a number of inherent and dynamic factors – chiefly the nature of the relationship between negotiators and the exchange of power between them, as well as the structural context of the negotiation.

As an ongoing and dynamic process, negotiation occurs not only in dyadic and multiparty relationships (see Lawler & Yoon, 1995 and Polzer, Mannix, & Neale, 1995, respectively), but also within individuals as suggested by symbolic interactionists (e.g., Blumer, 1969; Goffman, 1967). Again, the key phenomena in all these contexts is the communication of ideologies and motives, the process of interpretation, and subsequent action based on what the actors perceive to be the next, necessary steps to be taken. In addressing dyadic negotiations, Greenhalgh and Chapman (1995, p. 170) view "the relationship [between negotiators] as the context [Italics in original] in which the conflict and negotiation occur and through which they are given meaning." They further suggest that resolution of conflict through negotiation is more an attempt to restore a sense of "connectedness" that "...when strained by conflict, must be restored if an optimum outcome is to be reached" (Greenhalgh & Chapman, 1995, p. 170).

Connectedness in the relationship between clinicians and patients stems from a multitude of factors including trust, frequency of interaction, compatibility of preferences, concern for others, and so on (Polzer, Mannix, & Neale, 1995). It is also affected by the power dynamics between those individuals – power as broadly defined by such factors as the actors' occupations and amount of authority they possess within a setting, their knowledge and expertise, their role in
the particular situation, or their ability to appeal to higher authorities. The outcomes of a negotiation will be highly related to the amount of power each party has — Pruitt and Lewis (1977, p. 185) suggest the "willingness to face conflict and engage in [negotiation] is probably greater to the extent that both parties are equal in power" — as well as from the availability of options. Having and being able to exercise alternatives impact both the decisions to embark on negotiation and the course of the negotiation itself. As Strauss (1978, p. 238) notes:

If...parties to negotiation perceive that they can attempt persuasion, make an appeal to authority, manipulate political or social events, and so forth, then their choices of these [alternatives] will either prevent them from entering negotiation, or if they choose that also, then their choices will affect what transpires during the course of the negotiation.

The dynamics of power in negotiating relationships reinforce the dynamic nature of negotiation itself, and hint at the complexity of the study of negotiation as a concept. This is compounded when comparing negotiations between individuals, negotiations within and between groups, and the relationship of the negotiations of the former on the latter (Lawler & Yoon, 1995). It would be safe to suggest that the relationship between clinicians and patient-athletes are just one of the pivotal dyadic negotiations that occur within a competitive sport environment. Other dyadic relationships, such as between clinicians and coaches and between coaches and athletes, affect and effect not only the clinician-athlete dyad, but the larger organization and setting. The negotiation process is thus never static, but dynamic, multidimensional, and only bound to the specifics of time, history, and setting — that is, bound only to the larger social and structural context (Strauss, 1978).

While the study of negotiation is not a new phenomenon, current literature is quick to point out that this concept is most often studied in laboratory settings, and that few texts and theories encompass the complexity of the negotiation process between individuals and groups of individuals in situ (Kramer & Messick, 1995; Strauss, 1978). Furthermore, critics argue that
existing theories of negotiation tend to be situation specific – that is, devoted to the negotiation process in labour disputes, or in arms trade dealings, or in hostage situations, etc. There are few generalised theories of negotiation, and similarly few scholars who suggest that there could ever be one (Strauss, 1978). What we can take from this literature though is the acknowledgement of the importance of the social setting on the process of negotiation between individuals and groups (Strauss, 1978; Kramer & Messick, 1995). Even Lofland and Lofland (1995, p. 141) acknowledge “…the fruitfulness of looking first (if not foremost and only) to current arrangements, social circumstances, or situations in accounting for practices, meanings, or whatever…[and questioning] what combinations of current arrangements would conduce almost anyone to act in the particular ways observed” [Italics in original].

Strauss (1978, p. 2) acknowledges that “the choice of negotiation as a means is neither fortuitous nor divorced from the social conditions under which it is made.” In fact, numerous scholars construe negotiation as a form embedded in setting (Walcott, Hopmann, & King, 1977), and stress that “…larger structural consideration [needs] to be linked explicitly [Italics in original] with a more microscopic analysis of negotiation processes” (Strauss, 1978, p. xi). Strauss (1978) frequently emphasizes the necessity of understanding the negotiation process between any two parties as grounded within the structural context, or in other words, as grounded within the setting – setting not just indicative of a particular location or environment, but also a moment in social/cultural/economic/political time. The structural context is that within which the negotiations take place, in the largest sense, and which according to Strauss (1978, p. 12), “also affect how actors see social order and what they believe is, for themselves and others, possible or impossible, problematic or probable.” He goes on to suggest the structural context bears directly on the negotiation context, referring specifically to “the
structural properties entering very directly as conditions into the course of the negotiation itself" (p. 99). The relationship between these two contexts is as dynamic and reciprocal in nature as the concept of negotiation itself, and thus changes in one context may impact the other, and vice versa, reinforcing the need to analyse the negotiation patterns as grounded within the setting.

**Physician-Patient Negotiations**

While great attention has been paid to the study of the clinician-patient relationship, explicitly identifying it as a process of negotiation is a relatively recent trend within medical schools and the socio-cultural study of medicine (Dr. W. Himmel, personal communication, 1999). Even so, in such a short amount of time, many schools of thought exist regarding the relationship between clinicians and patients, as well as on the social factors that most affect that relationship, including issues of class, race, professional dominance, etc. This thesis cannot fully explore all these avenues of thought, but can outline some of the major bodies of work that have contributed to the discussion of the role of the clinician, the role of the patient, and the interaction between the two. It should be noted that existing literature tends to focus on the interaction between the patient and the physician, therefore, much of the following relates to all types of medical and paramedical clinician-patient relations.

Parsons was the first sociologist to explore these relationships, and our discussion of the clinician-patient interaction begins with his notion of the sick role. In Parsons' functionalist model, according to Gerhardt (1987), social systems were linked to systems of personality and culture to form a basis for social order. Unlike other social theorists, Parsons included an analysis of the function of medicine in his theory of society and, in doing so, was led to consider the role of the sick person in relation to the social system within which that person lived. The concept of the sick role is based on the assumption that being sick is not a deliberate and
knowing choice of the sick person, although illness may occur as a result of motivated exposure to infection or injury. According to Parsons’ (1951, p. 440):

By institutional definition of the sick role the sick person is helpless and therefore in need of help. If being sick is to be regarded as ‘deviant’ as certainly in important respects it must, it is as we have noted distinguished from other deviant roles precisely by the fact that the sick person is not regarded as ‘responsible’ for his condition, ‘he can't help it.’ He may have, of course, carelessly exposed himself to danger of accident, but then once injured he cannot, for instance, mend a fractured leg by ‘will power.’ ....[T]he core definition is that of a ‘condition’ that either has to ‘right itself’ or to be ‘acted upon,’ and usually the patient got into the through processes which are socially defined as ‘not his fault.’"

The physician-patient relationship is intended by society to be therapeutic in nature, where “medical practice [is defined as] a ‘mechanism’ in the social system for coping with the illnesses of its members” (Parsons, 1951, p. 432). Being sick, according to Parsons (1951), is not just experiencing the physical condition of a sick state because it involves behaviour based on institutional expectations and is reinforced by the norms of society corresponding to these expectations. Such expectations include the exemption of the individual from normal social roles responsibilities (relative to the severity and nature of illness); the belief that the sick person cannot get well by “an act of decision or will” (Parsons, 1951, p. 437); the obligation of the sick person to want to get well since sickness is an undesirable state; as well as the obligation of the sick person to seek “technically competent help…and to cooperate with him” in the process of getting better (Parsons, 1951, p. 437).

These expectations, particularly that which points to the necessity for the sick to seek medical advice and co-operate with medical experts, direct our attention to the situation of the physician. The patient has a need for technical services from the physician, and the physician is the technical expert who is qualified and defined by society as prepared to help the patient (Haas & Shaffir, 1991). The goal of the physician-patient encounter is thus to promote significant
change for the better in the patient's health. The physician-patient relationship is viewed within a framework of social roles, attitudes, and activities that both parties bring to the situation, such that neither party can define his/her role independently of the role partner. The physician-patient role relationship is therefore not a spontaneous form of social interaction (Lewis, 1998; Sledge & Feinstein, 1997), but rather “a well-defined encounter consisting of two or more persons whose object is the health of a single individual” (Mapes, 1977, p. 37).

Although the physician-patient relationship involves mutuality in the form of behavioural expectations, the status and power of the parties are not equal. The role of the physician is based upon an imbalance of power and technical expertise favourable exclusively to the physician. This imbalance is considered to be necessary because the physician needs leverage in his or her relationship with the patient in order to promote positive changes in the patient's health.

Accomplishment of the goal of health sometimes requires procedures that can be painful or uncomfortable for the patient, yet the patient must accept and follow the treatment plan if the physician is to be effective. As Hayes-Bautista, (1976a) states, the physician exercises leverage through three basic techniques: 1) professional prestige, 2) situational authority, and 3) situational dependency. A physician's professional prestige rests upon technical qualification and certification as a healer, while the physician's situational power refers to the physician having what the patient wants and needs. By contrast, the patient is dependent because he or she lacks the expertise required to treat the health disorder (Hayes-Bautista, 1976a). Haas and Shaffir (1991) note that the role of the physician is also enhanced by a certain mystique reflecting faith in the power to heal. This aspect of the physician role results from the dependence of the patient on the physician for life and death decisions. Since the physician has the responsibility to ‘do everything possible’ and because the survival of the patient may be at
issue, the patient may be likely to regard the physician with a strong emotional attachment in the hope or belief that the physician has a 'gift' or natural skill in the healing arts (Haas & Shaffir, 1991). Since medical practice is sometimes characterised by uncertainty, a physician's presumed talent can be a very important dimension in the physician-patient relationship.

It may be fitting at this time to turn to a brief review of the literature surrounding medical dominance, and the ways in which this particular profession, medicine, dominates health and healthcare (see Coburn & Willis, 2000, for a comprehensive description and analysis of the major theories on medical dominance). It is important to point out though that there is an exhaustive literature on the sociology of professions, and even on medical dominance, and that this description does not do the field justice.

Early theories, known as trait and process theories, argued that professions possessed particular traits or attributes, most often including an esoteric body of knowledge, a code of ethics, and an altruistic orientation (Coburn & Willis, 2000; Freidson, 1970). This view saw professions, such as medicine, as the embodiment of altruistic values. But since the late 1960s, a more critical assessment of the professions has emerged that argued that professions, medicine included, do not always operate in the best interest of their clients, or as Coburn and Willis (2000, p. 380) state, "medicine came to be viewed as self-interested." Freidson (1970) claimed that medicine was dominant in health and healthcare, and that it controlled both the content of medical work and also clients, other healthcare professions, and the context within which medical care was given (policy). Neo-Marxist theorists have attempted to locate the professions within the class structure. Marxist theorists argue that the source of professional power lies in its relationship to capital, and that physicians are involved in the control and reproduction of the working class (Johnson, 1972; Navarro, 1986).
These divergent views of the profession have led to conflicting assessments of the future of professions in capitalist society. Some writers have argued that the professions are being proletarianized in attempts to rationalize the work of professions (Coburn & Willis, 2000; Turner, 1995). Although professions remain a powerful group, they have lost some of their autonomy, power and prestige (Turner, 1995). In contrast, other writers argue against the proletarianization thesis. They contend that while the majority of professionals may work in bureaucratic organisations, this is not necessarily antithetical to professional autonomy since professions retain control over a specialised body of knowledge and hence over the content and boundaries of their work (Coburn & Willis, 2000). While these are some of the broad social theories on medical dominance, their effect can be seen in regards to the one-on-one negotiations that occur between physician (read clinician) and the patient.

The physician has the dominant role since he or she is the one invested with medical knowledge or expertise (see Haas & Shaffir, 1991, for a detailed exploration of the professionalization ritual for neophyte physicians, and the ways in which they adopt the symbols and cues that signify “a cloak of competence,” and that symbolise allopathic medicine’s authority on healthcare), while the patient holds a subordinate position oriented toward accepting, rejecting, or negotiating the recommendation for treatment being offered (Gerhardt, 1987; Williams, 1987).

Tessler, Mechanic and Dimond (1976) suggest that the role of the physician in meeting the needs of patients is quite broad and that physicians should be attentive not only to patient’s complaints, but also to whatever factors caused the patient to come to a doctor at a particular point in time. This sentiment is echoed by other scholars who acknowledge that the patient is not treated in a vacuum, but rather amidst numerous social variables and within a larger social
structure (Clark et al., 1991; Pearlin, 1992). Therefore, to assume that interaction between physicians and patients always follows a preset course in which all parties work together under the same set of mutual understandings, overlooks the potential for misunderstanding, uncertainty, or disregard of the physician’s proposed method of treatment by the patient. The quality of physician-patient interaction is sometimes problematic, yet the process is important because of its potential for affecting the care being provided.

Since Parsons formulated his concept of the sick role, two major additional perspectives on physician-patient interactions have added to the understanding of the experience. Szasz and Hollender (1956) take the position that the seriousness of the patient’s symptoms is the determining factor in the doctor-patient interaction. Depending on the severity of the symptoms, Szasz and Hollender (1956) argue that physician-patient interaction falls under one of three possible models: activity-passivity, guidance-cooperation, and mutual participation. The activity-passivity model applies when the patient is seriously ill or being treated on an emergency basis in a state of relative helplessness due to injury or lack of consciousness. Typically, the situation is desperate as the physician works to stabilise the patient’s condition. Decision-making and power in the relationship are all on the side of the physician, as the patient is passive and contributes little or nothing to the interaction. The guidance-cooperation model arises most often when the patient has an acute, often infectious illness, like the flu or measles. The patient knows what is going on and can co-operate with the physician following his or her guidance in the matter, but the physician makes the decision (Szasz & Hollender, 1956). The mutual participation model applies to the management of chronic illness in which the patient works with the doctor as a full participant in controlling the disease. Often the patient modifies his or her lifestyle by making adjustments in diet or exercise, is responsible for taking prescribed
medication and seeking periodic check-ups.

While Szasz and Hollender (1956) show the changing nature of the physician-patient relationship as affected by the severity of the patient's symptoms, Hayes-Bautista (1976a, 1976b) focuses on the manner in which patients try to modify treatment prescribed by a physician. Hayes-Bautista (1976a) suggest that they either try to convince the physician that the treatment is not working or they counter the treatment with action of their own, such as deliberately reducing or increasing the amount of medication they are to take. Physicians respond by pointing out their expertise, that the patient's health can be threatened if the treatment is not followed, that the treatment is correct but progress may be slow, or simply appeal to the patient to comply (1976).

The relevance of the Hayes-Bautista model for understanding doctor-patient relations is that he views the interaction as a process of negotiation, rather than the physician simply giving orders and the patient following them in an automatic, unquestioning manner. The model is limited, however, to those situations in which the patient is not satisfied with the treatment and wants to persuade the physician to change it.

According to Freidson (1970, p. 206), physicians create the social possibilities for acting sick because they are society's authority on what "illness really is." They decide who is sick and what should be done about it. In essence, physicians are the "gatekeepers" (Freidson, 1970, p. 206) to most professional health resources since these resources (such as prescription drugs, surgery, physiotherapy, hospitals, etc.) cannot be used without their permission. Thus, Freidson (1970) argues that the behaviour of the physician and others in the health field constitute the embodiment of certain dominant values in society – including the idea that 'health' is positive and should be sought after. Stipulated in the concept of the sick role is that the sick person is expected to co-operate passively with the physician, and then work actively to achieve his or her
own recovery and return to normal functioning. What is suggested in both the Szasz and Hollender and Hayes-Bautista models is that in non-emergency situations, patients do not necessarily act passively when interacting with their doctors in health matters. Patients ask questions, seek explanations, and make judgements about the appropriateness of the information and treatment physicians provide. This trend in participation is a recent phenomenon starting in the sixties and seventies with a counter-cultural shift towards the questioning of authority, including that of medical authority, and seen most recently in the increased use of the internet in accessing medical information. Numerous individuals with access to computers and the internet do medical research of some sort before approaching and interacting with the physician.

While this review does not examine comparative literature in the sociology of occupational health workers, the field of sport medicine does parallel the roles of general practice physicians and clinicians (i.e., occupational therapists) negotiating with patients engaged in risky (smoking, alcohol and/or substance abuse, etc.) behaviours and/or in high-risk settings/professions (mining, construction, offshore oil and gas exploration, military, etc.). In examining violence, risk and liability, Young (1993) shows some of the similarities between a professional sport culture and industrial workplace culture, drawing parallels between the ideologies of pain, risk, and injury between individuals involved in high-risk industries and in professional sport such as masculinity, character, and income. Does this parallel between professional sport and the industrial workplace 'cultures of risk' extend into other areas of sport and other cultures of risk, and how? In studying clinicians, one must ask how they negotiate with patients who engage in a 'culture of risk', whether in occupational or sporting contexts? How do clinicians approach patients who may or may not co-operate with their prescribed treatment plans, because of their previous and/or continuing involvement in a 'culture of risk'?
It is important to reiterate here that these questions are asked of clinicians in a ‘macho’ (and evidently increasingly ‘macha’) ‘culture of risk’ that fosters an acceptance and tolerance of playing with pain, and may hold negative consequences of those who fail to play with pain. All of this occurs within a context of (otherwise) excellent health, resulting in a sense of bodily betrayal by athletes and which prompts athletes to return to action as soon as they possibly can – sometimes at the cost of their overall health and wellbeing (see McIlvride, 1994).

Medico-Legal and Policy Related Issues

A literature review of the negotiation processes between clinicians and patient-athletes is not complete without a brief examination of the established legal and policy related literature in the area of sport medicine. Much of the existing literature concerns the interplay between sport, medicine, ethics and law at particular levels of professional competition and recreational sport. Much of the work in sport medico-legal circles that is accessible centres around issues of drug use and abuse as well as incidents of violence in sport at the professional or elite amateur level. Very little attention is paid to the daily ethical and legal obligations of the sport medicine practitioner in competitive sports systems, such as the Canadian intercollegiate system. In fact, much of the material accessible to this researcher was from the UK sporting scene, with reference to particular precedent-setting North American cases. This is not to suggest that sport medico-legal cases have not arisen in the United States or Canada – Grayson (1990; 1999) emphasizes that more cases occur in North America than in the UK – but there are no texts that examine the ramifications and consequences of the individual cases as a collective. Furthermore, the individual cases are not readily accessible for a project of this nature. Also, much attention is paid to the role of the sport physician, while the roles and responsibilities of paramedical
clinicians are largely overlooked. Thus, we need to extend our discussion on the ethical and legal responsibilities of sport medicine physicians to the broader category of sport medicine clinicians.

While many individuals look to medicine to enhance their performance and to treat their injuries, the literature describing the standards of care required of physicians generally and even more so, of the sport medicine clinicians is very limited and recent (Grayson, 1990). One possible explanation of this is that criminal and civil law is rarely seen to cross the boundaries of the playing field, the arena, the locker room, etc. Although ordinary principles are applicable generally to medical liability within the sporting context, there are two crucial generalities to consider:

...the absence of any traceable pattern of liability arising out of medical services in the UK which contain a sporting flavour. The other is a corollary to it: the general public’s and even judicial misapprehensions about claims for sporting injuries which have been expressed during the last three decades. (Grayson, 1990, p. 34)

This reinforces Young’s (1993) examination of how athletes, particularly in professional sport contexts, are seen to voluntarily assume exposure to risk and liability – the legal notion of volenti non fit injuria. There is a sense that if individuals choose to participate in competitive sports, especially in contact and collision type sports, then they choose to assume all the good and bad aspects. Having said that, no one can argue that physicians and paramedical clinicians do not owe their charges a duty of care, “a breach of which alongside a reasonable foreseeable risk of injury or damage creates liability in negligence, [and] should be recognised whenever a sporting injury requires treatment” (Grayson, 1990, p. 35).

Regardless of the sporting context, Grayson (1990; 1999) states that a number of categories of negligence can be gleaned from the various sport medico-legal cases that have arisen in the UK, the US and in Canada. These categories include (a) vicarious liability, (b) the
reasonably skilful doctor the usual practice the custom test, (c) misdiagnosis, (d) the problem of the novice clinician, and (e) the need to protect the patient from himself or herself (Grayson, 1999). In an earlier text, Grayson (1990) also includes negligence in treatment as another category of negligence. Grayson (1999, p. 30) suggests that “their application to the sporting scene can be summarised under each heading, but it should be realised, adapting a judicial aphorism from the world of property law, that ‘the categories of negligence are never closed’.”

While all of these categories are valuable for discussion, a few of them need to be emphasized including the category of “the reasonably skilful doctor the usual practice the custom test.” As Grayson (1999, p. 35) notes:

As a rule a doctor is not negligent if he acts in accordance with a practice accepted at the time as proper by a responsible body of medical opinion, even though other doctors may adopt a different practice. In short, the law imposes a duty of care but the standard of care is a matter of medical judgement.

This is important to consider in the broader discourse of professional dominance and medicine, and in relation to the developing field of the law in sport medicine. Thus, while medical clinicians, particularly physicians, may not be able to control the context of their practice such as fees-for-services, they can retain control of the content of their practice and their profession. In doing so, they retain their stronghold on being the authority of health and healthcare, and limit the power of ‘alternative’ forms of and ‘alternative’ authorities of healthcare (Friedson, 1970; Williams & Calnan, 1996). “[W]hat is remarkable about professional malpractice in the case of a doctor is that the courts have uniquely conceded to the medical profession the right to determine when there has been a breach of the duty of care” (Grayson, 1990, p. 36). In this sense, there is a distinct parallel with sport, which has also claimed authority over its own disciplinary matters. It is possible to speculate that, when external regulation does become involved in a sport medicine case, it must be both serious and extreme. Furthermore, because of
the power of professional dominance, one of the most often used guidelines in sport medico-legal cases, is the analysis and comparison of the defendant’s action by his or her peers. In short:

In the realm of diagnosis there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men…. The tried test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of failing to act as a doctor of ordinary skill would act with ordinary care. (Cited from Grayson, 1990, p. 41)

This is reiterated in the category of negligence of treatment, where Grayson (1990) suggests that negligence occurs if the error would not have made by “a reasonably competent professional man professing to have the standard and type of skill that the defendant holds himself out as having, and acting with ordinary care” (p. 42). Again, the power is placed within the hands of the medical profession, and not necessarily within the judicial system. Other physicians would be the ones deciding what ordinary care consists of, or what the standard of skill would be.

Having this power adds extra responsibility onto the shoulders of sport medicine clinician, since those involved in sport have an ethical and legal duty to provide competent professional services and to ensure that they practice medicine to a high standard. Macleod (1990) suggests that increasing consumer sophistication among athletes and coaches places increasing pressure on the medical profession to ensure that their knowledge is of the highest standard. Macleod (1990, p. 65) further notes that doctors have additional ethical responsibilities with regard to the prevention of injury by advising that appropriate protective equipment is worn, by making sure the environment is safe, and that “vulnerable individuals do not participate in an event when there is a risk of aggravating a primary injury or sustaining a second, invariably more serious, injury.” He states that if a doctor recognizes a pattern of events leading to injury, he has an ethical duty to draw this to the attention of the players, coaches and legislators, in the hope
that this pattern can be broken (Macleod, 1990). This coincides with Grayson’s category of negligence, protecting the patient from himself/herself, where:

The problem here is self-evident within the sporting scene; for instance excessively enthusiastic athletes striving to return to action when not fully fit or over-zealous coaches and team management committees, which are part of the recognisable pattern of command in every sporting discipline. Without firm medical guidance emphasising the harmful consequences of the zest for play overriding such medical advice, then a liability for negligence could well arise. (Grayson, 1990, p. 43)

Roderick and Waddington (2000, p. 175) also address the patient-athlete pressuring on the clinician to return to play, and acknowledge that in a professional team setting, clinicians feel they have discharged their responsibilities if they inform the athlete of all the short- and long-term risks of playing with injury.

Depending on the level of and type of sport competition, such as professional, elite amateur or intercollegiate sport, different demands are placed on the medical clinician above and beyond his/her responsibility towards appropriate duty of care. Mitten (1996, p. 276) stresses this point in relation to Grayson’s concern for the protection of the athlete from themselves as well as in relation to liability on the part of the sport medicine clinician by pointing out that:

The team physician who allows an athlete’s strong desire to play to interfere with the exercise of good medical judgement in making a participation recommendation might be liable for malpractice. It would be inappropriate for the team physician to provide medical clearance merely because the athlete offers to sign a liability waiver or threatens a lawsuit… The team physician’s ethical and legal obligations require an individualized, thoughtful, and practical consideration of the demands of participation in a particular sport and potential harmful effects on an athlete’s health as well as other participants’ safety. When the risk of life-threatening or permanently disabling harm is uncertain, it appears advisable to opt for caution and recommend against athletic participation, even though an athlete may legally challenge this recommendation.

Pipe (1998, p. 41) writing for a North American audience, particularly with regard to high school and college athletes also suggests that physicians need to “intervene with patients” to minimize risk and to place sport aspirations in a realistic perspective. While Grayson and Macleod discuss
the general responsibilities of the sport medicine clinician, Pipe, a Canadian physician familiar with the NCAA system, recognizes the conflicting role of the team clinician in this particular sport system:

As sports medicine physicians, we have unique ethical responsibilities concerning the athletes in our care, the sports organizations we work for, and the ideals of sportsmanship and fair competition. It is easy at times, when caught up in the pressure of competition, to lose sight of the full range of responsibilities…. Our primary responsibility is to protect athletes’ health and well-being as defined most broadly. Superficially, this role may seem perfectly compatible with the interest of the sports organization with which we and the athlete are associated. However, what’s best for an athlete’s long-term health may conflict with the organization’s short-term interest in winning. As a result, we may have a problem of divided loyalty, which raises significant questions about the ethical practice of our profession. (Pipe, 1998, p. 40)

Although Pipe is discussing more than just intercollegiate sport, it is important to acknowledge that, as shown anecdotally and by established research literature, the NCAA intercollegiate sport system is, in general, much closer in focus to professional sports systems with high demands on revenue-generation, treatment of student-athletes as ‘employees.’ In a professional setting, Waddington (2000b, p. 49) also recognises this conflict with English club soccer, and suggests that the fundamental assumptions that normally underpin the clinician-patient relationship:

[M]ay not apply in the same way, or to the same degree, in the work situation of the club doctor or physiotherapist in professional sport; as… the ‘team doctor, having been invited by the club or governing body of the sport in question, is acting as an agent of that club or body.’

Waddington (2000b) questions the conflict of loyalties between club clinicians and patient-athletes, and points out that there are no commonly held codes of ethics governing such matters as the amount and kind of information medical practitioners pass on to team management. This is of concern with athletic therapists and physiotherapists who have a particular ethical responsibility because, as Waddington (2000b, p. 51) notes, “…physiotherapists – perhaps more so than doctors, most of who work only part-time at the club – often get to know a great deal
about players’ private lives.” Waddington (2000b, p. 52) notes that the athletes in his study “expressed considerable reservation about revealing confidential information to club medical staff” due to the variation in how clinicians deal with various issues (see Roderick & Waddington, 2000).

This points to the need for “an agreed code of ethics for dealing with issues involving player/patient confidentiality and, more generally, for defining the obligations of club doctors and physiotherapists towards the club and towards the individual player-as-patient” (Waddington, 2000b, p. 53). Grayson recommends the World Medical Association on Principles of Health Care for Sports Medicine (see Appendix II) as one such global code of ethics. He suggests that the WMA’s guidelines for the ethical conduct of physicians (read clinicians) should be used by all medical practitioners in all sporting contexts to protect the patient-athletes and to outline the ethical and legal responsibilities of sport medicine clinicians. Grayson argues definitively the importance of each guideline, and correlates each to the Declaration of Geneva – the international code of medical ethics (see Appendix II).

While the WMA guidelines and Declaration of Geneva represent international policy relating to medico-legal issues in sport medicine, we can also examine the policy and related literatures in Canada and even more microscopically, in the University of Toronto. The Canadian Academy of Sport Medicine (CASM) is the major sport medicine organization in Canada that develops policies and guidelines for the conduct of clinicians in sport medicine contexts. While other organisations exist that outline the role and responsibilities of athletic therapists, physiotherapists, massage therapists, etc., CASM is a non-profit organisation of physicians interested in this field [www.casm-acms.org]. Interestingly, although CASM represents, arguably, the most powerful voice for sport medicine physicians in Canada, it does
not offer a set of guidelines or specific policies for the clinician-patient relationship. Rather, it directs attention to the position statements done by CASM members in various committees, e.g., research, sport safety, and women’s issues in sport medicine, (none of which address intercollegiate sport), as well as to the Canadian Medical Association (CMA), of which CASM is an affiliate society. The CMA [www.cma.ca] is a voluntary organisation representing the majority of Canadian physicians and affiliated medical organisations, such as CASM. Although the CMA cooperates with federal and provincial governments in many areas, it receives no financial support from the government (see Friedson, 1970 and Navarro, 1986 on how the creation of associations is one way of creating reputational prestige and status in pursuit of professional dominance). The CMA does offer a code of ethics for physicians (see Appendix II), but this is generalized and not specific to the particularities of sport medicine.

As for the Canadian intercollegiate sport governing body, the Canadian Interuniversity Athletic Union (CIAU), there is a similar absence in policy relating to the nature and conduct of sport medicine in varsity programs. The CIAU Policy handbook has a section devoted to its doping policy, but largely ignores the broader topic of sport medicine. However, there is a greater acknowledgment and statement of sport medicine in general at specific universities, e.g., the Faculty of Physical Education and Health at the University of Toronto (see the Varsity Blues Student-athlete Handbook which is distributed to all intercollegiate athletes at the beginning of their season, Appendix IV). Although this document does not outline the ethical and legal responsibilities of the sport medicine clinicians, and it is not an ethical or legal policy document, it does offer intercollegiate athletes some cursory information about the David L. MacIntosh clinic and its staff.
The David L. MacIntosh Sport Medicine Clinic (see Appendix V for a brief history of the clinic) is staffed by professional sport physicians, orthopedic surgeons, athletic therapists, massage therapists, physiotherapists, a sport chiropractor, and several students in osteopathic manual practice. The clinic provides preventive, diagnostic, and therapeutic services for physical-activity-related health issues, treating not only intercollegiate student-athletes, but non-varsity University of Toronto students as well as the general public. Although the clinic used to be a G-code clinic (a type of billing that allowed physicians to bill for ‘miscellaneous therapeutic procedures’ performed by others as delegated by the physician), due to changes in federal and provincial funding and legislation, the clinic has opened its doors to the general public as a private clinic. Students, both varsity and non-varsity, are not charged for medical services since these are subsidised by their student fees. The following chart projects the estimated number of services the DLM clinic will provide in 2000-2001, clearly showing the frequency of use by varsity athletes, non-varsity students, and non-students (D. Richards, personal communication, August, 2000).

<table>
<thead>
<tr>
<th># of Services</th>
<th>Projected Figures For 2000 – 2001</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physicians</td>
<td>Chiropractor</td>
</tr>
<tr>
<td>Non-Varsity students</td>
<td>2,477</td>
<td>210</td>
</tr>
<tr>
<td>Varsity Students</td>
<td>2,477</td>
<td>210</td>
</tr>
<tr>
<td>Non-Students</td>
<td>3,302</td>
<td>316</td>
</tr>
<tr>
<td>Total</td>
<td>8,255</td>
<td>736</td>
</tr>
</tbody>
</table>

There is considerable overlap among the different disciplines in the staff regarding which type of staff member provides what type of service. In the case of the regulated health professions (medicine, chiropractic, physical and massage therapy), the scope-of-practice is to some extent legislated, and certain “controlled acts” may be performed only by certain practitioners, such as
the prescription of drugs, and surgery only by physicians and surgeons (D. Richards, personal communication, August 2000). In other situations, the scope-of-practice is dictated by education. For example, athletic therapists have the strongest background in field care (emergency management of injuries on-site, and taping or bracing for injury prevention), but the physiotherapists’ education is perhaps stronger in spinal assessment and mobilisation. All staff have pursued further post-graduate training to round out their skills, and obtain certification as ‘Sports First Responders,’ as a minimum, in emergency care of activity-related injuries.

Returning to the Research Questions

The review of literature, broken into discussions of the socio-cultural nature of pain and injury, the process of clinician-patient negotiations, as well the current status of medico-legal/policy issues, points to the need for an examination of the relationship between a ‘culture of risk’ and the negotiation of treatment in sport medicine. Given that the literature and anecdotal evidence predict that a ‘culture of risk’ is promoted in clinician-athlete negotiations, this project attempts to discover if a ‘culture of risk’ exists amongst student-athletes in this institution. The project also examines how sport medicine clinicians understand and negotiate with athletes in a ‘culture of risk’, and how they deal with the dual, and potentially conflicting, roles of patient and competitive student-athlete. It is appropriate to ask in this context:

(1) In a Faculty that promotes physical, mental and emotional wellbeing, and education regarding the social constraints and dangers of competitive sport, does a ‘culture of risk’ exist amongst the student-athletes?

(2) If there is a ‘culture of risk’ among the athletes, how is it understood by, negotiated, and dealt with by sport medicine clinicians?
(3) How do sport medicine clinicians respond to the dual, and potentially conflicting, roles of patient (an injured individual in need of treatment which may prevent him/her from competing) and competitive student-athlete (an injured individual who may have an overwhelming desire to return to training and/or competition)?
CHAPTER 3
RESEARCH DESIGN

This chapter outlines the methodology employed in the project, and is divided into three main sections – background literature and rationale for the methodology, procedures, and methodological experiences. The first section offers a brief introduction to qualitative analysis and field research, the rationale behind inductive analysis and grounded theory, as well as the advantages and disadvantages of semi-structured in-depth interviewing in both one-on-one and focus group settings. The second section focuses on the actual procedures used in the project, the last section reflects on methodological experiences, concluding with a consideration of the influence and impact of personal risk and injury experiences on this project.

Qualitative Research – Related Literatures & Rationale

This section provides a brief introduction to and examination of qualitative research methods.

Qualitative Methods & Field Research

The decision to use qualitative methods arose because of the very nature of the research questions, and given the complex and diverse range of potential responses to these questions, a conscious decision was made at the onset of this study to attempt to capture the richness of peoples’ experiences in their own terms. While in socio-cultural academic disciplines, a “nomenclature chaos” (Lofland & Lofland, 1995, p. 6) exists regarding qualitative research, this project falls under field research connoting not only a locative quality, but also a methodological tradition that “is more like an umbrella of activity beneath which any technique may be used for gaining the desired information, and for processes of thinking about this information”
Schatzman and Strauss (1973) stress and support, along with other qualitative methodologists (e.g., Berg, 1989; Charmaz, 1983; Lofland, 1971; Lofland and Lofland, 1995), the need for researchers to utilize flexible research techniques, such as in-depth interviewing. The principle being to allow participants to speak for themselves using their own terms and categories, and to assign their own boundaries to the social processes, institutions and movements of which they are part.

Since humanistic and naturalistic sociological inquiry can never be value-free, qualitative research in this vein does implicate the researcher. Schatzman and Strauss (1973, p. 2) acknowledge that, “[f]or the researcher who is in the field the image of an experimenter in the laboratory is not a fit analogue…. He claims no antiseptic distance and noninterference from outside influence.” There can be no true separation between the researcher’s interests and the research process, and therefore the researcher must acknowledge and provide some explanation for the relationship. In this respect, it is important to comment on how some of my own characteristics as a scholar, a student-athlete and as a patient-athlete interact with those of the participants to, arguably, enhance the data collection and analytical processes.

**Inductive Analysis and Grounded Theory**

While the actual procedures are outlined later in this chapter, it is important to include a brief discussion of the inductive analytical method, grounded theory, underlying this study.

In conducting qualitative field research, the orientation of the analysis is towards exploration, discovery, and inductive logic. Inductive in the sense that the dynamics between clinicians and patient-athletes are understood by attempting to allow the categories and themes of analysis to emerge from the respondents’ narratives as collected vis-à-vis the interviews and
focus groups. Fieldwork facilitates this in that the responses collected from participants come in the form of open-ended narratives of peoples' experiences, sparked by a question on a particular topic, but not restricted to pre-determined, or standardized categories such as the response choices that constitute typical surveys, questionnaires or structured interviews. Thus, the patterns and themes that are analyzed with regard to the research questions emerge from the data, rather than being decided on prior to data collection and analysis. This is not to suggest that the researcher enters both the data collection and analysis stages of any project without some pre-existing ideas and concepts about the field of study – the very fact of a literature review negates that assumption immediately. But that review of literature is meant to show the researcher what has already been established by other scholars, where potential new avenues of discussion exist, and from what point the current line of inquiry may embark (Lofland, 1971). Inductive analysis, also called grounded theory (Glaser & Strauss, 1967; Corbin & Strauss, 1990), emphasizes "the cardinal principle of qualitative analysis...that causal and theoretical statements be clearly emergent from and grounded in field observations. The theory emerges from the data; it is not imposed on the data" (Italics in original) (Patton, 1987, p. 158).

Grounded theory, as a method of analysis, allows for the formulation of theoretical interpretations of the data to be grounded in reality, providing a means both for understanding the social setting under investigation and for developing action strategies that will allow for some measure of control over it. Developed by Glaser and Strauss (1967), and being one of many approaches to qualitative analysis, grounded theory is defined as "theory derived from data, systematically gathered and analysed through the research process" (Corbin & Strauss, 1998).

An analysis of the interview and focus group data followed Corbin and Strauss' (1998) threefold coding process including open, axial and selective coding. As cited in Lofland and
Lofland (1995, p. 187), “coding is analysis...codes are tags or labels for assigning units of meaning to...information compiled during a study.” According to Charmaz (1983, p. 111), coding begins “the process of categorizing and sorting [Italics in original] data. Codes then serve as shorthand devices to label, separate, compile, and organize data.... Codes [also] serve to summarize, synthesize, and sort many observations made by the data.”

Corbin and Strauss’s threefold process of coding – open, axial, and selective – offers one system of developing grounded theory. The first stage of coding, open coding, sees the “analytic process through which concepts are identified” (Corbin & Strauss, 1998, p. 101). This process is similar to process of initial coding, where “researchers look for what they can define and discover in the data” (Charmaz, 1983, p. 113). Thus, at the stage of open coding, the transcripts of the interview and focus group sessions were read and re-read in search of recurring themes, ideas, words, processes, etc., as brought forth by the participants. The recurrences were ‘labeled,’ and then grouped together in categories and sub-categories. Once categories were named, even tentatively, the analysis moved to identifying properties and dimensions of the categories in order to begin to identify broader themes and patterns. At this initial stage of analysis, emphasis is on thinking about and interpreting the data as openly as possible.

While the labelling of phenomena consisted of a word or a few words, the stage of open coding also saw the development of memos, designed to be the “‘researcher’s record of analysis, thoughts, interpretations, questions, and directions for further data collection” (Corbin & Strauss, 1998, p. 110). Memos were written out as “explanations and elaborations,” (Lofland & Lofland, 1995, p. 193) and as prose, were meant to tell what the code was about, what questions it raised, what should be investigated further in regards to it, the different properties and dimensions it held, etc. (Charmaz, 1983). The process of creating memos was also an exercise in unrestricted
analytical creativity, since as Lofland and Lofland (1995, p. 193) note, "[memos] don’t just report data; they tie together different pieces of data into a recognisable cluster, often to show that those data are instances of a general concept."

Open coding was followed by axial coding, which is the process of "relating categories to their subcategories" (Corbin & Strauss, 1998, p. 123). Thus, the categories and sub-categories that seemed conceptually similar were grouped together and were examined with regard to how they interacted and interrelated with one another. At this stage, there was an attempt to identify the variety of conditions, actions/interactions, and consequences associated with the categories. The memos reflected the search for cues in the data that denoted how the major categories may have related to each other, as well as the continuous comparison and cross-referencing of categories.

Axial coding led to the final stage of theory development, known as selective coding, defined simply as "the process of integrating and refining theory" (Corbin & Strauss, 1998, p. 143). Lofland and Lofland (1995, p. 192) suggest that this stage of coding, with some overlap with the previous stage, can also be called focussed coding where, "[s]ome codes begin to assume the status of overarching ideas or propositions that will occupy a prominent or central place in the analysis." It is at this stage where categories were refined and integrated into larger theoretical schemes – that the research findings began to take the form of theory. Codes and memos at this stage did not simply reiterate theme upon theme, but rather, looked to create central concepts and relational statements that could be used to explain what was going on in the research setting.

It is important to point out the artificiality of discussing the analytical method, in terms of three major steps. Very few boundaries exist in this form of inductive, qualitative analysis in
that the coding did not travel and progress in a purely linear fashion from open to axial to selective, but rather wove in and out of coding stages as the research progressed. Similarly, the analysis did not begin promptly at the end of data collection, but ran concurrently with it (Lofland, 1971). There was overlap at times, but the analysis that did occur after data collection ceased, seemed more a period of bringing final order to developed and developing ideas.

**Semi-structured Interviewing**

*The purpose of interviewing...is to allow us to enter the other person’s perspective.*

(Patton, 1987, p. 109)

A semi-structured interviewing procedure was employed in this study (see Fontana & Frey, 1994; and Patton, 1987 for detailed histories of interviewing and focus groups). As a type of field research, interviewing provides depth and detail to qualitative data through direct quotation, and is a major way in which qualitative researchers seek to understand the perceptions, feelings, and knowledge of people in various settings (Lofland, 1971).

Situated between formal and informal interview, a semi-structured interview is defined as, “a type of interview [which] involves the implementation of a number of predetermined questions and/or special topics...typically asked...in a systematic and consistent order...[but] the interviewers are permitted (in fact expected) to probe far beyond the answers to their prepared...questions” (Berg, 1989, p. 17). Participants are asked open-ended questions that may be worded differently depending on each interview, yet which follow an interview guide to make sure that essentially the same information is obtained from a number of people by covering the same topics during interview/focus group sessions. The semi-structured interview guide
provided a framework in which people could respond in ways that represented their point of view as accurately and thoroughly as possible.

While there were clear advantages to using interviews and focus groups as the data collection methods for this study, there are also some disadvantages to these techniques. Although accepted as valid forms of field research, interviews and focus groups are “at least one level removed from direct observation of and participation in independently ongoing natural settings” (Lofland & Lofland, 1995, p. 3). Thus, I relied on peoples' interpretations of their experiences and on their choice of language used in relating those experiences to me. The disadvantage of this lies in the fact that, as Willis (1978, p. 196) notes:

Language is a code and not a direct representation of reality. There are many other codes of signification. The researcher needs to be open to all the kinds of communication used in a particular setting, and to all the implicit contradictions between the different codes and between the substantive meanings communicated in the different codes. These contradictions need to be recognized, contextualized and, if possible, explained.

This reliance on the language of the respondent brings up its own difficulties, and required that I work at becoming a skilled observer (Patton, 1987), able to read non-verbal messages, and be sensitive to not only the content of the interview but also to how the context and setting of the interview affected what was said.

Another disadvantage of the interview lies in the fact that research participants offer a “filtered reality” (Lofland & Lofland, 1995), where descriptions, meanings and interpretations are applied to events when the participants themselves are looking back in hindsight. This information is filtered in that the descriptions, meanings and interpretation that participants use are based on and influenced by their social, cultural and political situations. As Lofland and Lofland (1995, p. 68) suggest:

...[A]ll human observations of the world (whether of the social, the biological, or the physical world) are necessarily filtered. Human perception is always human conception:
What we ‘see’ is inevitably shaped by the fact that we are languaged; by our spatial, temporal, and social locations (by culture, history, status); by our occupational or other idiosyncratic concerns; and, especially relevant here, by the scholarly discipline within which our ‘looking’ takes place.

However, counteracting these negatives, in part, is the fact that the researcher is not a novice in, or naïve about, the subject of the research. My own experiences as athlete and patient adds validity to my observations and interpretations during the interview process.

The Interview Guide

The semi-structured interview guide is significantly less structured, which Lofland and Lofland (1995, p. 85) suggest is, “…a list of things to be sure to ask about when talking to the person being interviewed….” Thus, interviews might more accurately be termed guided conversations” [Italics in original]. The interview guides for this project were developed using Lofland’s principles (1971), and the emphasis was placed on obtaining peoples’ experiences in their own terms. The actual wording of the questions about those issues was determined in advance, but there was a deliberate intent to adapt both the wording and sequence of questions to specific respondents in the context of the actual interview. Probes were used to deepen the response to a question, and to give cues to the interviewee about the level of response that was desired (Patton, 1987). The advantage of the guide was that, even though I was interviewing different people and different groups, the process was systematic and comprehensive by delimiting the issues to be discussed in the interview. The guide kept the interaction focused, but allowed individual perspectives and experiences to emerge (Lofland, 1971; Patton, 1987).

Both one-on-one interviews and focus groups were conducted in this project, the latter designed to supplement and add context to the responses gained in the former. Focus groups are advantageous for qualitative researchers in that information can be gathered from more people in one session as compared to a one-on-one interview, thus increasing the sample size (Patton,
Similarly, they provide, "...a control on the reliability of the data and a guarantee of a kind of validity...[since] the mutual historical knowledge of constituent group members usually...encourages individuals to express more what is common to all" (Willis, 1978, p. 195).

The focus group guide followed the one-on-one interview guide in terms of flexibility and spontaneity – the goal being to have guided conversations with participants. So, as Willis (1978, p. 195) points out, "during group discussions...although the researcher may start with general questions he should aim to generate a 'take off' whereby the discussion goes into areas quite unsolicited by him."

Procedure and Data Analysis

The data collection process included semi-structured interviews with sport medicine clinicians and intercollegiate athletes, as well as focus groups with intercollegiate athletes and coaches. This is a case and is not concerned so much with quantitative representativeness, as it is with understanding the negotiation processes between clinicians and patient-athletes. Since the direct nature of this project was to investigate the role of the sport medicine clinician when dealing with patient-athletes and their bodies, it is important to discuss the measures taken to give patient-practitioner confidentiality the highest priority. All information obtained was in confidence, and only those excerpts that were approved by the individual are presented in this study. Participants were informed at the beginning of each data collection session that any specific references to patients, clinicians, or situations would be disguised in the research beyond the transcripts. This was particularly applicable to data about particular injuries where the injury type or severity may have revealed either the athlete who sustained the injury or the coach/clinician who discussed the injury. In these cases, the injury type was not mentioned in
the thesis, if possible, or it was altered to render it unrecognisable. It is also important to mention that some specifics about the participants are not given, such as sport/team affiliation or type of clinician, because these would be highly identifiable. Transcripts of interviews and focus group meetings were made available to only those participants who expressed an interest in viewing them, although not one participant took advantage of this. Participants were given an adequate amount of time in which to review quotations that I wanted to use in the thesis, and to voice their concerns if they had any. Similarly, no one expressed any concerns. Research materials were secured in a locked cabinet, accessible only by the researcher.

Participants were also informed, via letter of informed consent of a clause in confidentiality that if there was mention of an unethical and/or harmful situation, I would consult directly with my supervisor. While this situation did not occur, this was an important ethical consideration due to the obligations of medical clinicians “to do no harm” (L. Mainwaring, personal communication, December 9, 1999). Participants had this clause pointed out to them in the consent form, and no one withdrew from the study.

(1) Sport Medicine Clinicians:

The sport medicine clinicians at the David L. Macintosh clinic were contacted via the Medical Director, Dr. Doug Richards. After discussing the project with Dr. Richards and gaining his approval for the project, we discussed the most appropriate way of approaching the rest of the clinic staff regarding the project. In order to gain access to the clinical staff, Dr. Richards was approached to facilitate opportunities for “getting in” – described by Lofland and Lofland (1995) as the ability to gain the acceptance of the individuals one wishes to study. It was agreed with Dr. Richards that the best way would be for him to raise the subject of the research project with the clinicians over the course of two staff meetings, where they would be
able to look over Dr. Richards' copy of the thesis proposal and volunteer to be part of the project if they chose to do so. It must be acknowledged that this way of recruiting clinicians may be considered a potential limitation of the study, since interested clinicians may have begun to formulate what they deemed would be appropriate and socially desirable statements and responses before the questions were even posed. But, since this method of gaining entry was deemed most appropriate by Dr. Richards, who was essentially the "gatekeeper" (Schatzman & Strauss, 1973) to the clinicians, my recourse was to be sensitive to this issue, and to be prepared to explore it further within the analysis and discussion of the thesis.

Dr. Richards sent me the e-mail addresses of the clinicians who volunteered; they were then contacted to arrange times and dates for interviews. E-mail was sent out to 14 clinicians including sport medicine physicians, physiotherapists, athletic therapists, and massage therapists. Five clinicians responded to the e-mail, expressing their interest in being part of the project, not including Dr. Richards who expressed his interest in being part of the project from the very beginning. Interview dates and times were arranged via one-on-one e-mails with four of the respondents — at their convenience, and with the full knowledge that their involvement would be completely confidential and optional. The fifth respondent was not able to be part of the study since we could not meet at a mutually convenient time to conduct the interview.

Interviews, lasting 60 to 90 minutes, were conducted at a mutually agreed upon location. At the beginning of each interview, all participants were asked to provide informed consent (see Appendix VI (i)), were assured of confidentiality and anonymity, and had their interviews tape-recorded. Participants were then informed that they may review their transcripts at any point of time in the research, and that they would be notified of and able to review any quotations that were to be used in the study. Before we began, I emphasised that their participation was
optional, and that they could withdraw from the study at any point in time without penalty. Participants were also told that if they did withdraw permanently from the study, their interview material (tapes and/or transcripts) would be destroyed immediately.

Only one interview was conducted with each clinician, with the exception of Dr. Richards who I had the opportunity to interview twice. All clinicians expressed their willingness to be contacted regarding further clarification and discussions of issues if need be. All interviews were semi-structured (see Appendix VII).

(2) Intercollegiate Student-athletes:

i) Focus Groups:

I faced a significant deadline in contacting athletes for both focus groups and for one-on-one interviews. Since the university/academic year was coming to an end, I ran the risk of not being able to contact athletes once the holidays began. Thus, instead of approaching the athletes during their respective team practices as planned, I contacted the Athletic Director to discuss various ways of approaching the students. On learning the nature of my project, the athletic director provided me with a copy of the University of Toronto Varsity Board member phone and e-mail address list. The Varsity Board consists of representatives from each intercollegiate team (including non-contact, contact and collision sports), both male and female. This fact also may be seen as complicating the research, since the individuals who sit on the Varsity Board are those individuals who may be the most socially and politically aware, most outspoken, or the natural/chosen leaders of their teams. Their point of view towards the ‘culture of risk,’ and the clinic, may be very different from their team-mates as a result of their participation on the Board, and/or their existing views about these issues may have influenced their desire to be involved
with the Board in the first place. Unfortunately, due to approaching summer holidays and other time constraints, this way of approaching varsity athletes was seen as the only viable option.

Two group e-mails were sent – one to women’s team representatives and one to men’s team representatives – outlining in brief the research project (e.g., gathering general information on the ‘culture of risk’ amongst student-athletes at the University of Toronto, as well as the interaction between sport medicine and competitive sport), and asking for their participation. The focus groups were not limited injured athletes in the hope of creating different patterns of dialogue, thus facilitating either the emergence or reinforcement of pertinent themes. The e-mails also included three potential dates and times, thus allowing respondents to sign up for the time most convenient for them. Those who responded to the e-mail were contacted again to confirm the date, time and place (all focus groups were held in the Athletic Centre). The most popular dates and times, i.e., the one that most respondents chose, was selected for the actual focus group session. Those who responded to a different date or time were contacted again, and asked if they could make it to the other time or if a teammate could. The initial e-mail messages also asked representatives to forward the e-mail to team-mates who they felt would be interested in being part of this project, either for a one-on-one interview or as part of the focus group, if they themselves could not or would not be involved with the project. This began the process of “snowball” sampling (Berg, 1989), where respondents may disclose other potential subjects to the researcher. As Lofland and Lofland (1995, p. 38) note, “...the major principle involved in...snowball or chain-referral sampling [is] a method that yields a study sample through referrals made among people who are or know of others who possess some characteristics that are of research interest.” This in fact was the case as a number of the Varsity Board members contacted did in fact forward the e-mail to team-mates who then contacted me, via e-mail, with
an interest in becoming involved in either the focus group or an interview. Similarly, three Varsity Board representatives e-mailed me notifying me that they would be unable to attend the focus groups, but would be interested in talking about their injury history and their interaction with the clinic in a one-on-one interview. Those three athletes were subsequently interviewed at a later date.

The tape-recorded focus groups were between 60 to 90 minutes in length, semi-structured (see Appendix IX), and began in a similar fashion to that of the one-on-one interviews. While ten female athletes and six male athletes agreed to be part of the focus group sessions, ultimately the women's focus group consisted of five athletes, while the men's focus group consisted of four athletes. The other athletes did not show up and only two contacted me with regard to rescheduling and/or being interviewed at a later time. Before the session began, respondents were reminded of the confidential and optional nature of the focus groups, and asked to provide informed consent (see Appendix VI (ii)). They were told that they could have access to the transcript of the focus group at any point of time in the study, and that they would be notified of and be able to review any quotations to be used in the study. They were also told that they could withdraw from the study at any point in time without penalty, and that if they did so, their involvement in the focus group session would not be transcribed, and that the group data (i.e., tape and/or transcripts) would be destroyed upon completion of the study.

ii) Interviews

Five student-athletes were interviewed using a semi-structured interview guide (see Appendix VIII) in the course of this project, three women and two men from all types of sports (one non-contact, two contact, and two collision). Three of the interview participants were recruited through the e-mail regarding focus group involvement, but none of the interviewees
took part in the focus groups as well. Two of those three were Varsity Board representatives for their respective teams, while the other was referred to me by his/her Varsity Board representative. S/he contacted me after receiving the forwarded e-mail and expressed an interest in being part of the study. The other two interviewees were contacted after the clinicians' interviews due to their involvement with particular teams and their history of particular injuries. They were approached privately through e-mail, informed of the nature of the project and asked whether they would like to participate to which both responded positively. In a number of ways, this was a sample of opportunity since it was by luck that I interviewed athletes from a range of sports, a range of pain/injury philosophies, a range of injury experiences from severe, acute trauma to chronic, overuse injuries, and a range of different sport medicine experiences.

All the interviews were conducted at a mutually agreed upon date, time and place, and took between 60 to 90 minutes. Before the tape-recorded sessions began, participants were asked to provide informed consent (see Appendix VI (i)), and were assured of anonymity and confidentiality. They were informed that they could review their transcripts at any point of time in the research, would be notified of and able to review any quotations that were to be used in the study, and that they could withdraw from the study at any point in time without penalty.

(3) Intercollegiate Coaches:

The coaches were contacted via e-mail using the 1999-2000 University of Toronto Intercollegiate Directory, provided by the Athletic Director, which included the phone numbers and e-mail addresses of all intercollegiate coaches. E-mail messages were sent to the coaches outlining the project – to examine their relationships with, their views on sport medicine clinicians, and their concerns about injured athletes – and asking for their participation in the study in a focus group. Three potential dates and times were also sent, which coaches could then
sign up for. The most popular dates and times were selected for the actual sessions. Although only one focus group was planned, there was enough interest from the coaches to warrant two focus group sessions.

Two sessions occurred on different dates and times in a mutually agreed upon location, consisting of four participants each (three female and five male in total), and representing all three types of sport (two non-contact, three contact, and three collision sports respectively). The semi-structured sessions (see Appendix IX) were tape-recorded, and were approximately an hour long. Similar to the interviews and focus groups with clinicians and athletes, coaches were asked to provide informed consent (see Appendix VI (ii)) at the beginning of the session, and were informed of their rights as participants (i.e., confidentiality, anonymity, access to the transcript of the focus group at any point of time in the study).

**Data Analysis**

This brief section completes the details of the data analysis, and the ways in which I coded the data. The data analysis truly began as soon as the interviews/focus groups were completed in that I wrote down thoughts, impressions, and ideas immediately following the interviews. The tapes were then transcribed verbatim, and were read and re-read while listening to the tapes, in order to gain a better sense of tone and inflection on the printed page. After the first couple of transcripts were reviewed in this manner, I returned to the transcripts and began to insert codes after themes or ideas that I felt were being repeated or stressed by participants, sparked something in my mind, seemed potentially valuable, or was of interest to me. I would do so after particular words, phrases, or even whole paragraphs. As I inserted these labels, I would also write memos after the codes which would elaborate my thoughts, question the
findings, or suggest new directions to follow in future interviews. These became quite valuable as the data collection proceeded, since data analysis and the interviews occurred concurrently and I was able to change interview directions to question these new areas. The memos varied in length and type, and included such things as diagrams, notes to self, questions about the research topic, and at times, questions about the memos themselves.

Once the transcripts had been initially coded, I revisited them and went through the codes and memos again, trying to elaborate further on the themes in relation to all the transcripts. Once the transcripts were completed and read a number of times in the initial stage of coding, I had a sense of certain themes that carried throughout all the interviews, and others that were particular to a group of participants or individuals. Some codes and memos were re-examined and developed further, while some others were put aside to be considered for future research.

I collapsed the interview and focus group transcripts together for the athletes, and grouped the transcripts by the group of participants, i.e., clinicians, student-athletes, and coaches. Once in these three piles, I began to literally cut the quotations out of the transcripts and re-group them thematically. Some quotes would be applicable to two or more themes, and I would duplicate it and place into all the thematic piles. Once this process was completed for all three groups, I took note of all the thematic piles that were created on cue cards, putting aside those that were weak (in terms of supporting quotations) or poorly developed. After creating the labelled cue cards and creating three large charts listing all the themes found per participant group, I began a process of putting together the themes from the three groups. Themes such as concussions or clinic accessibility were touched upon in some fashion by all three groups of participants. Once this occurred, I revisited the quotations and tried to find how the different
quotations spoke to one another. At times, I also returned to my 'cut file' and brought back themes and/or quotations that had been put aside.

Once the themes and the direction of the findings emerged from the data, I proceeded to narrow down which quotes I felt should be used in the thesis. Quotes that were selected best exemplified the theme that I wanted to discussed, and offered anonymity to the participants. Those that were identifiable were put aside, as well as those that repeated.

Methodological Experiences

The fieldwork strategy adopted in this study followed some of the field research principles outlined in Schatzman & Strauss (1973) and Shaffir & Stebbins (1991). Both texts document ‘strategies’ for conducting field research, and identify methodological stages including: “getting in”, “learning the ropes”, “maintaining relations”, and “leaving and keeping in touch” (Shaffir & Stebbins, 1991). While these stages are mostly relevant to ‘participant observation’ type fieldwork, they also have relevance with regard to in-depth interviewing and focus groups. It is valuable to conclude this chapter by briefly discussing these stages of the research, and identifying both the successes and problems that I experienced in this study, and which shape its final outcome.

Getting In

“Getting [into]” (Lofland, 1971; Lofland & Lofland, 1995; Shaffir & Stebbins, 1991) the field represents the “the first truly social moment of naturalistic investigation,” when the researcher attempts to “[get in] or [gain] the acceptance of the people being studied” (Lofland & Lofland, 1995, p. 31). In this project, this process was facilitated in a number of ways, but as
Lofland and Lofland (1995, p. 31) point out, "the specific form of relationship a prospective investigator has or will develop with the people or setting of interest generates its own set of problems, ethical questions, and solutions regarding the process of entry." ‘Getting into’ the clinic and even gaining access to the coaches and athletes involved obtaining the permission and approval of the Medical Director and the Athletic Director – two individuals with whom I already had “pre-existing relations of trust” (Lofland, 1971, p. 95). Both these individuals represented “gatekeepers” (Schatzman & Strauss, 1973) for this project, and while my relationship with the latter involved nothing more than a meeting and a brief outline of the research project, my interaction with the former gatekeeper had greater impact on this study.

Right from the beginning of this study, Dr. Richards, as the Medical Director, was contacted for his approval regarding the implementation of this project. He was aware of the design of the study and what it was to investigate, and approved the project as such. In order to gain access to the clinicians, Dr. Richards was again enlisted to ‘introduce’ the researcher and the project to the staff. This included having a copy of the research proposal available to clinic staff members to read and examine if they chose to do so. This process illuminates a number of factors that have affected the rest of this study. Firstly, I was openly identified as the researcher, thus becoming a “known investigator” (Lofland, 1971; Lofland & Lofland, 1995). While the clinicians may have identified me before as a graduate student, a varsity athlete or even as a patient-athlete, my project and its focus on them may have influenced their views and attitudes towards me, thus influencing their interaction with me both during and beyond the study. Similarly, by having the research proposal available to them, clinicians may have ‘prepared’ themselves to what they thought would be possible questions in order to give socially desirable answers. However, none of the clinicians, except Dr. Richards, viewed the interview guides.
While some may consider this as too much ‘giving away’ of information and intent, I contend that this was essential to gaining the co-operation of the clinicians to be participants in this study. Furthermore, Lofland and Lofland (1995) note that many subjects, even if given as detailed an explanation of the study, will not understand the concepts and terms in the research in the same fashion as the researcher. While I was fortunate in that none of the clinicians read the proposal, as far as I know, I still found that having the proposal in the clinic, and being known as a researcher, added to the open relationship between participants and myself. Clinicians knew that I was not out to expose them, to judge their clinical skills, or put them into compromising situations, thus encouraging discussion and exchange.

With regard to the student-athletes, I found that most athletes were very open towards my work and me. This may have been a result of the ‘minimal’ cultural and ascriptive differences between myself as researcher and them as the subjects (Shaffir & Stebbins, 1991). Thus being a middle-class, female intercollegiate athlete and university student in my mid-20s (similar demographics to the athlete respondents) may have enhanced my ability to enter the field and be accepted by the students.

I may also have enhanced the acceptance process by maintaining a certain degree of distance in initially contacting them through e-mail. By e-mailing them first instead of phoning and/or approaching them physically, I was able to maintain some comfort distance between us thus allowing the athletes to either accept or reject the project without feeling obliged in any way. Once aware of my role and the goals of the study, the majority of athletes approved of the work and agreed to be involved. A good rapport was further established with the athletes by simply being friendly, open and willing to meet and talk with them on their own terms – that is, at their convenience, at a comfortable place they chose, their time preference, etc. (Shaffir &
This was also a factor in my relations with the coaches, since I contact them initially via e-mail, outlined the goals and purposes of my work, and gave numerous options for focus groups dates and times. Much like the athletes, once aware of my intents and expectations as researcher, the majority of coaches expressed a desire to be involved in the study.

**Learning the Ropes and Maintaining Relations**

After gaining entry into a particular setting, the next stage of field research begins with learning about the setting, the people, and their activities – in short, learning the ropes. As an athlete in a varsity collision sport, and as someone who has been a patient-athlete and in rehabilitation settings, I invariably entered the field already familiar with the setting, relied upon personal experiences throughout the research process, and took advantage of it in establishing relations with participants. I recognise that this insider status and experience influenced how I approached this entire study, but as Corbin and Strauss (1998) acknowledge, “the ability to recognise the tendency toward bias” (p. 7) is a fundamental characteristic of a grounded theorist, and that it is “more helpful to acknowledge that [biases] influence our thinking and then look for ways in which to break through or move beyond them” (p. 99). Similarly, according to Berg (1989: 58), “knowledge about the people being studied and familiarity with their routines and rituals facilitate entry as well as rapport once entry has been gained”. I was able to communicate to participants that I was not a complete foreigner to their social world, and that the interview session was going to be about sharing experiences.

While trying not to appear as a foreigner to the field, I also tried not to appear as an expert on the topics that were raised in interviews and focus groups. I tried to follow Berg’s (1989, p. 56) advice to embody a neutral attitude toward participants – “appreciating the situation
rather than correcting.” The best way was through the prompts that were incorporated in the interview guides, allowing participants to articulate what they may have taken for granted or what they assumed I would automatically know or understand. While prompts did deepen the sessions, I did have to consciously try not to ‘lead’ participants with the wording of the probes.

During the course of the research, in maintaining relations with respondents, my immediate goals were to create an atmosphere that was comfortable for all. This included arranging interview sessions at their convenience, being courteous, emphasizing their rights to confidentiality and anonymity, and even in wearing the appropriate mix of clothing to communicate that the interview was neither a cold, scientific affair nor an unprofessional gathering. It became obvious that participants were comfortable with the interviews and focus groups – one interviewee even went so far as to remark at the end of the session that they did not expect the interview to be so relaxed, and that it was more of a conversation than an interview. Participants, particularly in the one-on-one interviews, felt free enough to volunteer names of patient-athletes with whom they thought I should talk, thus facilitating the snowball sampling technique. I tried to maintain the rapport and reciprocal nature of the interview/focus group throughout the session and at its end by asking participants if they had any questions to ask me. At this point in time, I would turn off the tape-recorder to further their comfort. Not many of the participants asked questions, and those who did tended to want to discuss the topics in more depth or to obtain my opinion of them. I found that these moments were as productive as when the tape-recorder was on in terms of themes and issues raised, and often spent between 30 to 45 minutes post-interview writing field notes and elaborating on the comments in more detail.
Leaving and Keeping in Touch

Since my ‘insider’ status affected my entrance into the field and the relationships I had with participants – arguably to add insight into the dynamics at play between clinicians, athletes and coaches – my departure from the field as a researcher was also affected by my familiarity with the setting and people. While the short-term, overt nature of my project allowed for leaving the field to be unproblematic, in a number of ways, I am not completely leaving the field of research since I continually encounter interviewees in the Athletic Centre, in the clinic, or around campus. None of the interviewees have approached me asking questions about the research, but by seeing others frequently, opportunities for further discussion always exist. This ability to re-enter the field with relative ease – to ask follow-up questions or to clarify material – is one advantage of remaining in touch with participants. Furthermore, by making sure that the quotes used in the actual thesis were reviewed and approved by the participants kept me in the field beyond the data collection period, and communicated to interviewees that their involvement in the research process was valued beyond their interview/focus group session as well.

Writing Myself “Back into the Narrative”

Using this citation from McDonald and Birrell (1999, p. 289), I would like to conclude this chapter by discussing how my own personal experiences as a scholar, a student-athlete and as a patient-athlete have influenced and impacted my methodological experiences during data collection, and invariably throughout the entire research process. This is critical since as McDonald and Birrell (1999, p. 289) acknowledge researchers have been facing a “crisis in representation” since the seventies and eighties when “field workers realized that absenting
themselves from the narrative accounts they were producing was not just a polite fiction; it was bad science."

Examining how my life intersects with this project is essential, since this project was borne out of my biography, and my desire to understand how and why I interact in particular ways with sport medicine clinicians. While I have admitted freely that I have been and still am assimilated into a ‘culture of risk’ via my participation in women’s rugby at varsity, club and representative levels, I have remained quite quiet up to this point about my personal experiences with risk-taking, pain, and injury tolerance. In fact, I am quite ambivalent towards that very subject since while I have critiqued and tried to educate others as to the dangers of the ‘culture of risk’ in competitive sport, I have played with pain and injury, downplayed and hidden injury from clinicians, and risked significant, life-long disability in doing so. While the researcher and scholar in me have frowned upon such behaviour, the athlete has seen this behaviour as necessary and ‘part of the game’ at the time. This is not meant to be a confession, but rather a way of understanding some of the assumptions I had to fight throughout the research process. For example, because of my own pain/injury position, I found that I would assume that most of the student-athletes who participated in this study felt the same way towards injury, pain and risk-taking. Thus when some of them would communicate resistance towards overconformity to the sport ethic, I would intuitively disagree with them, and in effect, narrow my focus on understanding their perspective. In fact, I believe that in some cases, my resistance towards ‘different’ pain/injury ideologies leaked into the ways I questioned and prompted participants during interviews and focus groups. By acknowledging this tension between my own assumptions and the narratives being communicated by the participants, I have attempted to re-open my focus and attention to the range of responses to pain and injury tolerance. This
enhanced the project in that I have a heightened awareness of my own biases towards pain and injury, worked to develop a sensitivity towards how I implicitly and explicitly communicated my personal views in my dialogues with participants, and worked to create a heightened awareness towards others’ philosophies of pain and injury.

Having declared and outlined my pain/injury position and my struggles with it, it is also imperative here to outline the other social, political and cultural variables that accompany me into this project, and which influence and impact the work. McDonald and Birrell (1999, p. 291) argue that in “reading sport critically,” a cultural studies perspective would include media, individuals, fashion, and subcultural practices, such as those towards pain/injury in sport and/or sport medicine, as “cultural texts or artifacts.” They further emphasize that cultural texts “are ideologically coded and affected by larger political struggles related to age, race, and class divisions,” and that they “cannot be artificially separated from their material roots, as they both constitute and are produced by social practices in particular institutional contexts which have histories” (p. 291). While this is true of the subcultural practices studied in this project, this also strikes a chord in situating the researcher within the research. Being a young, middle-class woman from a Persian-Canadian ethno-cultural background, who participates in a traditionally male sport, has a particular political re/articulation that reverberates throughout the thesis, and which has affected and affects its outcome. We cannot underestimate the fact that a different researcher may have elicited different perspectives on the ‘culture of risk’ and sport medicine from the participants. In trying to be a critical interdisciplinary scholar, I must locate myself, adapted from McDonald and Birrell (1999, p. 286) as a “reflexive political subject, working through [my] own contradictions of loving the solidly British [hegemonic masculine, and pain tolerating] institution[s] of [rugby/sport] while understanding its ideological import in
reproducing British [masculine, and 'culture of risk'] hegemony in [Canada, women's rugby, and sport in general].” Thus, we are not just attempting to situate and investigate cultural practices within the struggles of race, gender, class and history, but also the researcher within those same power struggles, and the interplay between the two. As Mills (1959, p. 9) succinctly puts it, “[n]o social study that does not come back to the problems of biography, of history, and of their intersections within society has completed its intellectual journey.”

Although this chapter has considered some the broader issues behind qualitative research, the actual procedures used and some of the methodological experiences, it is important to conclude by pointing out that methodology and the researcher are both influenced by setting and context, including such intangibles as history, and biography. In discussing the project results, this is an important issue that will surface throughout the subsequent chapters.
CHAPTER 4
RESULTS and DISCUSSION, I

The results of this study are presented, and discussed in two chapters. This first brings together the themes found in the subjects’ responses to the research questions, in answering the research questions (reintroduced below). Chapter 5 is devoted to developing several models that attempt to trace, visually and theoretically, the ways in which the clinicians, athletes and coaches negotiate pain and injury in a ‘culture of risk’ in intercollegiate sport competition. The two chapters overlap, which highlights the interplay of concepts in this preliminary attempt to identify the negotiation processes involved in sport medicine. While this chapter addresses the questions originally outlined for this project, Chapter 5 discusses in more depth the context and content of sport injury/pain negotiations as seen in this case study. The second section also examines more closely the influences of the coaches on the interaction between sport medicine clinicians and patient-athletes. It is important to point out the ways in which participants’ quotations are differently identified from interviews and focus groups. Using athletes as an example, in an excerpt from an interview, the interviewer and athlete are identified, while in focus groups, the different athletes are identified as Athlete 1, Athlete 2, etc., every time they speak.

Question 1 – Existence of a ‘Culture of Risk’

While academic and anecdotal sources indicate a ‘culture of risk’ exists, this first question attempts to determine if in a faculty that promotes physical, mental and emotional wellbeing, as well as advanced understanding of the social constraints and dangers of competitive sport, whether a ‘culture of risk’ does exist amongst its student-athletes? The evidence from this project, especially the responses from the student-athletes, indicates that a
'culture of risk' does exist amongst the students. Since this was not a comparative study between institutions or between teams/sports, it is difficult to gauge and measure the levels of assimilation into a 'culture of risk' by the students in various sports and on various teams. However, it is safe to say that the participants' responses support research done by Young and White (1995), and Young, White and McTeer (1994). While these studies also examined the gendered and gendering aspects of pain and injury as interpreted by athletes, I did not investigate fully the relationship between gender and the 'culture of risk' in this study. This is not to say that gender differences were not evident among the participants, but that they were minimal and supported Young and White's (1995) assertion that the difference is a matter of degree between how women and men understand, interpret and experience pain and injury. While the focus of this study was towards investigating the broader negotiation processes between clinicians, patient-athletes and coaches, future studies need to investigate the intricacies between how female and male patient-athletes negotiate with female and male sport medicine clinicians within a 'culture of risk.'

"Injury Talk" and Risk Rhetoric

As acknowledged by Young and White (1995), and Young, White and McTeer (1994), there are particular ways of speaking and communicating that reflect the uncritical and unquestioned acceptance and tolerance of pain and injury. Young, White and McTeer (1994, p. 182-183) term this "injury talk," and argue that it involves "[linguistic] strategies [that] are articulated as rules of conduct, or norms, but [which] also include various techniques of neutralization." They outline four such strategies including "hidden pain," a coping mechanism that denies and attempts to ignore pain; "disrespected pain," the development of an attitude of "irreverence" for pain and injury; "unwelcomed pain," the concealment of injury from others;
and "depersonalized pain," a "particular way of thinking and speaking about pain, including the use of certain discursive techniques that result in its depersonalization and objectification" (Young, White & McTeer, 1994, p. 182-186). Young and White (1995, p. 53) acknowledge that all these strategies involve the "suppression of effect" – the effect of pain/injury – and that sport experiences around pain/injury can be ambivalent and contradictory as athletes rationalize their injury-tolerating norms. An example of this can be seen in the contradictory answer a contact sport athlete gave in recounting her injury experiences during the season.

Interviewer:
Did you have any injuries this year playing ___?

Athlete:
Nothing major at all, nothing that I had to take time off for [pause]. Well, what I did have was a strain in both my quads actually, big time. It was pretty minor, and I didn’t play for a week or two.

While the athlete commented on her seemingly minor injury, she contradicted her suggestion that it minimally affected her life by adding that she did not play for a couple of weeks. The effect of the injury was suppressed in such an uncritical manner that the injury, one that required taking a significant period of time off from participating, was normalized as insignificant.

The last neutralization strategy outlined by Young and White (1995), and Young, White and McTeer (1994), "depersonalized pain," involves distancing injury from the rest of the body, as well as the articulation of bodily damage through "the use of impersonal and techno-rational discourse" (Young, White & McTeer, 1994, p. 186). This can be seen in the response of a collision sport athlete who described the injury experienced during in his/her competitive season.

Athlete:
...[S]o what did I have this year? Pelvic injury, it was a chronic injury. I had unstable stabilizing muscles that just weren’t there. My left side of my pelvis, all my adductors, my hip flexors, my gluteus, and my lower abdominals. So all those had to be strengthened. And what was happening was my hip was just mal-aligned, which caused pain in the pubic symphysis area and all around the inside, where it shouldn’t hurt. Yeah, it caused me pain running, walking, everything. So we got that fixed.
Interviewer:
But you kept playing?

Athlete:
I was rested for maybe a week, so I missed the first two games of the season, but then I played. But then it flared up afterwards again.

Although this athlete acknowledged ownership of his/her body in pain by referring to the anatomy as “my,” s/he expressed a distance from her injury by saying that “that,” meaning the pain and injury, was “fixed.” S/he furthered the depersonalization by saying that “s/he was rested” as opposed to ‘s/he rested’. This implies a degree of impersonalisation and objectification of the athlete – s/he “was rested,” as though his/her body was an object that could be put aside for a week or two, and then reactivated to play again.

Other athletes expressed their pain in terms of hiding it and concealing it, interestingly enough from themselves as well as from their teammates or coaches:

Interviewer:
Has anyone here downplayed an injury, or not been completely honest with an injury? [Laughter from a few people sitting around the table]

Athlete:
First my ankle and then my shoulder injury. I think I almost convinced myself that I wasn’t injured.

Interviewer:
And who did you downplay it from?

Athlete:
Besides myself? [Pause] My coaches…everyone. Like with [mention of another contact/collision team that athlete participates in], it was my first year starting last year, and I want to stay where I am, I don’t want to give up the opportunity I’ve been given. With , there’s only [a small number of team members] on our team, so we feel obliged…..

Two more athletes, both participating in individual, non-contact sports, provided similar rationalizations during another focus group session.
Athlete 1:
I think you might not hide it from the coach, but you hide it from yourself. You say, 'It's okay. I can do it. I qualified.' Sometimes you'll be pushing all year and say just before competition, you get a pain or something and you hide it. You say to yourself, 'I don't feel it. Think, I'm gonna do it, I've trained all year. I don't want to lose what I have.' Cause it's your own results that get you there, your coaches have nothing to do. It's not like a team, so it's not the same.

Athlete 2:
Yeah for sure. And I mean for example, that girl who snapped her Achilles. She's trying to [participate] again this year, and I think if you asked other people on the team, they'd say 'Well, she'd admit that she's not ready. She shouldn't be back. She's not ready.' But she keeps insisting that she is, so yeah, you're psyching yourself. And it's ambiguous...you can never tell for sure. She knows how she feels better than anyone else, but...she just loves the sport so much, so passionate about it, she keeps pushing.

These comments echo and supporting comments in Young and White's (1995) and Young, White and McTeer's (1994) findings. Another athlete, participating in a contact sport, positioned the need to hide injury in other terms, commenting on feeling the constant need to justify her pain and injury to others.

Interviewer:
So, have you ever felt the need to hide an injury?

Athlete:
No, I've never felt I've had to from coach or teammates...[pause]...actually, quite often, I don't know where it comes from, but I know when I've had injuries when I've had to take off from practice, I really feel like I have to really justify it. I don't think that comes from any individual, just...[motioning with hands while trying to find the words].

Interviewer:
From all around?

Athlete:
Yeah.

As with athletes hiding their injury, this athlete felt the need to validate leaving practice early because of injury due to a sense that her teammates and coaches would perceive the situation as her wanting to get out of the exhausting work of drills and exercises.
When discussing injury talk with athletes in team contact and/or collision sports, it is evident that these sports invest heavily in the ‘culture of risk’ rhetoric, and also include linguistic strategies in their rationalizations of pain and injury.

Athlete 1:
Almost the opposite of what these guys are saying. I think there’s a big time, especially in sports that I’ve been involved with, there’s a huge suck-it-up attitude. And it’s almost like you don’t even want to tell your closest teammates what’s actually hurting on your body, like you don’t want them to think you’re a suck. You just play with pain, and it’s something that after training camp or the first game, it’s something you’re just gonna have to deal with for the rest of the season. I think you could ask anyone, even on the hockey team, or any physically demanding high contact sport, players play with some degree of pain throughout the entire season, I would have to say. There’s always something nagging, you’re never in top shape. I mean maybe after the Christmas holiday in hockey, you kinda recupe, but other than that there’s always something nagging at you. I would say that almost every player hides some sort of, not necessarily an injury, but something that’s bothering him. I’d say that of every player on highly contact types of sports.

Athlete 2:
It’s true, I used to play hockey all throughout high school, I used to play triple A in high school, MTHL, and it’s the same. I broke my thumb, and I just put a cast on. You took a shot off it, it hurts but oh well keep going, right. I think hockey is different, you have so much equipment...you have so much protection. Even if it’s hurt, you can still tape it or you can still do something.

The language of these two athletes expresses both “unwelcomed pain,” and “hidden pain.” The latter strategy denies and ignores pain in an attempt to rationalize it, as seen in Athlete 2’s discussion of his experiences during high school. Although his thumb was broken, he put on a cast and kept playing. There was pain, but there was also an attitude to “keep going” – to keep accepting the risks and playing through the pain (Coakley, 1998; Hughes & Coakley, 1991).

Nature of Sport

While these two athletes discuss their involvement in contact and collision sports, it is important to point out that, in this study, the overall nature of sport (i.e., non-contact, contact, or collision) made little difference in how the athletes interpreted a ‘culture of risk’. Where
collision and contact athletes would acknowledge that injury and risk-taking were more visibly prevalent in their sports, non-contact athletes also showed injury-legitimating attitudes towards injury and risk-taking. The nature and types of injuries incurred varied between non-contact and contact/collision sports — arguably, a greater proportion of chronic overuse injuries in the former, as compared to more acute trauma in the latter. But overall, all three types of athletes expressed values and ideologies that indicated an acceptance of a ‘culture of risk.’

Having an Athlete’s Mentality

A number of the athletes couched their acceptance and tolerance of pain/injury in terms of having a particular mentality or philosophy that was unique to being an athlete. One participant argued that:

I think, well, having an athlete mentality, it’s important to participate in every practice so that you could be named to the team, so you can show your coach what you’re worth. Even though your coach would probably be looking out for you. Well, we know our coach is really into ‘Make sure you have a doctor’s note, make sure your concussions are cleared before you get back onto the field.’ And that I think is very important, but only athletes only know how far they can go. Being an athlete, you’re probably going to push yourself much farther than your body can handle.

S/he continued:

Even if you know your limits as an athlete, oftentimes you’ll push way past that, especially if you have a very short season that last only six/seven weeks, like ___ did. And you know if I play this game, I am going to die, and it’s gonna hurt so much, but I’ll have the whole year to rehab. Well, for a sport that lasts until March, like ___, there’s a different sort of understanding of what your body can take, and you can kinda push that limit.

Again, we see attempts to rationalize and normalize the bodily risks being taken, not only in having a particular athletic mentality, but also in terms of the amount of off-season time available for rehabilitation and recuperation. In this case, the athlete recognized that s/he could “push his/her limit,” because his/her season was shorter and s/he had more time to recuperate,
thus his/her philosophy towards pain included, arguably, a greater acceptance of injury because
of a greater time to heal. For another athlete, his/her philosophy towards injury and pain
changed after experiencing a significant acute injury requiring surgery and year-long
rehabilitation, and prompted reflection on his/her transition from being “hypersensitive” to injury
to “[riding] things out more.”

Interviewer:
Do you think then that because of that experience, you deal differently with injury?

Athlete:
I think before I was very hypersensitive to injury. Like all through high school, I’d come
home and think ‘Oh my gosh, I think something’s wrong with my shins,’ and my mom
would be like ‘No.’ I think I was almost a… not a hypochondriac cause that’s for illness,
but in that way. And I think that I go through things a bit more and I ride things out a bit
more. But I’m still aware of the point when I should go to see someone. Whereas
before, I think I went too early a lot of times, and they were like ‘No, I don’t think
anything’s wrong.’

As with other athletes who expressed their current views about injury after experiencing
significant trauma, there is a sense of ambiguity between tolerating injury and pain more so than
before, and yet also being aware of the point when treatment and therapy may be needed. It was
clear though, from the athletes’ responses, that the point at which treatment was sought varied
depending on a host of factors, some of which are discussed in Chapter 5, but which for the most
part were vague and indeterminate.

Stage of Season/Varsity Career

The stage of the season and/or varsity career, and the nature of competition, were also
seen as important factors in the acceptance of the ‘culture of risk.’ Participants were more
willing to sacrifice the wellbeing of their bodies when they were closer to the end of their season,
and even more willing when it was the end of their varsity careers. Similarly, athletes spoke of a
greater desire to play with pain when the competition was during playoffs or finals, or even when
it was a competition that decided whether or not they started on their teams. As a varsity athlete described, making it the OUA team for his/her sport meant that nothing, including pain or injury would stand in his/her way.

Athlete:
Well, me, I got selected for the OUA ___ team.... And this was the first year I got to go, so I was pretty excited. And the week before I was thinking ‘Oh my god, I can’t run, I can’t run properly.’ I was thinking that I can’t run properly, so I went and [the therapist] said ‘Okay, I want to see you Monday, and then Wednesday, and then the next Monday and Wednesday.’ So I got the first two in, and then I tried to book for the next week, and it was just like ridiculous. It was ‘I’ll see you at seven a.m.’ Like I said, it was very difficult. But I was so pumped, I didn’t want to tell my coach, I didn’t want to tell anybody that I was hurting ’cause I wanted to go, right.

Interviewer:
So you ended up going?

Athlete:
I ended up going and I did okay, but it hurt.

Interviewer:
It was painful?

Athlete:
Yeah, afterwards I took a couple of weeks off ’cause that was the end of our season.

While issues of accessibility of clinic and clinician services are discussed in Chapter 5, it is important to emphasize the athlete’s lack of hesitation to compete at the finals with an injury.

Another participant echoed this lack of hesitation to play with pain when discussing the different tolerances of injury when an athlete is nearing the end of his/her varsity career.

Interviewer:
Does it make a difference if it’s their final year?

Athlete:
Yeah, if it’s their final year too, people tend to play through more things as well, cause it’s like, ‘Well, this is the last time I’m going to be playing this sport at this level.’
Different dynamics begin to take affect at this point in time – dynamics that encourage continued participation regardless of the short-term consequences of increased pain and the potential long-term health implications. Another participant best expressed this rationalization by noting:

Maybe I’m in a biased position 'cause I’ve taken four years of phys. ed., but you understand different reasons for participating in sport, and it’s not all about winning and getting points in a game, or suiting up or dressing. Sometimes you just have to draw the line, but I think for a lot of players, if it’s the last straw, the last chance, it’s a whole new motivation. There’s a whole new reason to suck it up, I guess. And I think that’s the same across all sports, I would say that that’s not just a team sport thing or individual sport thing. Even more so in individual sports. If you think you can fight through your own personal problems, and still become victorious, like, you’re still winning, even more so than you would normally.

This excerpt reinforces much of the ‘culture of risk’ rhetoric expressed by all the athletes participating in this study – a rhetoric that is contradictory and ambiguous, yet which clings to ideologies of pushing limits, keeping going, and still winning in the face of challenge. The norms expressed in these ideologies corroborate Young and White’s (1995, p. 53) argument that they represent the “cornerstone principles of the dominant masculinist model of sport, and are adopted for a number of reasons,” including the display of courage and character, retaining membership in the team and its identity, or “to help make sense of compromised health in a lifestyle that demands and reveres fitness.”

Question 2 – Negotiation of the ‘Culture of Risk’

Since we have documented that a ‘culture of risk’ does exist in a number of ways among the athletes, how is it understood by, negotiated, and dealt with by sport medicine clinicians? In examining the influence of the ‘culture of risk’ on how people interpret and understand pain and injury, it is important to point out that the risk rhetoric is not only employed by the patient-athletes, but also by the sport medicine clinicians. In some ways, the sport medicine clinicians’ understanding of the ‘culture of risk,’ and their ways of negotiating with their patients within that
culture, explicitly and implicitly supports the athletes' acceptance of risk, pain and injury. This is not to suggest an unequivocal and definitive promotion of pain and injury tolerance on the part of the clinicians—there is no empirical evidence from this study to support such a claim. Rather, the responses garnered from this study indicate that sport medicine clinicians are influenced by, and influence, a 'culture of risk,' and thus negotiate with athletes within that context. The practices of the sport medicine clinicians are constituted by, and constitutive of, a 'culture of risk' much the same way the practices of the athletes are constituted by and constitutive of a 'culture of risk.'

It is important to emphasize here the subjective nature of the ways in which the clinicians negotiate with the athletes in this 'culture of risk.' While there are protocols and practice guidelines in place for clinicians to deal with particular injuries and/or to help ascertain particular information relevant to diagnosis and treatment, much of the content of the interaction between clinicians and patient-athletes occurs on a continuum that ranges from easy to diagnose and treat with minimal clinician-patient negotiation as compared to difficult to diagnose, treat, and encompassing a great deal of clinician-patient negotiation. However, most of the interaction often circulates in a middle space of ambiguity, give-and-take, definition and interpretation. As one clinician acknowledged:

All this stuff is so grey, Parissa. And so I, as a medical professional, I find myself relying on my belief system and my value system to determine what is a potential catastrophic situation versus what is a nuisance situation. If somebody has an arthritic ankle, is that a catastrophe versus someone who is paraplegic? And if I use examples like that, I suppose, pretty much everyone would agree that spinal cord severance resulting in paraplegia or quadriplegia is catastrophic. That's something that no one wants to take an appreciable risk on, cause everyone would agree that that's a shitty situation to be in. An arthritic ankle is a debatable thing. Like I said earlier, some people 'Yeah, so a sore ankle? So? What else?' Well, there are a lot of lines in between those extremes. What about someone who is likely to hurt their back in such a way that is likely that they'll have chronic low back pain everyday for the rest of their life? But I find that professionally, people who come to the clinic with chronic back pain, are much squeakier wheels then people with chronic knee problems.
Interviewer:
What do you mean by that?

Clinician:
Well, they're much unhappier. It affects their lives much more. They can't work, they can't sit, they can't play sports, they can't have sex. All kinds of things. If they have knee pain, they never come and tell me that it hurts their sex life. I get a lot of that.

The clinician's description of the lines between different types of injury and different effects of injury on the wellbeing and overall health of individuals, are emphasized by the use of the word "grey." There are no clear cut answers to how clinicians understand, negotiate, and deal with the 'culture of risk' with their patient-athletes, just continuous decision-making and weighing of the perceived risks and benefits of playing and/or not playing with pain. While the concept of weighing risks and benefits is investigated more fully in Chapter 5, here, I examine some of the ways in which clinicians explicitly and implicitly support the 'culture of risk,' particularly during important times during the season and/or important competitions, when dealing with athletes from different types of sports, or even with different levels of intercollegiate athletes (i.e., starter vs. substitute, varsity athletes with representative potential).

Before discussing those particular sub-topics, it is important to recognize that, for a majority of the clinicians, their understanding of the 'culture of risk' was influenced by their personal sport backgrounds - backgrounds that often included injury experiences and admissions of their own acceptance and tolerance of pain and injury. When speaking about his/her own involvement on a varsity, collision sport team as an undergraduate and his/her subsequent retirement from the team due to injury, this clinician's comments support Hughes and Coakley's (1991) description of overconformity to the sport ethic, and may be implicated in the clinician's current understanding of the 'culture of risk.'

I can't speak for anybody else, but a good part of my identity for ten years was being a ___ player, especially a varsity ___ player, cause that gives you such a sense of identity.
If you’re killing yourself, you’re obviously doing it for a reason, you’re doing it for the pride of the school, you’re doing it for yourself, it means a lot to you, and you don’t want to let your teammates down or yourself down. And because it’s such a big part of your identity, if you can’t be playing __, then you’re not who you are. And you honestly wear it almost as a badge of courage, that’s why it was so emotionally painful. And I was going into the training room everyday and see the guys there, but it wasn’t the same.

In fact, since the majority of the clinicians’ personal sport backgrounds included injury experiences, and in most cases the acceptance and tolerance of a ‘culture of risk,’ it is not unreasonable to suggest that those experiences helped to shape their current attitudes toward negotiations with their patient-athletes. How those experiences influence the negotiation processes varies considerably, but ultimately includes a sense of empathy and connectedness with the patient-athlete – a feeling of ‘I’ve been there, and I know what you’re going through.’

A key consideration to make here though is that the ‘cultures of risk’ the clinicians’ experienced were in most cases, significantly different than what current student-athletes are experiencing. We need only to compare the zero-tolerance policies now in place in this institution for head injuries, with the protocols that were in place ten years ago which diagnosed a concussion only when an athlete was knocked unconscious (D. Richards, personal communication, August 10, 2000). In discussing his reasons for not becoming involved with medical coverage of a professional sport team, one clinician highlighted not only his current philosophy about the place of contact/collision sports in the overall health of athletes, but also the personal, social, political, and sporting transitions he made throughout his career.

Clinician:
[Covering a professional collision sport is] tremendously busy, because there’s a lot of violence and a lot of injuries, and I’m not really into it. I played football for nine years, at high school and in university… and my participatory background was really limited to football and ice hockey. So, I was a rough and tumble boy, as a lot of my contemporaries were, and I have a different perspective on collision sport.

Interviewer:
Such as what?
Clinician:
I've gradually become more of an advocate of sport/physical activity for health and less. I still believe that sport is fun, and that's what makes it the best physical activity for me. I don't like running to nowhere as much as I like playing a game. Whether it's the competitive nature in me or whatever, I need something to focus on, a goal. I don't know what it says about my personality, but I like playing squash better than lifting weights. Or playing volleyball better than running, the one exception being cycling. Having said that, I've grown to think that some aspects of some of the sports that we popularize or are popular are excessively violent. And they negate the obvious health benefits of the exercise, and to some extent, it becomes a trade-off between cardiovascular and psychological health co-opted by the physical activity on one side versus the musculo-skeletal and neurological injuries suffered on the other side. And, you don't want those trade-offs.

Interviewer:
Now, were you always like this?
Clinician:
No.

Interviewer:
When you were an athlete, what was the attitude then?
Clinician:
Kill the fuckers [laughingly]. I wasn't a high level football player, but I had a football player's mentality.

Interviewer:
What do you think happened?
Clinician:
Well, a couple of things. Without knowing it at the time, I was concussed a number of times while playing football. No one ever used the word concussion and I never saw a doctor about it, I was a medical student, none of my classmates thought anything about it. That's how unknown it was, we weren't taught anything about mild concussions. Concussions started with loss of consciousness essentially, and I was never knocked out, so I was just having my bell rung. And at the time I weighed a hundred and seventy pounds, and I played centre and middle linebacker. And we all changed in the lockers with the other team, and the last game of my last year, so it wasn't that I retired prematurely.... Some great big guy, well over six feet and 200 pounds, says to me 'So, does anyone on your team want to be a surgeon?' I was still interested in neurosurgery, and said 'Yeah, I want to be a brain surgeon.' He said 'Good, I'm gonna break every fucking bone in your hands.' And I said, 'You have to catch me to be able to, you big fat bastard,' and I got out of there as fast as I could. And he said 'I got your number 45!' When we got out there on to the field, and I got down over the ball to snap it on the first play, I look up and guess who was the nose tackle, grinning at me 'Hi 45.' He beat the living tar out of me for 60 minutes, and I remember thinking 'Why am I playing this stupid game?' But it was my last game anyway, so I really didn't think anything of it. I
continued to be a football fan and ice hockey fan, and continued to play pick-up and semi-organized adult ice hockey for about ten or fifteen years.

Interviewer:
Do you think that mentality that you had as an athlete played into when you first started dealing with athletes?

Clinician:
Sure, yes, my attitude about injury and sport, about the culture of sport has definitely evolved over the years that I’ve been in sport medicine.

Interviewer:
What it is more a factor of?

Clinician:
Well, it’s my own personal evolution as influenced not only by spontaneous maturation but by, I think, by having my eyes open, by seeing and hearing things that other people bring to my attention. By scholars talking about the culture of sport and things, or friendships I’ve gotten or people in the business who have a different perspective than mine and share theirs with me, and I’ve been influenced by their perspective. It’s been a learning and growth process, and I never stop changing, no one does. I, for one, have changed radically, my thinking, my politics are significantly different than [in the past].

Both clinicians speak of the impact of their sport participation on their identities as well as the transitions they made from that period of time in their lives to the present. These experiences invariably influence how clinicians interact with their patients, and should be kept in mind as the focus of the section turns to negotiating within the ‘culture of risk’ during important times throughout the season; to the treatment of different types of athletes; and to the different types of sport in which athletes are involved.

Timing of Season

Just as athletes approach the end of their season or the end of their varsity career with different motivations to play with pain, sport medicine clinicians also acknowledge the different stakes involved during moments of negotiation during these times.

Interviewer:
Is [the ‘culture of risk’] amplified when it’s closer to the end of season or end of career?
Clinician:
Yes, definitely we see that, the swan song syndrome. ‘This is my fifth year, fourth year, whatever, this is my last playoffs, I don’t care if I get injured. I don’t care if I can’t play after today, this is my last game.’

Interviewer:
Do clinicians’ radar go into overdrive or whatever when it gets closer to championships?

Clinician:
Yeah, I think we know that there’s a different level of intensity in the competition and there’s a different tolerance of pain or different desire to or willingness to play hurt. Cause now ‘It’s for keeps,’ ‘This is what it’s all about’ – all those cliches that get trotted out during play-offs. We implicitly and explicitly support that. Explicitly in that we, where there is a conflict for services, we explicitly give teams, that is within the varsity cue, remember I said that it’s the same for all teams, that’s true, but the one distinction that we make is teams in CIAU play-offs come ahead of teams in OUA play-offs come ahead of teams in regular season come ahead of teams in exhibition come ahead of teams between seasons. So we prioritize, so if there’s one appointment available and two athletes want it, and one of them is going to CIs tomorrow and the other one is finished for the year, the one going to CIs is going to get it. So that’s sort of an explicit support of the importance of championships. Implicitly, I think anyone in the sports business supports it. There is a certain importance of playoffs, you know. It’s important to the athletes, it’s important to the coaches. We are working for them, we obviously enjoy it, we enjoy working for them or else we wouldn’t be here, we’ve all grown up playing sport or being part of it, so there is a certain understanding of the competitive sport model and how there is implicit and explicit support of that. And I don’t have a huge problem, as long people are still making an intelligent and informed decision.

While the clinician is not suggesting that the health of any athlete would be compromised because it is the playoffs or the last season of their career, implied within what is mentioned is an understanding that pain/injury limits do shift towards a greater tolerance and acceptance of the ‘culture of risk.’ Another clinician positions his/her understanding of the importance of playoffs and championships in other terms:

Interviewer:
You were talking before about play-offs and championships, does timing of season make a difference?

Clinician:
Sure, players are a lot more likely to get injured at the end of the season, where they’ll say ‘Oh, just one more game, and then I’ll have the rest of the off season.’ Whereas with the beginning of the year, they get hurt during training camp and I always say, ‘You’ve
got the rest of the season to go. This is your last year’ I always put it in terms of seasons too, ‘Oh, you’re only in first year, second year, you have 2-3 more seasons to go, don’t mess up your shoulder or knee for the last two seasons. Even though you may lose this season, you’ve still got two more, as opposed to if you screw up your knee majorly, you’re not gonna have [it] anymore.’ And I always put it into context…. And if it’s bad enough, you just say right off the bat…. ‘Write off your season’…. At the beginning of the season, what I say is ‘We’ll try to get you back for the end of the season or the playoffs, but you need to fit all of the…’ [motioning different levels with hands in air]. Again, you explain to them, ‘You have to fit this criteria before you go back,’ and they understand and it gives them an incentive to work harder and do their exercises to try to get back by the end of the year. It all depends on how well you educate the student ’cause if you don’t explain why they can or can not do something, they’re just gonna use their own judgement, which may or may not be in their best interest.

Here the clinician works within the ‘culture of risk’ by emphasizing to the athletes, those whose injuries are not “bad enough,” that if they are injured early in the season, the clinician and patient-athlete can work together to get the athlete back in time for the end of the season or for the playoffs. S/he positions this as an “incentive” for the athlete and one, could argue, as an articulation of the value placed on performance above health when dealing with the playoff/end of season contexts. On the other hand, this could also be seen as a way of motivating athletes to actively participate, commit, and persevere through rehabilitation and therapy, an interpretation exemplified by his/her comment that patient education is a key factor in this situation. Another clinician echoed sentiments about how lenient to be with injured athletes during playoffs and championship, and while s/he did not explicitly acknowledge patient education, s/he mentioned that a key factor must be that the patient-athlete does not worsen the existing injury, and that the athlete has the approval of a physician to participate:

Interviewer:
Do you think that timing of season makes a difference?

Clinician:
Sometimes if it’s start of the season, a heavier training session, and maybe they’re out of shape and not ready to participate at the level that they’re supposed to, then you find they may exaggerate their injuries, or their injuries seem to somehow take extra long to heal, ’cause they don’t want to get back into that grinding task that they were doing. But at the end of the season, and it’s the final game, you know, they’re going back into the game—
We’re not sitting out for nothing.’ Provided they have medical approval for that, by myself or the medical director or doctors, that’s fine. We had a situation this year with an athlete had a fracture... and it wasn’t displaced, it was a closed fracture and stuff, and s/he had a special splint made that s/he could play with. But s/he didn’t do anything the final two weeks before the [finals], and... came back to [the finals] because it was the championships. And it was his/her last year, and s/he had clearance, and... could participate even though s/he had a fracture. It was in the healing stages, it wasn’t completely healed, but it wasn’t acutely fractured, a week old kinda thing as well. And s/he went out and played his/her heart out, even though s/he was in pain and had some limitations because of that. Whereas if it had been the beginning of the season, ‘No, you just gonna sit out until it heals, then we will get you back in.’

Interviewer:
Did you have issues with [the athlete being allowed to compete]?

Clinician:
No, because s/he had range of motion... and... strength, s/he could do things, s/he was functional, and the x-rays were showing that s/he was far enough in his healing that if s/he had adequate enough protection with the braces, s/he had a very rigid brace that was going to keep it in place, that s/he wasn’t going to damage the healing. If s/he didn’t have the brace on, there was no way s/he could play. But if s/he had the brace on, s/he could still participate and not further his/her injury along.

Interviewer:
So that was one of the circumstance where you would let the athlete come back to play sooner than...

Clinician:
Yeah, you’re not going to make the injury worse. You’re going to have some discomfort or pain, but you’re going to manage that in various ways to minimize the pain and swelling. But provided they can still function at the level or in terms of the capacity that they’re needed to function... [The team wasn’t] relying on him/her to score, but s/he was their best defensive person, and created a lot of steals and opportunities to generate the offensive.

In this situation, a key criteria to consider in letting the patient-athlete return to competition for the finals was that the condition would not worsen, and that s/he was cleared to play by the medical director. This is an example of the softening of return-to-play criteria when in these unique circumstances, indicative of how clinicians can play complicit roles within the ‘culture of risk.’ What this excerpt also implies is differential treatment for important players on teams, particularly when those teams are competing during playoffs and/or championships. One must
question whether if, this athlete had not been the “best defensive person,” he would still have been permitted to play in the finals.

Type of Athlete

It is possible to argue that the differential treatment of patient-athletes based on their involvement with an intercollegiate team is also indicative of how clinicians operate within the ‘culture of risk’ in ways that reinforce the acceptance and tolerance of pain and injury. This is not to suggest that intercollegiate athletes receive preferential treatment, but rather that their status is acknowledged in such ways as quicker service, frequency of treatment or even in more leniency with return-to-play criteria. The ‘culture of risk’ is reinforced in that non-varsity patient-athletes or off-season varsity patient-athletes, those athletes who are not in situations where winning competitions are primary and immediate goals, are given different priorities than varsity and/or in-season athletes. As one clinician acknowledged:

Well, I always treat someone the best that I can, so it doesn’t really change how I treat them. But I’m still gonna try to get them better as quickly and as effectively and safely as possible. And that’s just standard for varsity athletes, UofT students, or outside patients, they’re all treated the same way. It’s just more of the frequency we may have of them coming in. An in-season varsity athlete, we may say ‘Okay, come in every day.’ Whereas if you’re not in season, it’s not crucial to get you healed as quickly as possible, well ‘Maybe you only have to come two or three times a week.’

Therefore, one could argue that the priorities shift to favour those athletes still in positions to compete, to win, and to further the name and reputation of the university. Those athletes who do not fit these criteria are thus, arguably, left to deal with the same level of quality service, but less time or priority for treatment and therapy. It is interesting to position what the clinician says about the prioritization of services between varsity and non-varsity patient-athletes, with what one athlete recounts about his/her experiences after suffering a serious, acute trauma injury.
Interviewer:
Do you think that with the treatment that you got with the clinicians in general, do you think it would be different if you weren’t varsity?

Athlete:
Oh, yeah. I don’t think that [the treatment] would have been as quick, I don’t think the urgency would have been there. Because also I’m a possible national athlete, like everywhere Dr. ___ went it was like ‘I have a future national athlete here,’ and s/he constantly reinforced that. It was generally very positive for me the fact that s/he was regarding me like that as well, just ’cause I regard him/her highly, the fact that s/he was looking at me like that said a lot. Definitely, especially within that clinic. I don’t know if it’s as bad anymore, or such a varied difference, it seems like it’s changed a bit.

Interviewer:
Between varsity athletes and non?

Athlete:
Yeah, I just haven’t been in there in [a long while]. But definitely, when you were a varsity athlete, you went in there and say ‘I’m from the ___ team’ and they say ‘Okay,’ whereas a person who was standing beside you who wasn’t varsity, they’d wait for two weeks.

The athlete acknowledged that the clinic seems to have transformed its attitudes towards varsity and non-varsity patient-athletes, and that even s/he does not know whether the clinic still expresses priority towards varsity patient-athletes in the same manner. Still, such a comment does indicate that being a particular type of athlete, in this case a varsity athlete as compared to non-varsity, within the institution can garner certain advantages. This athlete also recognizes that his/her distinction as being a potential national athlete may have resulted in quicker service.

While some distinctions are made between varsity and non-varsity student-athletes, the differential treatment of athletes based on their calibre, whether as potential representative athletes or team ‘stars,’ also seems to imply that clinicians operate within the ‘culture of risk’ in ways that reinforce it. As one clinician acknowledged:

I certainly treat differently by calibre. So that the elite athlete, who’s going to notice a change in performance much more than a recreational athlete, I’m going to be much more aggressive in treating than I would a recreational athlete. So, if an Olympic level athlete came in here with tendinitis, then I would say ‘Come in here for therapy, twice a day five days a week, you should be here doing this.’ Whereas a recreational athlete, I’ll say ‘Be
here two or three times a week.’ Ideally, you should be treating them the same, but you know the impact on their ability to perform isn’t as great, so as the calibre goes up, [so does] the aggressiveness with which to manage it or pursue it.

Interestingly, this clinician does not extend that comparison to elite athletes versus intercollegiate athletes. For another clinician, the discussion of differential treatment of star athletes includes an understanding of the impact of coaches’ influences on the athlete as well as the clinician:

Interviewer:
So, first the importance of the athlete to the team, a star versus a rookie.

Clinician:
Well, this is a difficult issue on which the coaches bring much pressure to bear. Again, some of the same coaches who bring pressure to bear on some of the other issues. But I think this happens with any coach, that if their star athlete is injured, it’s obviously a greater concern for them from a team performance perspective. They may be equally concerned for them from a personal health perspective for that individual, but from a team performance perspective, they’re very concerned about their star athlete getting injured. We start from a position…we discuss this, so it has been explicitly discussed amongst our staff, that we do not alter our recommendations based on that. Whether it’s the starting star or the person with splinters in their butt who has never seen the field. Recommendations are made based on health. Having said that, they are recommendations, and in so far as the decision to return to play is a balance between perceived risks and perceived benefits, perceived benefits may be different for the star athlete than the bench jockey. They may feel differently about it, you know, ‘The one time coach asked me to play, I want to play.’ Others may be like ‘It’s not worth it, I haven’t played all year, and I can’t play now, I’m not going too.’ We give the same recommendation. However the coaches bring tremendous pressure to bear on their star athletes, most coaches.

S/he continued:

But, there definitely is a perception, regardless of which doctor you interview, that star athletes are more likely to play hurt, more likely to choose to play hurt than non-star athletes. I say that, but I feel there are exceptions. You know, some of the ones that are borderline are equally vociferous about their right to play hurt because they fear the Lou Gehrig syndrome, where you take one game off, your substitute takes your spot and you never see the field again. So, they really want to play their position…if they’re on the fringe, they don’t want to lose it. And maybe there’s a middle position where they’re more comfortable to take a day off?

Here the clinician concedes that the “balance between perceived risks and benefits” of playing or not playing with injury is different depending on the level and importance of the athlete to the
team. But, s/he also recognizes that other athletes, “that are borderline” or “on the fringe” in terms of starting, have other motives for playing with pain – to retain their spot on the team, or to show their coach and their teammates they should be a starter, or to not lose their sense of group identity and belonging. S/he offers a much complex reasoning as to why star athletes may play with pain, and in doing so, shows how clinicians understand those situations.

Nature of Sport

As noted previously, the athlete participants in this study came from all three types of sports – non-contact, contact and collision – and while intuitively one would suggest that individuals in contact and/or collision sports would adopt a ‘culture of risk’ more readily, it was evident that all three types of athletes would play with pain and tolerate injury as part of their sporting experiences. The differences lie in the types of injuries and types of reactions to those injuries as a natural extension of the types of sports being played. Athletes in contact and collision sports, such as basketball, wrestling, rugby, football or hockey, deal with a different set of injuries and with different frequencies of injuries – more acute in nature – as compared to athletes in non-contact sports such as swimming, or track and field. Athletes in the latter sports may be more likely to have chronic overuse injuries, but may still feel the need to tolerate pain and accept playing with such injuries as part of their sport/team identity. The ways in which clinicians understand and negotiate with athletes from different sports provided insights into how clinicians treat these athletes differently:

Interviewer:
Do you think that it’s the nature of the sport, like contact, collision or non-contact? Does that make a difference in what kind of athlete comes and talks with you or how you deal with the athlete?
Clinician:
Some situations you have to consider certain athletes, or you have treat certain athletes in certain ways. Like rugby, they will generally tough it out a little bit more, 'cause they’re used to physical contact, the pounding and stuff. With some other sports, where they aren’t used to that, they’re gonna be a little more apprehensive about returning to play or when they’re injured, they’ll over-exaggerate their injury because they might not have been hurt before or experience those kinds of emotions. Generally, you’ll find too, and I don’t how whether that directly relates to how many times you’ve been injured in the past, so rugby players usually have had several injuries in the past and are more accommodating to things. While in other sports, maybe a volleyball or basketball type of setting, they haven’t had those injuries before, they may overreact or sometimes just panic.

Here the clinician simply speaks to the different types of reactions that athletes from different sports have to their injuries, and interestingly, positions athletes from contact/collision sports as “[toughing] out their injuries more.” Another clinician speaks more explicitly about the ways of negotiating with athletes from different sports.

Interviewer:
Do you think in general though that there are different athletes coming in from different sports? I mean for instance, rugby, ’cause it’s a collision sport, a high-risk sport, athletes from the rugby teams would be coming in...

Clinician:
No, each of the sports have their own inherent injury profile. So yes, you can look at the statistics of and compare one sport to another, and see the frequency of injuries and the number of days off of play, and calculate who’s coming in here more. Are the collision sports coming in here more than the trackies? I mean the trackies are the more high end, thoroughbreds who break down very easily, whereas the football players get bashed around and only come in when their shoulder’s out. It takes a different threshold to show up, than say some of the other athletes.

Interviewer:
But in terms of that bargaining and negotiating...that aspect of it.

Clinician:
Oh, I see.

Interviewer:
I mean is it harder to get the football player with the shoulder out to be honest with their injury than some other type of sport, say a swimmer?
Clinician:
From sport to sport where one sport tends to be a minimizer and one sport tends to be a complainer? There’s a perception that the track athletes tend to be whiners, and you could probably put the swimmers into the same group. That may in part be due to the fact that their injuries are less obvious, so you know, when you see them, it’s their tendinitis and stuff like that, and not necessarily as evident as football players with shoulders out. And I don’t know if this is a personal bias, but we certainly, I do think, tend to place the contact athletes who are beaten up more of the time as more resilient than we do the endurance athletes, like the track athletes or swimming athletes. I think the threshold of disability is higher in, say rugby and football, than in swimming or track. Now, it may be that there is greater emphasis in those sports of getting things seen sooner before they come an issue, so if your shoulder is bothering you, get in and get it dealt with now, whereas with football, it’s an expected thing that you’re going to hurt when you play, so unless it’s a real problem, then you show up. So I think that there’s a bit of environment in the sport that lends itself towards the... you know, the track athletes know when their Achilles start bothering them, it’s gonna show up in their training sooner than waiting for it to become full blown, whereas the football players, you know, don’t have to sprint as far, so they might not be bothered by it.

Interviewer:
So does that make a difference in how you would treat that football player, knowing that they come from that environment that preaches that suck-it-up attitude?

Clinician:
I think so, probably yeah.

Interviewer:
How so?

Clinician:
You might tend to refer the track athlete or the swimmer a little more quickly to therapy, let’s say. I mean I try not to distinguish between the athletes. What I try to do is look at each athlete, individually, not necessarily because of the nature of the sport. If I see, I’m more likely to be persuaded if I see the athlete minimizing their injury than the fact that it’s a football player with an injury. So to me, how I treat them has more to do with how I see them and my perception of how much they want done for it. So, how much of a limitation, how much of a bother, are they just here to check it out, or do they want something for it. So I don’t think I do that—that I necessarily group by sport and treat differently by sport.

The clinician emphasizes that s/he is more persuaded to offer different recommendations based on his/her perception of athletes “minimizing or complaining” about their injuries. S/he does admit that minimizing or complaining about injuries are idiosyncratic of certain sports, and that there are different characteristics and/or reputations when comparing athletes from different...
types of sports — characteristics that fall along a continuum of “resilience,” “getting bashed around,” “whining,” and “threshold of disability.” Another clinician also discussed the intersection between the nature of the sport and ways of negotiating along similar lines:

Interviewer:
Does the nature of the sport make a difference in how you deal with athletes?

Clinician:
Perhaps slightly. I consciously try to make that a no, and in fact, that’s where some of the negative PR I’ve had amongst the athletes has arisen in that I don’t make concessions to the culture of a particular sport with my recommendations. So I would recommend the same treatment for a concussion in a football player and badminton player. The athletes’ interactions with me is very different based on the sport. So the reactions to my recommendations with respect to an injury have in the past tend to be different amongst athletes from different sports.

Interviewer:
Can you think of any examples?

Clinician:
Concussions, for sure. The football team, or hockey team, men’s ice hockey have tended to, or have reacted negatively to what they view as overly cautious recommendations.

Interviewer:
What about other types of injury, such as musculo-skeletal injuries?

Clinician:
My recommendations are gender independent and sport independent. The interaction with the athletes varies somewhat, depending on the individual, but I think that there are some generalizations that could be made about the culture of different sports. There are some sports that the culture promotes a culture of playing hurt, playing with injuries, being tough, so the interaction amongst these is different. Now my position [is that] I am giving the athlete advice and it is their prerogative to follow it or not. So, the interaction stems from that frame of mind.

Interviewer:
Do you expect different levels of co-operation? For example, in a sport where there’s a culture of pain and playing hurt, and if they avoid coming to you until the last minute as compared to sports where the athletes are most ready to jump on anything and come to see you, how do you deal with that?

Clinician:
Well, taking a detailed history, one attempts to ferret out those sorts of details. So, when they finally do come to me, whether it’s the day after they first felt pain or a month after, I obtain that information. ‘When was the first time that you got this twinge?’ And I
generally expect athletes to, and when I say 'expect' it's based on experience not that I think it should be, but that in fact, they are relatively stoic as compared to the general population... With respect to playing with injury, there are different levels of injury. With overuse injuries, tendinitis and stuff like that, every sport is like that. I would expect, I've encountered I should say, the same injury from a badminton athlete and a football athlete in terms of playing all season on a knee that hurts every time they lunge. That's very individual, some people can tolerate pain and some people cannot. I suppose there are generalizations, [inaudible] and this is all anecdotal...but certainly the impression is that there is a little bit more of a culture of pain in some of the collision sports, and most of the rest. Having said that, most of our swimmers swim all season long with shoulder pain. Name a sport — it doesn't have to be a collision sport... We'll get [athletes] coming in before play-offs with [injuries], saying 'The coach says I need to get anti-inflammatories.' How does the coach know you need anti-inflammatories? If you have pain, why did you leave it so long before coming in? Now, with a week before [championships], there's no hope in Hades of resolving the mechanical issues in your shoulder, here's enough drugs to hide it for a week, so they can go and [compete] in pain without knowing it. That's widespread.

Interviewer:
What about athletes who come in continuously with injuries? Naturally it's the individual and the particular injury, but are there particular sports or particular athletes who always say "Oh, I have a twinge here, I have a strain here...?"

Clinician:
Yes, we, I think it's widely perceived from us, sport med staff, and we even discuss jokingly sometimes the different personalities. The classic trackie is a name for the track and field athletes, who rarely have demonstrable structural injuries, torn structures or broken things. For example, imaging tests and MRIs would usually be negative 'cause it's not a high-velocity collision sport and they don't tend to break things. But they feel very in touch with their bodies, they feel every tight fiber. So they'll come in and say 'I have a tight fiber in the lateral aspect of my calf muscle' as compared to the kinda complaint you get from an athlete in a number of other sports, most other sports.

Interviewer:
So, does the clinic deal then differently with the different teams?

Clinician:
Well, each team has their own primary therapist assigned to them. Over the years, a sort of best-fit arrangement, which therapist and which therapist's skills and personality best suit which team... So for example, for the _____ team, one of our...therapists, is very suited to dealing with those issues, and his skill set as a...therapist [is geared towards] working with these athletes who are bothered by...feelings of asymmetry or muscle tension... We have other therapists who come out of working with [collision sports]...who although very professional and if someone came in with something, wouldn't roll their eyeballs in front of them. But they may be rolling their eyeballs internally [chuckles], thinking this isn't a real injury, nothing's cut or broken, which isn't appropriate. Everybody's injury is their issue, and we all do that, we all take everybody
and all of their issues seriously. Having said that, there are these different cultures and the issues some teams bring into the clinic routinely and repeatedly are very different in nature, that doesn’t mean they are lesser issues but are different.

This clinician reiterated a number of the themes presented by the previous clinician in that s/he would not alter his/her recommendations based on the nature of the sport, but recognized the tendency in attitudes of athletes in particular types of sports. S/he acknowledged that his/her interactions with athletes is “very different based on the sport,” on the part of the athlete, and that in fact, this has become a point of contention between him/her and some athletes. While s/he recognizes that some sports “[promote] a culture of playing hurt, playing with injuries, being ‘tough’,” s/he does not differentiate his/her recommendations to athletes, and risks criticism and a negative reputation amongst the student-athletes. S/he also points out that certain sports are known for their pain/injury idiosyncrasies and refers, much like the previous clinician, to “trackies” as the classic track and field athlete who may not have any “demonstrable structural injuries,” yet can feel “every tight [muscle] fiber.” While s/he does admit that some other clinicians may “roll their eyes internally,” implying that some injuries are more real, worthy, or even important than others (see Walk, 1997, for a description of how athletic trainers look forward to acute trauma not only in terms of hands-on education, but for the excitement of treating “big,” “significant,” or “cool” injuries), s/he does emphasize that “everybody’s injury is their issue, and…we all take everybody and all of their issues seriously.” The clinician also mentions frustration with coaches who doctor their athletes, as well as with the “widespread” practice of painkillers used in lieu of the treatment of the structural injuries. While interpretable in a number of ways, it does reinforce the notion that playing “tough” is not limited to contact/collision sports.
It is important to re-emphasize here that this study produced no evidence to suggest that sport medicine clinicians working with athletes in the Canadian intercollegiate athletic system deliberately reinforce and promote the 'culture of risk' and/or value the performance of the athlete above his/her health and wellbeing. While Nixon (1992) would argue that an alliance exists amongst administrators, coaches, and sport medicine professionals in perpetuating the acceptance of cultures of risk by athletes, Walk (1997, p. 53) points out that "...there has clearly been a premature leap from theoretically based critiques of 'sportsnets,' devoid of empirical support, to recommendations for institutional and structural changes to medical services within 'sportsnets.'" I endeavour to not make that premature leap here. What the evidence does point to is a need to more fully understand the ways in which the 'culture of risk' "frames the medical practices" of the clinicians (Walk, 1997, p. 33). A need to understand that the clinicians are working in an environment, a competitive sport system, in which, at times, health is under-valued in relation to performance — essentially tolerance of pain, injury and risk are valued above health. The sport medicine clinicians are influenced by this 'culture of risk' and influence this 'culture of risk' in turn, thus emphasizing the dynamic nature of responses to pain and injury in varying contexts — from beginning of season to championships, from rookie season to end-of-career season, from the team starter to team substitute.

The fact also that pain, perceived risk, and health are subjective concepts further complicates, or rather, makes more dynamic, the ways in which clinicians negotiate with patient-athletes. As the 'culture of risk' frames the ways in which the clinicians negotiate with the patient-athletes, so too does the 'culture of risk' frame the ways in which the patient-athletes negotiate with the clinicians. Given such conditions as the playoffs, the last game of their career, or the game in which whether they become a starter or not is determined, the athletes use a
similar discourse to that of the clinicians – the limits of acceptable pain and injury shift, and different motivations for playing with pain take effect.

**Question 3 – Conflicting Roles**

In the final section of this chapter, we question how sport medicine clinicians respond to the dual, and potentially conflicting, roles of patient and competitive student-athlete? How did the clinicians interpret the role of athletics in the lives of student-athletes based upon their experiences? Was this an issue in the Canadian intercollegiate athletic system as compared to other competitive sport systems? One clinician positioned this debate between the realities of concussions for professional athletes or scholarship-athletes in the NCAA sport system as compared to CIAU student-athletes.

**Clinician:**
You know, for me, I’ve dealt with both professional athletes and student athletes. If a professional athlete has a head injury, and they recover adequately and get another head injury, they may not be able to play, but they are still gonna be paid by their team because they have insurance to cover it. But as a student athlete...one of the negotiating things that I tell them, is why this is more of a concern than just your sport, and try to have them broaden their scope of what they’re looking and not just at this weekend’s event, but at the whole school year. . . . I try to get them to see the big picture.

**Interviewer:**
Does it work?

**Clinician:**
Yes, ’cause it make them ‘Oh, I’m here at school ’cause I’m here to get an education as well, and if there is a risk that I may lose my semester.’ That’s much more a concern to a lot [of athletes]. Some of them aren’t, they don’t care, they’re here to play sports. But it’s not in the States, it’s a bit different here. They’re paying their way, it’s not like they’re on scholarship and are gonna get a free ride no matter what they do because they’re athletes. But, yeah, it makes them more aware...it takes the blinders off a bit, and makes them more aware that they have a life around.
Making sure that student-athletes know the correct balance between sport and academics also arose in conversation with another clinician about an athlete dealing with premature retirement from sport participation due to injury:

Interviewer:  
And how is this athlete dealing with...?

Clinician:  
Well, she, in my opinion, has a very intelligent perspective on the place of varsity sport in life. And it’s a wonderful, enriching experience that provides her an opportunity for regular, disciplined physical activity, camaraderie and social interaction with her teammates. But, the bottom line is that it’s the icing on the cake, it’s not the cake. She has other aspirations, life aspirations, doesn’t see herself playing in [professional sport], she has no delusions about playing ___ for the national team or the Olympics, so the risk of playing for one more year varsity ___ [motioning with hands, not worth it]...

Interviewer:  
Do you find that that’s a typical student-athlete who comes to see you?

Clinician:  
Yes, most of our Canadian university sports. Amongst our Canadian university sports, if you look at which of them feeders, feeder system to higher levels of sport participation, it’s radically different for different sports. For instance, if you look at ice hockey...it’s been fifteen years since one of our guys has even had a look at the NHL.... And if they were NHL bound, they wouldn’t be playing CIAU hockey. Not so for the women...five or six varsity blues alumni are on the women’s Olympic hockey team. Basketball, there’s one UofT woman on the national team now, and we’ve had several in the past. Men’s basketball, not a chance.... Football more than any other has the opportunity for professional sport, because the CFL still look to Canadian universities.... Some of those guys have somewhat realistic aspirations to a small living, but I try to point out to them...that the average CFL career is 3 years and the income is $60,000, so we’re talking about $180,000 which over a lifetime of earnings is small potatoes.

Interviewer:  
That’s for students who have professional aspirations?

Clinician:  
Most of them don’t.

Interviewer:  
Most of them don’t, but do you find that the athletes that come to see you and the other clinicians realize that they are student-athletes?
Clinician:
Oh yeah.

Interviewer:
The majority of them?

Clinician:
Oh yes.

Interviewer:
And that makes a difference in how they deal with their injuries?

Clinician:
Absolutely, I think so. Especially, with head injuries. I don’t know if it changes the mentality with respect to knee injuries and stuff like that. But, especially with brain injuries, many of them realize that their brain is their gift, not their squash serve. Like I had one ____ player who was seriously concussed this year who was a computer science major. Very bright girl/guy who was not going to make his/her living playing ___, and s/he knows it, and was very concerned about brain damage. And so, it was not at all difficult to convince him/her that s/he needed some time from his/her life’s greatest passion, other than computers. S/he’s a computer scientist who’s a high-level ____ player, not the other way around.

With knee injuries and stuff like that, despite the fact that our client group is of above average intelligence, sometimes you wouldn’t think so with the knee injuries and stuff. There, I get less on my high horse about it too, because hey, if they don’t mind hobbled around later in life, and having sore knees when they’re 50 years old, you know. I tell them that if they’re serious that ‘You’ll be arthritic, you are arthritic now. The more you do this, the more arthritic you’re going to get.’ It isn’t as catastrophic to me as someone who can’t think or talk or walk at all as opposed to arthritic knees. I know lots of very happily arthritic people, and with brain damaged people, even if they’re happier, they’re suffering on a different level. Those are the pictures I paint when I…discuss [the] risks and benefits with athletes…giving them advice saying ‘It’s your decision, but the fact of the matter is if you play…the risk of you doing further damage is high.’

This acknowledges that, in the case of head/brain injuries, his/her experience with student-athletes has been positive in that his/her patients have recognised their dual roles as scholar and athlete, and have favoured the former. But, those potential role conflicts are not as easily resolved in the case of musculo-skeletal injuries. Even though the clientele tend to be “of above average intelligence,” greater risks are taken with the body by the student-athlete, and less admonition is given by the sport medicine clinician. This implies different tolerances of risk, where head/brain injuries are not tolerated by anyone, and where ‘other body’ injuries, are
perceived as areas that can be risked more, and are weighed differently by both clinicians and athletes in the equation of perceived risks against perceived benefits of playing with pain.

This issue is developed further in Chapter 5, but I would like to conclude this section by commenting on how university-based sport medicine clinicians value their clientele as being more aware, more knowledgeable, and more open to discussion in most cases. This is important since it is perceived as an advantage by the clinicians to be working in an environment where education is held in such high regard.

Interviewer:
Does the educational setting here change how you interact with your patients?

Clinician:
Yeah, a lot of times. Like with the ____ player, I told him ‘You’re here getting a degree. You get a few more concussions, you won’t be able to concentrate, you won’t pass. And so, your goal of being in university is not playing ____, otherwise you wouldn’t be playing university, you’d be playing in a better league.’ So, I think a lot of the times, a lot of the students have a fair idea of physiology and anatomy, so they understand what we’re saying.

Interviewer:
And so is that an advantage?

Clinician:
Yeah, I think it’s an advantage.

This focus on education as an extension of setting re-emphasizes the importance of context, and the ways in which context encircles the ways in which pain, injury and risk are negotiated between clinicians and student-athletes.
CHAPTER 5
RESULTS and DISCUSSION, II

Interpreting Sport Medicine and A ‘Culture of Risk’

This chapter adds context to the data and interpretations offered in Chapter 4, and presents some models that help to organise the interpretation of how sport medicine clinicians negotiate with patient-athletes in this particular environment. These models are presented as schematic representations of one way of interpreting the negotiation process. While there are exceptions to any pattern that attempts to simplify and summarise, these are the processes that emerged from the data. These models are explanatory devices, but this does not mean that they are to be interpreted as the explanations. Each model presents a potential way of interpreting the negotiation processes that emerged from the research, but I must emphasize that they are not the only possibilities in the process of negotiation. These patterns attempt to capture an essence, not the essence, of the process of negotiation between sport medicine clinicians, patient-athletes, and the coaches. The overall goal of these models is to show how negotiation is a process that is dynamic, fluid – constituted by and constitutive of its context – in this case, intercollegiate athletic competition and the ‘culture of risk.’

The chapter is divided into two broad areas, with the second area subdivided into three sub-themes. Overall, the models move from a macro-level examination of the broader sport/health context in which this particular sport medicine clinic is situated, to a micro-level analysis of the actual factors involved in one-on-one negotiations. As with material presented previously, there is a fair amount of overlap, indicative once again of the fluid nature of negotiation in a ‘culture of risk’. Furthermore, while the first section consisted mainly of the views of student-athletes and sport medicine clinicians, this chapter draws upon and analyses the views of the coaches in this tripartite relationship. As is shown throughout this chapter, we cannot underestimate the influence and role of the coach on patient-athletes and clinicians.
Spheres of Influence

This first model shows five levels of influence, ranging from macro- to micro-level factors, which surround the central space of interaction that shows the two-way relationships and interactions between patient-athletes, sport medicine clinicians and coaches (see Figure 1). It begins with an understanding of the larger, ‘societal’ understanding of the ‘culture of risk,’ which represents the broader construct of risk as seen in numerous areas of social life, and which we influence and are influenced by. This understanding of the ‘culture of risk’ includes such intangibles as media’s re/production of risk as exciting and glamorous; coverage of professional and elite amateur sport; occupational cultures of risk (see Young, 1993); and socio-historically situated notions of character development as related to risk-taking (see Goffman, 1967).

Each successive level of the model becomes more focused, beginning with the Canadian healthcare system. While this thesis can not fully go into the structure of the Canadian healthcare system, it is important to understand that changes to this system, nationally and/or provincially, have a tremendous impact on the nature of the interaction between the major actors. This becomes readily apparent in discussing the accessibility of the clinic and the clinicians to patient-athletes, since decreased transfer payments from the federal government to the provincial governments, and political choice made by provincial governments, have resulted in decreased monies to provincial healthcare facilities and services, and have, arguably, contributed to the restructuring of billing at this particular clinic (D. Coburn, in-class discussion, Winter 2000). This restructuring has seen the opening of clinic doors to the public in order to subsidize the services available for student-athletes and the university community, but has also altered the time and frequency with which student-athletes have access to the clinic.
“Societal” ‘culture of risk:’ Larger construct of ‘culture risk’ as influenced by media, professional sport, elite amateur sport, occupational ‘culture of risk,’ norms of character development

- Canadian healthcare system
- CIAU system and structure
- Faculty of Physical Education & Health: An academic and athletic centre
- Sport Medicine Clinic: A place as well as the authority on sport medicine at the university

- The state/institution can control the context of the sport medicine interaction, but it cannot control the content of the interaction
The next level acknowledges the position of this institution under the Canadian Intercollegiate Athletic Union (CIAU), and the impact of being in such a system on the 'culture of risk.’ While anecdotal evidence and established literature have documented the ways in which other competitive sport systems, such as professional sport or NCAA, value athlete-scholars, one could argue that the CIAU system positions the sport participant as a student-athlete. Decreased focus on sport/team revenue-generation, and the fact that Canadian student-athletes have limited access to athletic scholarships are just two of many ways in which the CIAU differs from these other competitive sport systems. For a number of participants, this was one key reason why, in their opinion, the student-athletes and coaches in this institution were less likely to tolerate pain and injury as normal and acceptable parts of their sporting experiences.

One clinician touched upon these issues in discussing his/her experiences in a variety of settings.

Clinician:
I had a ___ competitor who was competing at the nationals, and this was more of an impression I got from the physician who referred, that this was someone who was trying out for the national team and his nationals were coming up, and he had injured himself and he wanted to compete. And my perception was that he wanted to compete ‘cause he wanted to get on the national team, but after talking to him...it was clear that he wanted to be able to compete because he wanted to be able to compete, but in fact his ranking was so low that he wasn’t going to be able to make the national team. And he was aware of that, so I told him it’s better that he not compete, and he was quite accepting of this. But with respect to this, to your particular area of interest in terms of the relationship that I have with the coaches, from can they return, not return, when should they return, things like that, I sense the coaches’ frustration about the athlete not being able to play, but I don’t really find here that I get any pressure at all.

Interviewer:
Really?

Clinician:
Very little.

Interviewer:
From the coaches?
Clinician:
From the coaches. I don’t really have pressure here [from the coaches] to play [the injured athletes]...they want to know whether they’re eligible to play, so they can make plans to replace them, but they don’t give me a hard time...

Interviewer:
Do you think it’s a setting related issue?

Clinician:
Oh, for sure.

Interviewer:
You worked at another clinic as well...

Clinician:
I’ve worked at a private clinic, and there, there are a lot of OHL hockey players, like guys that are top prospects. And their coaches come in, and it’s different there, because the...you’re not on the same team. You’re the guy who might...who’s gonna help, but who might stand in the way of letting them participate. And yes, the coach wants what’s best for the player, but what’s best for the player is that they be seen by the NHL scouts. And, a lot of them have trouble...more of them have trouble with the recommendations for limitation than the risk of playing...the risk of being able to play and being seen. And that’s because, there some aspect of this that might become a financial thing. You know, a player does well, gets drafted, the coach becomes an agent. You know, there might be other factors. But I see that way more in that setting than here. In here, the pressure comes from the athletes who don’t want to have to sit. And the time that you get the most bargaining, or when I see a lot of bargaining, is with the head injuries,... None of [the coaches], I haven’t had one of them last year come down with one of their injured athletes. Never. You know there is a hierarchy, they’re doing their things, the trainer is doing their thing, and the athlete. Sure, in the big US schools, there’s a big difference there. You know, the coach is there with the player wanting to know and hear.... It’s more supportive here of your decision to hold an athlete from play or not, whereas I would imagine, in some big US schools, where there is more pressure on the coach to succeed. There’s less intense light on the coaches here. I guarantee you, on situations ...I’ve worked with, when the pressure is on the coaches, when the spotlights greater on the coaches, they’re more intensively managing every aspect of their stuff.

The clinician recognizes that the nature of his/her interaction with coaches and student-athletes are different than other interactions as a function of the setting. S/he suggests his own theory as to why that is by acknowledging that less pressure on the coaches to succeed results in less pressure to play injured athletes. However, while the CIAU system may promote less tolerance of pain and injury, this particular clinician still feels that athletes subscribe to risk-taking and
injury-legitimating norms, and are one source of pressure on the clinician since they “don’t want
to have to sit.” The same clinician reiterated these points later in the interview:

...I think that if it was an environment where there was more spotlight, more pressure,
more demands from all the different components, then I might feel more inclined to say
that ‘Yeah, the coaches should back off, they’re too pushy with the athletes, they don’t
give them enough time to recover.’ But I don’t really see that happening so much here.
With respect to my dealings with athletes, most of the athletes are pretty bright, pretty
level-headed. They get frustrated because they’re injured, they can’t participate and I
consider this sort of bargaining. I see, I know exactly why they’re coming, I laugh and
say ‘Let’s start the bargaining now.’ I’ll even say to them, ‘Okay, you want to bargain
right. OK, this is what we can bargain about....’ I’ll point out the fact that we’re
bargaining now. As for things to change...no, as far as this environment, the lines of
communication with the athletes, with the trainers, with the coaches are pretty open and I
don’t find I have a lot of persistent conflicts or procedural...problems.

At the next level, we need to recognize the impact and effect of the Faculty of Physical
Education and Health (FPEH) in which the teams, the athletes, the coaches, the clinic and the
clinicians are located. The significance of FPEH lies in the fact that it is not only an athletic
centre, but an academic one as well. Woven into the material of FPEH in all of its different
functions and services is an educational mandate (see Appendix I). The sport medicine clinic is
located within such a space, follows such a mission, and has its own services geared towards
health education. Having said that, the structure of FPEH, the relations between the
administrators at all levels, fosters an environment that supports the sport medicine clinicians in
their recommendations, ideally in protecting the health and wellbeing of the patient-athlete. In
discussing his/her experiences with a collision sport club team, a clinician recounted an episode
of an athlete who clearly went against medical advice in continuing to play with a head injury.
When comparing that situation to this institution, s/he immediately acknowledged that the
administrative structure supports initiatives to safeguard the health of the athletes:

Interviewer:
Have you ever had such an experience here?
Clinician:
No, 'cause at UofT I have a little bit more power here over a recreational athlete that I'm just supervising.

Interviewer:
What do you mean by power?

Clinician:
In terms of having the backing of the Faculty of Physical Health and Education [sic], and we have very strict guidelines. Especially for head injuries. If you have a head injury, we have very strict protocols and guidelines in place that you're out for at least 24 hours. You have the backing of the coaches 'cause if the coaches go against you, they're liable to the Faculty as well, and come under criticism from the department because everything is so related and together. So, if we say something, that goes to our medical director, which goes through to the assistant dean and up to the dean and on from there. There's a chain of command that backs you in your decision being the medical representative there, you are respected for your opinion. If that player can not play, that player does not play and the coach takes them out, you take them out, the coach is gonna support you...

This is a source of endorsement of his/her efforts as “the medical representative,” and s/he interprets this as respect for his/her medical judgements. Interestingly, this clinician also hints at issues of liability, in this case when s/he discusses that coaches who go against medical advice are “liable to the Faculty,” and “come under criticism.” While liability will be more fully analysed in the last subtopic of this section, we do need to be aware of the tremendous significance of liability in this sport system. One could argue that the issue of liability and the threat of being liable often influences the final say in negotiations between clinicians and coaches, with coaches feeling the greatest threat if they go against the recommendations of the medical authorities. The same clinician conceded that such administrative support – even if nothing more than a threat – empowers him/her in his/her work.

Interviewer:
You were saying a couple times that it's the setting that makes the difference, and being an educational setting, a faculty that is devoted to health. Do you agree with that?

Clinician:
In terms of supporting our decision, yes. It's helpful to have that structure behind you. Generally, it doesn't affect how I decide things, but it just gives you a big brother type of thing behind. You know, ‘You have to answer to this, not just me, but to them too.'
From a different perspective, one could argue that the educational setting itself is the key behind understanding the negotiation processes between patient-athletes, clinicians, and coaches.

The clinician here best summarizes this idea that the educational mandate of the clinic is the key to its success in terms of operations and patient treatment.

Interviewer:
...you’re in a faculty that is an educational faculty that is quite progressive. How does this administrative structure affect the clinic? Is there an educational core to everything?

Clinician:
No, this clinic is different from a clinic in a non-educational environment in a number of ways, and I repeatedly tell my bosses that’s why we’re all willing to work for less money than we’d make if we worked outside.... We, the staff, choose to work in this slightly underpaid environment because of other less material benefits that include... administration [support that sees] us providing quality therapy which means therapists seeing two people per hour. We have explained to them, and they understand and appreciate, the difference between high quality therapy operations where therapists see a couple of people per hour and some of the windmills that are out there in the community where they see six per hour. They support us developing a business model that requires some subsidy by students, but supports quality therapy for students who would otherwise never be able to afford it. And we do that by far the best than any other university in Canada. And I appreciate the support of the administration on that. On the field care side, we utilize students but we are the most educative of the schools in Canada. We educate our students, we require them to take ‘Sports First Responder,’ we have in-service training on other issues not covered by ‘Sports First Responder,’ we have in-service orientation from everything from intimate relationships with client-provider relationships and ethics, and we cover all kinds of stuff that other places don’t touch, other educational institutions don’t touch. Not only are we an educational institution, we actually live by that. We teach our students, we supervise them, we evaluate them. You know, that’s very much part of our culture and our model and our business plan, so that’s different from an another environment or even in another school....

S/he continued:
I’ve worked in a number of clinics and I enjoy this form, in part, this sounds elitist and it is elitist, the clientele here are on average of above average intelligence and want to talk, they want to learn, they want to know, and they utilize the information that we provide to their benefit, they respond. I’ve worked in environments where, and it’s disheartening, where people are coming in, consumers of health care services and emergency departments and so on, and they really don’t care, you know. Well, you shouldn’t do this, okay, but they come back the next week with the same issue. You have pneumonia, stop smoking. Or you’re leg is broken, stop running. So I enjoy being here, it’s a good environment, it’s very educational.
Another clinician stated that patient education is key to the treatment and rehabilitation of patient-athletes, and reemphasized the role of education within the space of interaction.

Interviewer:
Do you think that patient education has to do with a setting?

Clinician:
The fact that we have more time to spend with patients is one of the reasons why this clinic is so good. The fact that we have the time to explain to people, mind you I can't speak for other people.... Personally, from my own experiences, when I didn't get educated about certain things, I wouldn't do them, and I wouldn't get better. If someone explained them to me, I understood why I was doing it, would do it and get better.

Interviewer:
Does it make a difference too knowing that they're not just athletes, that they're student-athletes?

Clinician:
Sure, that's why I like working here, because you know they're competent, they're smart, and they're gonna appreciate your knowledge as opposed to others who just want to get better... And people like that, even if they're smart, if they just want to get better, they don't care what you have to say, they're not gonna get better 'cause they don't know why they're doing what they're doing. They don't understand why they're doing the exercises, and just assume what we call the 'sick role model' and just sit back and let us do everything, massage them, give them medication, everything. Which is not gonna get them better. The only way you strengthen or stabilize a joint or muscle is by exercises and we can't do that for you, that's why I have to coach them. And even now I find my practice going away from ultrasound and IFC, you know the hands-on kinda stuff, and doing more education 'cause that's what's gonna make a difference. Honestly, I'll give you an example, an injured athlete, they may have a muscle imbalance and be doing something in a wrong way that would be causing pain. I could do all the hands-on stuff, they may feel better in a few weeks probably from rest, and they go back and do the exact same thing, it's gonna flare up again. Whereas if you teach them why it's like that, teach them to strengthen certain muscles, how to change the way they do things, that is what's gonna make them feel better. As opposed to putting a band-aid over it, wait for it to heal and have the same thing occur all over again because you're not taking the source of the problem, you're just covering up.

Interviewer:
What do you mean by the sick role model?

Clinician:
There's a thing that you're taught in medical called the sick role model. Traditional medicine basically has adapted that. Basically you're sick, you let us take control of everything, tell you what to do, take what medication, you don't do anything, we tell 'Well, sit back and relax.' Well, for us in [therapy], we identify that and we work against
that, 'You take control of your situation, you do these exercises, you learn about what’s wrong with you and you learn what you need to do to get better.' I always say this to every patient, 'What you do is more important than what I do two or three times per week at the most for a half an hour, because you’re gonna be with yourself 24 hours a day, seven days a week. What you do has a way more profound impact on your health.'

In a discussion that is meant to educate the interviewer, this clinician realized that his/her own practice is shifting to favour patient education “cause that’s what’s going to make a difference.”

The last layer of this model shows the sport medicine clinic itself – not only a location, but also the authority on sport medicine at this institution. This is important to recognize on a number of different levels. Firstly, that this place has not only a locative quality, but is also the space on campus that has professional dominance in the field of sport medicine, and which can be seen as the authority on the health and the healthcare of the athletic body. Secondly, there are no other spaces or locations on this particular campus that offer such specialized care. Thus, one could argue that there are no other spaces or locations or groupings of individuals that can dispute the actions, the decisions, or the power of this clinic. Clearly as seen by the other levels, the clinic does not operate independently of the Faculty or the larger institution of the University of Toronto. It is accountable and ‘liable’ to these structures, yet, since it is ‘only one of its kind’ on campus, the clinic may potentially be able to afford opportunities not to be found in institutions where there is more than one sport medicine centre.

This discussion ultimately brings us the core of this research, and the space of interaction between patient-athletes, clinicians and coaches. What is key here is the recognition – in keeping with some of the major critiques in the sociology of medicine on healthcare systems – that the state and/or institution can control the context of the sport medicine interaction, but it can not control the content of that interaction (see Navarro, 1986; Williams & Calnan, 1996). The state/institution can control the hours of operation of the clinic, the type of billing, or the number of patient-athletes seen per hour per clinician, but it cannot control the ways in which
individuals communicate with one another, the ways in which pain and injury are negotiated, and the ways in which people perceive, interpret, define and act upon that information. However, while state cannot directly control content of negotiation, regulation and policy have changed the climate in which the content occurs, and have defined limits on what that content can be. This is integral in understanding what follows, since it epitomizes the fact that each negotiation between clinician, patient-athlete, and coach is unique to time, date, character, and circumstance, as well as pre-existing and pre-defined limits. To emphasize again, all negotiations occur along a continuum that is dynamic, fluid and framed by an equally dynamic, fluid understanding of risk.

**Cyclical Nature of Sport Medicine within a ‘Culture of Risk’**

Figure 2 models the cyclical nature of sport medicine within a ‘culture of risk’, and suggests a series of stages that include: making contact with clinicians; negotiating with them; leaving that relationship; and returning to competition and to the risk of potential and/or actual injury. This model can be entered at any point, but we should qualify this by suggesting that student-athletes enter this system once they enter the institution as students. The remainder of this chapter focuses upon examining the first three stages in this cycle (see Walk, 1997 for an in-depth discussion of the return to competition and potential/actual injury stages), but it is important to point out that these three stages are not be taken as *the* first stages in the cycle. By that I mean that there are different possibilities for entering and exiting this cycle, and thus it is extremely difficult to claim that one stage is the beginning point and another is not. However, these stages underneath the broader context of a ‘culture of risk,’ re-emphasizing the need to understand the negotiations as determined in large part by the context within which they occur.
Figure 2: Cyclical Nature of Sport Medicine within ‘Culture of Risk’

Culture of risk: Overconformity to the sport ethic

- Potential and/or Actual Injury
- Making Contact
- Return to Competition
- Sites of Negotiation
- Exiting Clinician/Patient-athlete Interaction
While in Chapter 4, I focused on the ways in which the athletes understood and adopted a 'culture of risk' that tolerated and accepted pain, injury, and risk-taking, this subsection considers some of the ways in which the other actors, particularly coaches, understand and are complicit in the re/production of injury-legitimating norms – that is, the reproduction of the 'culture of risk.' This is important since coaches can be seen as intermediaries in the relationship not only between student-athletes and sport medicine clinicians, but also in the relationship between student-athletes and health and/or medicine in general. Studies in this area acknowledge that coaches have a tremendous impact on their athletes’ views on a wide range of subjects, including risk-taking, injury tolerance, and the value of good health (see Nixon, 1994). The data from this study support the fact that the influence of the coaches’ views, implicit and explicit, on the student-athlete cannot be underestimated. In one particularly interesting exchange between a number of coaches in a focus group session, a tension is expressed amongst the coaches about the value of having therapy available to their athletes, as well as a sense that the presence of clinicians motivates athletes to opt out of training or stop pushing themselves physically.

Coach 1:
I don’t have any problems with therapists, I have only problems with student therapists, [who do not have] knowledge of the sport. There’s a lot of problem[s] with that. It’s not a question of training, not when they have no knowledge of the sport, it’s very hard for them [to understand]...how...the injury is here? They don’t understand it. And other than that, I don’t know if I’m going off topic, but in the...years that I’ve been a coach...when there’s a therapist in the room, I think I’ve had more injury occurring. I don’t understand it. When therapy’s there, I think what, athletes tend to...you know as soon as something feels [motions with hands when something is off], they stop and they tend to go to the therapist. When they’re not there, I find they that they work through it. And when they’re really, really injured, they go out and go actively see a therapist. I like that better, and I don’t want them to be present constantly in the room because I find that athletes don’t push their limit, they just stop and go to therapist.
Coach 2:
Have you see the therapist walk. This is if there’s a therapist present. [Gets up and proceeds to walk a few step dragging left leg behind him. Other participants laugh and nod their heads]

Coach 3:
Have you been to some of our practices? [Asking Coach 2, jokingly in agreement] I agree with what you say. [Looking at Coach 1, nodding head]

Coach 1:
I don’t know. I think that they are very important in our sport, every sport I think. And they’re vital, but by over-presence, I think we lose our training.

Interviewer:
So you find that as well?

Coach 3:
See, the student therapist came...once a week. Our top athletes did not go to the student therapist. If something’s wrong with them, they would go right to the clinic and try to get in there. Even if it had to be me who had to go...and say...sometimes I had confrontations at the front desk saying that ‘No, that’s not good enough. You said two weeks, they need to see somebody now.’ And usually if I followed up on it, I could get them in there. I don’t like doing that, you know, pulling some of my powers, but if they have to get in there. Now, on the Tuesday night, when this person was there, I totally agree, ‘cause some people, and usually it’s the less talented [players] that all of the sudden ‘Oh my gosh, my shoulder is sore. Oh, my ankle is sore. I’ve been having a problem with my feet.’ Whatever, they would get out of the workout and go to see the student therapist.

In this passage, the coaches communicate their intolerance of athletes who do not endure pain and injury to their liking. The coach’s portrayal of “the therapist walk” to the laughter of the other people in the room, or the concession that athletes “don’t push their limits” when the clinician is in the room, imply that the coaches see the clinicians as promoting their athletes to not play with pain at times when the athletes should be doing so. Even though the coaches agree that the clinicians are vital to sport, this is overridden by the sense that the coaches feel the clinicians are working against them in their efforts to push their athletes’ limits. Implicit within this exchange is the acceptance of a ‘culture of risk’ as normal aspects of sport, as well as a lack of trust on the part of the coaches towards their athletes. This is communicated through the
belief that the athletes look towards the clinicians as an excuse to not train or participate in the practice. Clearly the coaches question the motives of the athletes, and in this one exchange, not one coach acknowledged that the injuries or the pain may be legitimate, or that the athlete is doing the right thing by seeing a clinician. The only exception is when the coach points out that when the injuries are significant, “when they’re really, really injured,” those are the times when the athletes should actively pursue medical treatment. One question is how serious the injury must be, for an athlete to be perceived as “really, really injured” by the coach?

In another exchange with the coaches, they discuss what they perceive their athletes’ philosophies of injury to be. In doing so, they communicate in some ways their own philosophies of pain and injury, and the ways in which they promote pain and injury tolerance. I draw particular attention to the coach who attempts to bring attention to the supposedly “positive” aspects of injury tolerance.

Interviewer:
Going back to the type of athlete, what do you think your athletes’ philosophies are in regard to...we’ve already said that there’s two different, almost extremes, of athletes [motioning with arms two separate points]...

Coach 1:
Well, more than two different types of athletes.

Coach 2:
There are...I mean one end of the continuum to the other you do get the extremes on. You really have to find out and get to know the athlete as to where they fit in, and are they a chronic complainer, and ‘I’ve got a hangnail and I can’t do my workout,’ but they go ahead and do it. And you get the type of person who his or her shins may be killing them, and they’re pumped up with two or three Advil, and they’ll go through their training session, and obviously, everything between there.

Coach 3:
We have that exact same thing [inaudible] and you got to deal with it. And I, ‘Oh, it builds character,’ you know, I bring [out the] positive. You know, I don’t want an athlete with a sore finger [to not] want to [play], you know, ‘Get the tape on, get in there.’ But, I don’t want to be Vince Lombardi, ‘No pain, no gain,’ I don’t want to have that mentality either. If they’re hurt, if they’re really serious, I think that they know that if they’re hurt, go get ice or go get therapy.
The conflict here lies in that while s/he states that he doesn't want to foster a "no pain, no gain" mentality in his/her athletes, s/he still subscribes to such notions that tolerance of pain and injury build character. Interestingly, during another focus group with athletes, two athletes comment on this very notion as espoused by their own coaches.

Athlete 1:
There have been days when I’ve [gone to compete] going like this [holding her hands to her back], and the coach is like ‘What’s wrong with me,’ and I’m walking around like I’m a pregnant lady. ‘What’s wrong with you?’ ‘Oh, my back.’ ‘Okay, get back [into the game].’

Athlete 2:
Yeah, it builds character. I’ve heard that way too many times.

Athlete 1:
I told him, ‘I have character oozing out of every pore, I don’t need anymore character, thank you.’ [Laughs]

Returning to the coaches, as they continue their dialogue on their athletes' philosophies of pain and injury, the interaction turns to acknowledging and understanding the role of the coach's philosophy of pain and injury, and how that is communicated with the athletes.

Coach 1:
Well, it's interesting, there are a lot ___ programs where the coach's philosophy is that if you don't practice, you don't start. And so the coach has that philosophy, so how does that impact the therapist? 'Cause usually the therapist's philosophy is if it hurts, don't go to practice, and you might eventually get to play. But the coach is saying, 'Don't go to practice, you don't play.' And that's a pretty common philosophy. I'm not so black and white in my philosophy. There's too many reasons why an athlete may not be able to get to practice on Wednesday, but he'll still be able to play on Saturday.

Interviewer:
And do you tell your athletes this philosophy?

Coach 1:
If that was part of my philosophy. I try to treat them individually now, but I mean, there certainly are some athletes who...consider it taking a holiday.

Interviewer:
Anyone else? Do you sit down with your athletes and say 'This is my....'
Coach 2:
To the team, we would say that ‘The clinic is down the hall, if you’re injured or if you’re sick.’ That varsity athletes are suppose to have priority, but it doesn’t work like that [lowered voice and rolled eyes], to go down there, especially first year athletes, that they can go there if they are sick and that the sports doctors know which drugs that can take, which they can’t take. If they don’t go there, go to another clinic, but take the drug bible with you to make sure they know what they can give you. In terms of training with pain, I find our international athletes tend to be the ones that want to ignore, they don’t want to sit out for an injury. And they tend to be the ones with the higher pain tolerance, and that will [compete] through pain. And I mean there’s five weeks to go before Olympic trials, and I don’t care how sore their shoulders are, in the next five weeks, they’re not gonna stop. And some of them won’t even tell us, you have to watch for warning signs in them.

There is the tension again between needing to watch their athletes closely and “watch for warning signs” that athletes will push themselves too far, and suggesting that some athletes consider rehabilitation as “taking a holiday” (see Roderick & Waddington, 2000 for similar examples of coaches and management interpreting the athletes’ rehabilitation time as holiday).

What the coaches here do not acknowledge, in either excerpt, is their own ways of interacting with athletes once they are injured. They speak of how they view the role of the clinician, complain of what they believe are inadequacies on the part of the clinic services, and even discuss the philosophies of their athletes, but they do not discuss the role they play, or the way they interact with an injured athlete. Interestingly, a clinician offered one opinion on how the coaches react around injured student-athletes.

Clinician:
I mean there’s this whole environment or whole other side of things where when an athlete gets injured and whether they feel part of the team and whether the coach still talks to them cause they know…. ‘Cause…when an athlete gets injured, there’s a whole process that happens where they don’t feel part of the team and the coach doesn’t bother with them unless they’re at the practice or there is no sort of communication that they would normally have ’cause they’re telling them to do this or that, and the coach has nothing to say to the athlete other than ‘How’s it going or how’s your injury feeling?’ Some are better than others of making the athlete still feel part of the team, and others are ‘You’re injured, when you’re better come back and we’ll talk again. We’ll have our normal coach-athlete relationship.’

Interviewer:
Do any athletes ever come to you and talk about that?
Clinician:
No, it’s just... just assumed, it’s normal. What coaches should be taught is what the reaction an athlete has when they’re injured and what are they thinking, and how should a coach’s treatment of an injured athlete support their recovery. So one of the things would be to make them feel like they’re still part of the team. I think some coaches are more personable than others, and they want to know about the rest of your life, not just what you can perform for me on the court or on the ice today.... The coach can teach the athlete to perform, but if the athlete can’t perform, then there’s nothing the coach can teach. But if they have a better relationship for whatever reason, they can talk about other things. They can still have a relationship where the athlete doesn’t feel as alienated from the team.... Whether the athlete will be more motivated to come back or part of that environment of being on a team is fear of the coach, that’s a pretty strong motivator. So if you’re too chummy with the coach, and if you can get away with another few days of being injured, whether that’s helpful or not... I don’t know, that’s a whole other...

Interviewer:
But again, it’s interesting because I certainly never mentioned it to anyone while injured—ever, and yet it is this sort of a common element.

Clinician:
It’s just sort of, well that’s what happens when you get injured. I don’t think you necessarily take it as a snub, I don’t think you necessarily think the coach doesn’t wish you well or hope you get better or doesn’t like you anymore because you got injured. That might be a few coaches who give that impression. Most people just assume that everyone just goes on with their normal life, and that you go on with your normal life.... But, I don’t know if it psychologically harms you unless your coach thinks you’re dogging it. And you know then, you really start to feel alienated because then the coach doesn’t believe you’re injured to the extent that you are.

The clinician points out that there are “normal” feelings of isolation and alienation that are felt by anyone who is unable to participate in the same sort of activities as the rest of their colleagues, friends, or teammates, and also points out that some coaches cease to communicate or interact with their athletes once they are injured. This is not to suggest that all coaches are like this, but rather that there are some coaches who communicate better with their injured athletes. However, it is not until the very end that the clinician questions the potential harm of a coach not communicating to his/her athletes, and positions it within the rhetoric of lack of trust as implicitly communicated by the coaches. The clinician understands the impact of the coach
communicating a lack of trust to the athlete, and recognizes that potential psychological pressure may be more harmful in the long run than physiological injury.

Much the same way that different moments during the season, such as playoffs or championships, changed the limits of acceptable pain and injury for the student-athletes, coaches and clinicians also understand the 'culture of risk' differently. As one coach pointed out, because there is limited clinical service for their team and a great deal of demand, the coaches and clinicians have worked out a system that prioritizes who gets therapy and who does not, ultimately favouring those who are competing in the finals. While this may be one way of tackling the imbalance between supply and demand, the coach goes on to note:

Coach:
One thing, because we only get [mention of a number of therapists] once a year or twice a year, before we go, we usually, like a couple days before, they want us to give them a priority list of who’s going to be treated first because... I mean we take [a certain number of ] men [and] women to conference and nationals, and there has to be priority. And our athletes know this, they’re very well aware that the priority is people who are [in the] finals, consolation finals, and the people who don’t make finals [motioning at the bottom of the ladder].

Interviewer:
And how do they know this?

Coach:
We publicize that right from the beginning of the year, and when we pick the OUA team, we’ll say ‘OK, we’ve got two therapists...’ and they’re all ‘Oh, yeah, yeah!’ and ‘The priority is going to be, oh injured, actually injured are the very first priority issue, and then finalists, semi-finalists and non-finalists.’ That they want to know, who’s injured that they haven’t seen. Sometimes some of them will see [mention], but sometimes they see other therapists in the clinic. And [the clinicians] want to know who’s injured, who’s not injured, is there anybody who absolutely has to [compete], and especially if you’re in a points race, there are times that well, we do have confrontations. Well, not confrontations but they’ll say, ‘Well, maybe they really shouldn’t [compete], well, do you really need them to [compete]?’ And in some years, it’s like ‘No, it’s alright, let’s pull them out’ and other years it’s like, ‘We really need them to [compete]. What’s going to happen to this girl who has a 100 degree fever if she [competes]? Oh, she’ll be fine. You know, she might be down for another two days, but she’ll be fine.’ OK, she’s gonna [compete]...
In mentioning the confrontations that sometimes occur, such as whether the athlete with the 100 degree fever should compete, we see another example where coaches push their athletes, and the limits of the 'culture of risk,' in favour of participating and competing in the finals. This is not to suggest that the athlete in this situation may have even wanted to not compete him/herself, but it does implicate the role of the coach in endorsing him/her at a time when her performance was valued above his/her health. This passage implicates all three major actors in promoting and reinforcing a 'culture of risk' particularly at a time when the importance of 'playing in the game' increases. In another example, a similar concession is made for an athlete who was given a recommendation to not play, and was then permitted to participate because s/he was part of the OUA team.

Coach:
There was only one problem this year, and that was just before OUAs for ___. And the Thursday before we were leaving to go...our therapist came up and told me that [one of the players] may not be able to play in the OUA championships, and we don't have another [person to play that position]. I didn't even know that s/he was being treated for anything. S/he'd been practicing the whole time...

Interviewer:
The student therapist?

Coach:
No, our actual therapist came upstairs to tell me this, and said that [the physician] had said that s/he shouldn't play. So I guess the therapist had said to [the physician] that 'Well, they're going to OUAs and they don't have another [person to play that position], and why is it all of the sudden that s/he can't play?' S/he'd been in apparently for two weeks seeing the therapist, and we had a lot of problems this year with not having a lot of coverage. At most of our practices, we had nobody, at all... So, our [player] was going, but s/he was going to treatment, s/he was uncomfortable with his/her back, but it wasn't major, it was sort of preventative and maintenance on his/her back. I guess then [the physician] saw him/her, and said s/he could possibly have a disc problem, and shouldn't be playing. So then the therapist said to me 'Well I told [the physician] that we were going, you were going to OU’s, so did he really think that s/he should not be absolutely playing, 'cause if so then we would have to do something very quickly to get someone else, or is it that s/he probably should be lightening his/her load but s/he could play this weekend?' And then s/he said 'Well, I guess, s/he could play this weekend, but then after that s/he shouldn't be playing.'
Interviewer:
Did you get this message from [the physician], or via the therapist?

Coach:
No, via the therapist. And I'm here, so I could've gone down to the clinic and had this discussion. Got it via the therapist. So then we went out, had to go out and buy him/her a brace for his/her back. Got the name of the place, did all of that on the way to [the championships]. Not the therapist, not the clinic, but the team. The team bought the brace, I bought the brace, and the therapist went with him/her to pick it up to make sure that it was right for him/her.

Interviewer:
Now was there any communication between you and, other than the therapist, the clinic?

Coach:
Nothing, just totally out of left field. Didn't even know there was a problem.

Again, the limits of 'acceptable' and 'tolerable' injury change when the context shifts to championships and playoffs. Amidst what the coach communicates about the news coming "out of left field," and being a complete surprise, is that the clinician changed his/her recommendation, according to the coach, once s/he found out that the team had no replacement for the player, and that they were on their way to OUAs. This is not to say that this clinician, or any other clinician, automatically changes his/her recommendations during important times during the season or important competitions, but it does indicate that such times influence individuals to think differently about pain and injury tolerance. In this situation, the clinician altered his/her recommendations in a way that supported the goal of the team to compete at the championships with this particular player on the roster, but in another situation, we see where the clinician's recommendations go against the desires of the coaches and athletes during an important season.

While covering a collision sport game, with a team that was en route to the national championships, a clinician recounted a situation that resulted in him/her garnering a negative reputation amongst the athletes, and a great deal of criticism from the coaches. As compared to
the other two examples, the context is similar in that these negotiations are occurring during championship/playoffs excitement, but the end result was quite different.

Clinician:
...[O]ne of the athletes had a mild concussion, and I got into a fairly heated argument...about whether this [player] should play or not. And I didn’t think s/he should, and everyone else, including the player, thought s/he should play, so I lost the argument. And s/he got hurt again, and I really started screaming. And so s/he did wind up sitting out a few games, and that’s when I acquired the nickname Dr. Death from the...team. And got called that for the next couple of years, until all those people who were on that team graduated or whatever. But, I tried to stick to my guns, and at that point...I was still being far more cautious than the then published guidelines at that time.... And that includes that anyone whose been concussed, in any degree of severity, should not play for at least 24 hours. It is still the norm in this practice to still allow people who have been concussed to play on the same day. Not on my teams.

Interviewer:
Was that athlete on the...team a key player?

Clinician:
Yes, starting offensive star.

Interviewer:
Do you think there would have been such a stink if s/he wasn’t?

Clinician:
Course not. No, it was that I was trying to gut the offense by making this [player] sit...and this was a team that was undefeated. A championship calibre team, and they were on a roll and I was rocking the boat.

I include this passage simply to emphasize and highlight the varied ways in which the negotiations between coaches, clinicians and athletes can travel. One questions what the exact factors or circumstances were that were key in changing how one negotiation ended with a player being allowed to participate for one more big game, and for another negotiation to end with resentment and feelings of hostility towards the clinician?

In moving on towards the stages involved in understanding the negotiation process, it is important to conclude this discussion by reemphasizing the ways in which coaches can be seen as influencing or not influencing their athletes towards the tolerance of a ‘culture of risk.’ In
answering a question about whether athletes feel a sense of entitlement to the clinic and the clinic services, a clinician points out the connection between the coaches' and the athletes' attitudes.

Yes, athletes develop a sense of entitlement, in my opinion, as a function of their coach. So, the [athletes] on the ___ team have a reputation amongst our staff as prima-donnas, extremely entitled to high level service, violation of appointments, show up when they want to, don't show up when they don't want to, that kind of stuff. And we get a lot more respect from athletes in sports where their coaches communicate effectively what we tell them.... But yeah, we sense a difference in the attitudes of the athlete that is highly aligned with the attitudes of the coach.

This clinician points out clearly that, in his/her opinion, a relationship exists between the attitudes towards sport medicine and the sport medicine clinic/clinicians as expressed by the coaches, and as perceived by the athletes. As we move into the other stages, we need to remember that while we focus upon the negotiation relationship between clinicians and patient-athletes, we cannot ignore the influence of the coach on both these individuals.

**Making Contact**

Before examining the space of interaction, what I term the 'sites of negotiation,' we must investigate the ways in which patient-athletes, clinicians, and coaches contact one another. Figure 3 outlines one way that contact is made, but it is important to stress that there are a multitude of ways of approaching and interacting with the clinic/clinicians that are not encompassed by this one representation.

This model suggests that there are a series of stages and decisions that injured athletes go through before making contact with a physician and/or a therapist (or another clinician if need be). The boxes and lines that are dotted represent intangibles that may or may not influence the making contact process depending on the athlete, the team, the sport, or the coach. They include the criteria for obtaining treatment, issues of accessibility and the influence of others on that, as
Figure 3: Making Contact with Physician/Therapist

Criteria for obtaining treatment

Injured athlete

Primary decision as to whether seeing a clinician is worth the effort

Secondary decision as to whether seeing a clinician is worth the effort

Accessibility:
- Availability
- Immediacy
- Consistency

Site of Negotiation:
Contact with physician

Tertiary decision as to whether seeing a clinician is worth the effort

Influenced by coach and/or team therapist

Potential "bypass" as result of severity of injury and/or coach-clinician relationship/athlete-clinician relationship

Site of Negotiation:
Contact with therapist and/or other clinician(s)
well as the potential bypass of the system due to severity of injury or a key relationship. All athletes weigh the criteria for obtaining treatment, as defined by themselves most often, but once have opted for advice and treatment face issues of accessibility in getting to the physicians, as well as when they need to access the therapists. It is important to point out that in the clinic under study, technically, any individual seeking therapy must receive a referral from a physician, therefore their first point of contact, or rather first site of negotiation, with the clinic is often with the physician.

Before any discussion of the actual ways in which individuals, particularly patient-athletes, contact the clinic, it is important to understand the way in which clinicians, especially the therapists, are assigned to intercollegiate teams. What follows is the history of how therapists are assigned, or are not assigned, to the varsity teams as related by the medical director. I should acknowledge that this was the only version of the story that I received, and that it is based on one person’s point of view. Given this limitation, it is valuable in our discussion of how the ‘system’ works, and may even point to ways in which it does not work.

Medical Director:
When I first became director, [we] laboured over a semi-quantitative system where I would assign points to a therapist working with a team based on their skill sets. ...[W]e did a sort of match and algorithm, we looked at the needs of teams with respect to...first response. For example, you’re not going to take a massage therapist who is not trained with first response and put them with the rugby team, because you need someone who can take a broken neck and can safely put the person on a spine board. Since then, we’ve trained all of our therapists in sport first response, so even our massage therapists, who get no training in that in school, are reasonably safe. Nonetheless, the massage therapists work with teams that are less collision or contact in nature, but are more likely to experience overuse issues, so track and swimming basically based on skill set are assigned to massage therapists, and based on their demand.... So through this point matching system where we match peoples’ skill sets, experience, if they’re experienced with sports, and their desires...we did a best-fit matching based on who the coaches and therapists would like to work with, and based on skill set which was the primary criteria.

Interviewer:
When you say we, who’s we?
Medical Director:
The whole clinic staff did this as an open participatory exercise with numbers on the blackboard, and…

Interviewer:
And how were the coaches contacted?

Medical Director:
By us. And there were a smaller number of teams that got coverage by that time, so it was an exercise with something like 12 teams at the time. …[S]o we went through that time-consuming and complex exercise once, and since then, it’s been a year-by-year evolution from that as staff have gone and so on and so forth, and people have expressed a desire for a different sport or have not had a good year with a particular team for whatever reason, we’ve changed things around. It is now the head therapist’s job to do that matching, and in fact, I haven’t been involved for the past few years… And the matches are still determined on logistical issues, well skill set is the most important, but logistical issues such as schedule because we have multiple teams assigned to each therapist now, we can’t have them in conflict with each other…. And, personal fit, personality fit, culture of sport fit, sport experience fit, are still in the equation, but they’re secondary to skill set match and scheduling match…

Interviewer:
Now all the teams do get full-time therapists?

Medical Director:
Correct.

In discussing the therapists, the Medical Director outlines the three categories of therapists, including massage therapists, physiotherapists and athletic therapists, as well as the different types of student therapists working with the intercollegiate teams. He continued:

Medical Director:
We assign every team, 44 I think, every one of them has a designated therapist. For over half of them that means that there is a therapist who is responsible for reviewing the annual health questionnaires we give to the athletes before their year commences, flagging any respective difficulties and getting that person come into the clinic to talk about those potential problems with a physician. Also if the coach has any questions about an athlete on their team, they are supposed to contact their designated liaison, so it is more a liaison role and a supervisory role, not a direct hands-on field care role. For the other half of the teams approximately, approximately 20 of the teams, receive on field care of one sort or another.

In turning to the evolution of the therapist assignment system, he stated:
We have gone through quite a history in terms of the politics of how that’s evolved and which sports are covered and which are not. And it’s been a gradual mixture of history, risk management and gender equity initiatives, and board equity initiatives, if you can call it that, meaning just equity amongst teams at UofT. There are different factors that come into play, that and the evil budget concerns, a reality that prevents us from doing what we would like very often.

So historically, when I arrived onto the scene, four teams received field care…end of story. None of the other teams got any field care, and maybe if we were hosting championships, the athletic therapists on staff which we only had one and a half therapists on staff, no physicians, no physiotherapists and no massage therapists, so we could only cover so much. How and why those four teams were chosen? At that time, and it still is league rules in the OUA, that football and men’s ice hockey require that level of coverage, they must have an athletic therapist or a physician or a sport physiotherapist level 3 present by [the] rules. So, the school had to do that, but that is not the rule with basketball, and still is not, so the fact that basketball was covered…was that the athletic director of the time was the basketball coach…. One certainly had a hard time justifying that [system of coverage] based on risk, given that we had a rugby team that received no coverage, and operated an intramural tackle football program that had no coverage, but had coverage for every game and practice of the basketball teams.

My arrival coincided with the arrival of a new director, he’s the guy who hired me. He wanted to shake that up, and he looked at it and said ‘This is based on history and politics, not on rational behaviour.’ So, his push was towards a two-tiered system to intercollegiate sport where there would be relatively well-funded teams, and essentially non-funded teams that received central support only in the form of some administrative support, but they would have to raise their own funds for their program. We called them intercollegiate teams and club teams, whatever, and in some sense, we still have a descendent of that model with our T and U division sports, but that’s not how our field care is assigned to them, so we have to go through the history….

Following that, the next change…we’re talking up [into] the early nineties, there was a strong and overdue and welcomed move towards gender equity, and this is something that I am proud to be in the forefront of in this department, in that I fought hard to have a gender balanced budget for intercollegiate sport when I was a manager…did not succeed, but certainly fought the fight. And I was the first service manager in this department to table a gender balanced budget, the clinic’s budget was gender balanced since ’93 and on. That resulted in a lot of fights because I got bad-mouthed by some coaches for doing that. I took the money for field care and divided it into two envelopes. Since the sports within those envelopes are different and have different requirements, we allocated field care among them differently, which resulted in non-uniform treatment of similar appearing teams of different sexes. …[T]he total envelope including salary for field care was…$70,000 per each sex. Within the men’s envelope of $70,000, half of that is consumed by men’s football, leaving the rest to be divided amongst the rest of the teams. Well, there is no comparable lion’s share sport in the field care envelope for women, so we had $70,000 to be distributed amongst the rest of the teams with one additional team… This resulted in a situation where outside football and men’s ice hockey, the coverage for men’s sports was reduced to home game attendance by a therapist and no coverage of exhibition tournaments, exhibition games, etc. etc., or even just a student with the men’s teams compared to their female counterparts…. And the men’s teams
were jealous understandably. And when they repeatedly came and complained...I just held my ground and said 'I refuse to take money from the women's envelope to the men's unless I am absolutely told I must do that by my boss.' And my bosses didn't tell me to do that. The climate at the time was a push for gender equity...and this continued for several years.

Through this period...there was a continued attack on that not only by the coaches, but by the therapy staff. ...[A]ll the staff disagreed with me and felt care should be assigned by risk basis and need basis, not a gender equity basis. I took the position that I would happily see our budget unbalanced if, and only if, more money was spent on women elsewhere within the intercollegiate program. So that if field care was looked at part of the overall intercollegiate program, and it is deemed that men's sport require more field care than women's sports, that would be okay as long as the women had the additional money to spend on their programs in some other way. But that was not the case.... We just see an overall intercollegiate budget, we don't see how much is being spent on different sports, so I don't honestly know what current state on gender balance in the intercollegiate budget is.... So over my objections, the dean, well at that time he was the acting director, and the associate director of programs ordered me, essentially 'cause I had to hold my nose to do it, to implement a risk-based model, at least more risk-based model from what we had.

We still had a two tiered system, and the associate director asked that we table a model that involved similar coverage for all the sports in the funded division. So taking the dollars available and figuring out how we could spread them, we said okay, we will provide staff care for home games and student care for road games. And that's not a bad model, given that at home, students would get supervision of the staff and would have the chance to get to do some things on their own, and the assumption is that when the teams are on the road, the hosting team has someone more qualified available if the student finds themselves in a problem.... So we did that across the board, but that didn't work with football. Football is just too plagued with risk and injuries, and we had terrible situations develop...terrifying I should say, nothing terrible happened, no catastrophes, but we just came too close.... All the sports in the funded coverage receive the same coverage, that is home game and student coverage on the road, except for football which gets professional coverage of everything. And I objected to this imbalancing of the money being spent on women and men, so we created extra programs for the women's teams. We assigned a therapist to 30 hours of injury preventive conditioning and strengthening to each women's team that they were assigned. And we had a budget of a certain amount of therapists' staff time to teach women in seminars about their health and injury prevention, women's health implications. If you took the money spent on actual field care and added this additional money that was being spent on women's programs in health education and conditioning, they balanced. And I was okay with that, because I said it doesn't have to be balanced within field care, unless there's some counter-balancing money being spent on them elsewhere within the intercollegiate envelope. And that's what happened, and it's still actually within the sport medicine envelope because we kept the money for those initiatives in the sport med budget.

Two further changes have ensued. One, and we're happy about this, we got a green light to expand funded field care beyond the T division envelope. This is a few years ago, and extend it to all teams based on risk. So we provide coverage for all the funded teams, several of which are low risk, like track and swimming, and some of the unfunded, or
relatively less funded teams. Some of the higher risk sports that I mentioned receive the same level of field care as the funded teams. So I'm happy with that, with developing a model of coverage that is logical and defensible on the basis of risk, at least some of it is, some of it is not. Some of the additional coverage provided to football is risk-based, but it is now gender imbalanced. The faculty took away the money for women's health education, they still spend it, so it's balanced outside of our envelope I hope, but I no longer see that money so I'm not personally assured that it's gender balanced. But the field care envelope itself now is unbalanced, so that sits a little uneasily with me, and I hope that in fact the counter balancing of other intercollegiate programs still exists for women.

Thus, the Medical Director offers one version of how the system of therapy assignment originated and developed, and situates this process within some of the other institutional political changes. What is also revealed in this narrative is the social and political awareness of the Medical Director towards other issues such as gender equity. I point this out since being his vision and/or approach to issues such as gender equity, and even issues on pain and injury, influences the rest of the clinic environment. This is another example of the ways in which context plays a key role in the negotiation process, since we can argue not only that the clinic is located, physically and ideologically, in a Canadian educational centre with its own progressive views on gender/ethno-cultural/sexual diversity equity, but is also directed by an individual who shares and actively participates in those same initiatives. We cannot argue against the fact that the views of the director of any group do set a tone or facilitate the atmosphere for the rest of the group. This point is best exemplified when we turn our discussion to the negotiation, or rather the non-negotiation, of head injuries and concussions.

In continuing with the model of making contact with clinicians, we start by examining the criteria that student-athletes define for themselves that motivate them to seek and pursue medical advice and treatment. While there exists a multitude of reasons as to why athletes choose to seek advice and treatment for some injuries and not for others, one particular exchange among student-athletes in a focus group highlights some of the more relevant ones.
Athlete 1:
It's pretty much, if it's not something that anybody from the team has experience with, it's just make an appt., just go to the clinic. But it'll probably happen four or five times before they do it.

Interviewer:
But only for certain types of injuries?

Athlete 1:
Like I said, it doesn't happen that often, but when it does happen, and nobody's there, you go get ice. Like for the most part, ___ had a problem with his/her shoulder, and I had the same problem, so like okay, s/he's gone to see the physiotherapist and s/he knows roughly what can help, so okay you can talk to him/her about it or talk to the coach, 'cause they've both played nationals and I'm sure they've gone through a lot of various injuries or at least seen it. If they don't know, it's not a big deal, at least get it looked at.

Interviewer:
So what kind of injury would get this [player] in?

Athlete 1:
Like our goalie, s/he [has] problems with joints, especially with the knees...so something like that. And pretty much what we do is ice something like that down, but I think his/hers got to the point where it was affecting his/her play, we'll suggest that s/he make an appointment.

Interviewer:
What about any other sport, what type of injury would you go to see the doctor about, or what degree?

Athlete 2:
Something that you've never seen before maybe. Every sport has fellow teammates, there's always older people, like I'm 21 and people on our team are 29, and they've been [competing] for years. And they know, and the coaches, I think at different levels, are Olympians or nationals. You can always ask somebody, but if you're like, 'I've got a weird thing,' or if it really bothers you and...

Athlete 1:
Once it starts affecting play, then for sure. That's a clear-cut line, but before that it's up to you, how much pain you can handle.

This passage points out some of the reasons why student-athletes make the decision to seek treatment including the experiences of teammates and coaches with that injury, the number of times the injury must happen before it requires treatment, whether the injury is "weird" or "really bothers you," and whether or not "it starts affecting play." These particular athletes all play on
teams that do not receive primary field coverage, simply an assigned full-time therapist in the clinic. We must question whether these would be the same responses for athletes on teams that have a therapist, student or otherwise, available to them on a more consistent basis. If there is a clinician present during a practice or game, would the athletes still rely on self-doctoring and team-doctoring? This is one question that we need to keep in the back of our minds as we move throughout this process – how different is it for athletes from non-primary field coverage teams to access the clinic and the clinicians than athletes from teams that receive primary field coverage?

The next stage in the model is the issue of accessibility to the clinic in terms of availability and immediacy of appointments, as well as consistency in therapy coverage. This was important for both athletes and coaches throughout the contact process, and highlights some of the differences between teams that do and do not receive primary field coverage. While athletes from non-covered teams were quick to point out that they could not access the clinic, and the clinic's services, few athletes from covered teams spoke about difficulties they have encountered. For example, in one exchange between athletes in a focus group session, athletes, both from non-primary coverage teams, comment upon the difficulty of making appointments with physicians and therapists.

Interviewer:
So, did anyone have any notable experiences with pain, injury or with the clinic this year?

Athlete 1:
Yeah, well I hurt my hips...and I was getting some pain, but I went to the clinic for a couple of visits and I don’t go there anymore.

Interviewer:
Why?
Athlete 1:
I hated it. It was very difficult to book an appointment, and this might be off topic, but you’d book an appointment and you’d get it two weeks ahead. The therapist was great.... But otherwise, the first appointment was fine, it was that week, the next appointment, ‘Oh yeah, ___’s not free for two weeks except for seven o’clock in the morning,’ and I’m a commuter...so for me to get here at seven is really difficult.

Interviewer:
So what happened when you said, I’m just not going in...

Athlete 1:
Oh, I went to a place back home, where I could get there early in the morning, so I could just get on the bus and come down here.

Interviewer:
But did the clinic people say anything to you?

Athlete 1:
No, they kinda said ‘We’re busy, we’re in transition,’ and you know how they’re expanded and still trying to, they’re in the process of hiring more trainers and stuff like that. But, I don’t want to say that it was all bad. Like when you call me and told me the subject, I thought ‘Oh, this is great,’ this is exactly how I was feeling three months ago when I was hurt and I couldn’t run. I almost missed [the championships].

Athlete 2:
Like in terms of the quality of care, the reputation is good, and they say you should go. But I mean, there were a couple times this year where I thought about going, ’cause I was hurt, but I didn’t just because of what you’re saying. From what I heard, it’s actually hard just to make an appt. And I was way too busy with other stuff...

Interviewer:
So what did you do?

Athlete 2:
Well, I basically didn’t do anything [laughter from around the table]. I let it go, and took a week off, that kinda thing. But they were small things, little muscle tears [inaudible].

Interviewer:
And was it in terms of just getting a doctor’s appointment that was too long, or a doctor and therapist...

Athlete 2:
In terms of just getting an appointment to just go and see people, see anybody.
We must acknowledge that the choice that Athlete 1 took may be an option for only a limited number of patient-athletes, who have access to resources that facilitate their going to another clinic – money, transportation, and free time. Similarly we must acknowledge that while Athlete 2 may not have compromised his/her health by not pursuing clinical advice and treatment, depending on the severity of the injury, his/her ambivalence towards the clinic based on its reputation of inaccessibility can be shared by other athletes – particularly those who do not have primary field coverage. In another focus group session, other athletes discussed the accessibility and availability of field care by therapists. In this exchange, Athlete 1 (high-risk contact sport) participates on a team that receives field care only during playoffs while Athletes 2 (high-risk collision sport) and 3 (low-risk non-contact sport) receive primary coverage throughout their season.

Interviewer:
Well, does everyone here have someone with their teams?

Athlete 1:
We only had someone come to OU’s and CI’s for our sport.

Interviewer:
And that’s it? [Athlete 1 nods]

Athlete 2:
And that’s a full contact sport. That’s sketchy.

Athlete 3:
We had someone all the time.

Interviewer:
For practices and meets?

Athlete 3:
Well, at some practices we had a student, and then for all of our competitions, we had one or two...

Athlete 2:
Are you a CIAU sport? [Looking at Athlete 3, Athlete 3 nods] That makes the difference, all the difference in the world down here.
The point made by Athlete 2, that the status of the sport makes “all the difference in the world” in terms of field care, was a sentiment shared and expressed implicitly and explicitly by a number of athletes throughout the project. Athlete 2 expresses shock that a full contact, high-risk sport would receive such limited coverage as compared to Athlete 3’s situation as part of a low-risk, non-contact team that is recognized as a CIAU sport.

In looking at other factors involved in accessibility, a number of athletes pointed out the importance of seeing a clinician as quickly as possible once injured, in order to be able to adequately express their pain.

I don’t know, I found that they would do a few exercises here and there, but they would never really fix it. And I never got...I mean relief, I’d walked in there and all I would want was a really deep massage cause my muscles hurt so much, and they’re [motioning with his/her finger, gently poking into the air with a falsetto voice] ‘Okay, does that hurt? Okay, well, you saw a doctor, now you have to wait two days to see a physiotherapist.’ By the time I wait two days to see them, the immediate spasm would have subsided and it wouldn’t be as prevalent. They’d be trying to do the motions with me, the range of motion exercises, and I’d be like ‘Yeah, well, it kinda feels bad but I really don’t know,’ but I mean, you don’t know. So I was really feeling frustrated because I wanted someone to see it the day that it happened so I could really tell them what was wrong.

While his/her expectations for same-day service may be unrealistic, s/he does bring up the argument that the longer patient-athletes wait to see a physician and/or therapist for advice and treatment, the less likely they will be able to express their pain (depending upon the injury) effectively (cf., Scarry’s (1985) discussion of the temporal and elusive nature of pain).

It is important to reiterate here that many of the athletes acknowledged that the greatest effort involved throughout the entire negotiation process was in making contact with the clinicians. In answering a question on whether the athletes have ever hidden or downplayed their injuries from the clinicians, two athletes, both athletes from non-primary coverage teams, point out the stupidity of doing such a thing once they have gotten into the clinic.
Athlete 1:
To me it seems a bit backwards to hide it from the therapist. If I’m gonna get the effort up, the courage whatever, to go and see him, I’m gonna tell him ‘It damn hurts here.’ I think so.

Athlete 2:
The effort is trying to get in there.

Athlete 1:
As soon as you’re in there, you’re gonna say ‘Oh, that’s killing me here.’

The key difference between the two different types of teams, those with primary coverage and those without, is that accessibility for non-primary teams is quite different than primary teams, since the latter have increased exposure to a clinician, student or otherwise, therefore they have increased exposure to clinic services, and thus and may be more likely to access and make contact with the clinic more often. Again, we must question whether the presence of a clinician has, or does not have, an influence on patient-athletes’ frequency of use of the clinic.

The coaches expressed similar concerns about the accessibility of the clinic and the subsequent impact on their athletes. Interestingly the most vocal coaches were those of primary coverage teams, and their concerns focused primarily on the consistency of field care therapy and then secondarily, on access to clinic services. In the following exchange between three coaches, all of whom are coaching high-risk, contact/collision sports, emphasis is place on the difficulty of working with inconsistent field care therapists.

Coach 1:
My problem this year... was more of the case of having student therapists who I had on a rotating basis, where I would have one therapist on Monday morning, then another therapist on Tuesday and Wednesday, and a third therapist on Thursday, and then you get to Friday when you have the game. So something might happen on one of those days, and there wasn’t communication... so it was very difficult to communicate what was really happening a lot. And I’ve made it a practice in the past, because I ran into this in my first year of coaching, I wasn’t finding out early enough that so and so wasn’t playing – Friday night we’d play a game, and Saturday, I’d show up at the arena expecting someone to be in the lineout and finding that they’re injured and can’t play. So I’ve made it a point of staying on top of the therapist all the time, and having them mad at me ‘cause I’d always be calling going ‘What’s wrong with this....’ But for my own sake, I
was the one who would stay on top of it...I would always make it a point of calling myself. This year was more difficult with so much of a rotation, but I still tried, myself, to call. I don’t know if I should have to do that, and they should be communicating with me all the time...but it was a pretty difficult time this year with therapy, so...

Coach 2:
There’s a lack of continuity when that happens, so... I mean that’s the same thing that happened with us this year with different people all the time. And nobody knows really what’s going on.... And I just don’t think it’s the coaches’ responsibility, I think it’s the medical staff’s responsibility. And I know when it’s worked really well, and it’s when we had a therapist who was with us all the time, and they were assigned our sport. And they were assigned to practices and games, it didn’t matter home or away, they were with us all the time. And then, you didn’t have the problem of lack of communication, didn’t have lack of continuity, you knew that you could build up a rapport with that person, and you know the level of trust was built up throughout the whole team with the medical staff. Right now, when there’s a rotating door, the kids don’t get use to the therapy staff, the coach doesn’t get use to it and you’re not sure who to ask, on any given day, can she play, what about next week, the whole practice?

Interviewer:
Does that change how you deal with injuries, or how even the athlete deals with injuries?

Coach 3:
Well, [Coach 1’s] already said s/he’s changed his/her situation because of the way it was, and I felt like at the end of the season, exactly like s/he said, that I would have to stay on top of the therapist.

Coach 1:
First thing is, and I’m not complaining about the actual people, ’cause we’ve had some very good people working with our team. It’s the situation that they’re put into, or I don’t know why the situation the way it is.... But to have someone there on Monday, and someone else on Tuesday and Wednesday, and someone else on Thursday, that just doesn’t work. Of course, we’re all used to it, so we deal with it and...the longer you coach, I guess you shut out a lot of things that don’t have to do with the competition.... But, I guess you learn to deal in that situation, when that’s the situation when you don’t have a person all the time. But you have to have somebody...for continuity. And I think the athletes are the same in that they know that this person could be with them everyday, or a new person tomorrow, and they have adjusted to that. Now, whether that’s the best thing for them?

Interviewer:
What do you mean adjusted to that?

Coach 1:
They just know that maybe they like the way the person on Tuesday and Wednesday treated them, and they’re not so keen on the way the person on Thursday treated them, so
they don’t get treated on Thursday. I’m sure they made adjustments, I haven’t spoken to them specifically, but…

Coach 2:
I think your question is interesting on how that affects the situation with injuries. The thing that I would wonder, and I’m not too sure and you guys can jump in, but I wonder if there’s a lot of things that slip through the cracks?

Interviewer:
Like what?

Coach 2:
Well, I wonder if…you know, like that thing with our [player], I really felt badly about that. Because I had no idea about that, that that was happening, and I had quite a stern discussion with him/her about the fact that I didn’t know that, and that I have to know that, and she said, ‘Well, I thought the therapist had talked to you.’ Well, if there’s a rotating group of therapists, then we can’t make that assumption. And I felt bad ’cause I was working him/her hard in practice, ’cause we were getting close to OU’s, you know, we were in final preparations, and everyone’s working very hard, and here’s s/he is close to being not able to play because of an [injury]. And, but I wonder if things slip through because of that? Until it gets to the point where they can’t play.

Interviewer:
So, an athlete would not talk about an injury, or get treated…

Coach 1:
Oh, they might talk about it, but they would tell this person assuming that this person would know, assuming that person will tell that person without telling you, and…[gesturing on the table with his hand levels/steps/stage]

Coach 2:
And it doesn’t get there.

Coach 1:
I mean if it’s really, really serious, of course it’ll get out, but if it’s minor, then it may not. And then, as you said, it gets to the point where now it’s not minor anymore, they can’t play. Like you didn’t know about it when it was minor because…

Coach 3:
Because it was minor. And then it grew, and suddenly it wasn’t minor anymore.

For the coaches, the inconsistent nature of clinicians results in a profound loss in communication about the health of the athletes and a sense that “things slip through the cracks.” While this conversation equally implicates the coaches’ different and personal styles of interaction with
their athletes on the topic of health – only Coach 2 points out that they discussed health and healthcare with their injured athlete – it also points to how the coaches perceive the importance of the clinicians in the team/sport as well as their reliance on the clinician to act a liaison or communication link between coach and athlete. As another coach discusses, this communication connection is valuable in light of the nature of their sport.

Coach:
In our sport... the therapist, the full-time ones when we had them more often, also alert us to different problems that especially young women athletes are having. And we run into quite a few eating disorder problems in our sport... and there are also student-athletes that come in with a lot of other types of problems that if the therapist and the coaches talk, they can put two and two together on what’s actually happening with the athlete. Whether his or her marks are going down very quickly, haven’t been showing up to workouts, and you really can almost prevent a major problem from happening.

Interviewer:
So that’s why you rely on the therapist to be there...

Coach:
Well, for a lot of things. Not just for the actual physical injuries that they receive, the emotional/psychological situations that they might be going through at this time.

Interviewer:
And so when the therapist is not there...

Coach:
You don’t have that link.

The previous conversation between the three coaches also points out the perception amongst some of the coaches that, without consistent clinician presence, their athletes tend to let “minor” things progress into “major” things. Another coach of a high-risk, contact sport that does receive primary coverage, reiterates some of those ideas in their discussion of what their athletes do when consistent coverage is not to be found.

Interviewer:
Do you think that your athletes deal differently with their injury seeing that they don’t have consistency in terms of the therapy?
Coach: Probably, I mean I don’t know. I mean I think my athletes become more independent [laughs].

Interviewer: Do you think they would just avoid seeing anyone cause it was too much of a hassle?

Coach: No, by the end, we had people seeing our... students [therapists], when they were there. But the problem is when they are not there, and then what do they do? 'Cause there is a need to have a regular routine, especially with people who need to be stretched properly before the practice and need to cool down properly after practice. I think that we're in the situation where my athletes are not getting the proper treatment, and are not doing anything about it.

Interviewer: Until it deteriorates?

Coach: Yeah, well, until they can’t play, and then you have the problem of trying to deal with it, when it’s too late.

Again this positions the student-athlete as quite passive and as heavily and uncritically entrenched within a ‘culture of risk,’ but it points to the perception that coaches have of their athletes in these types of situations. That they are more likely to let injuries “deteriorate” without telling anyone, rather than talk to the coach or actively seek advice and treatment at the clinic.

Accessing the clinic was also a concern for a number of coaches, interestingly much like their athletes, in terms of availability and immediacy of appointments. As one coach points out:

I guess for us, the only concern we have is accessibility. We touched on it at the very beginning. Regarding the quality of care that the athletes get are, I truly believe, second to none. But it’s getting them there. It’s just getting them there. Even in our, right before the finals, it’s very difficult to get the athletes in there.

This frustration is echoed by other coaches in another focus group, one of who points out that for teams with shorter seasons, the inaccessibility of the clinic is of great concern.

Interviewer: And there is no way of getting to the doctors?
Coach 1:
Well, they can make an appointment to come and see a doctor. Actually, generally, you can see the doctor quicker, but you can’t get therapy quicker, so, they don’t get any therapy. So, they’ve seen the doctor, and they’ve made an appointment to see so and so in this one slot, but it’s a week later, so...

Coach 2:
And they don’t get the fact that, you know what, we can’t wait three weeks for treatment. Like our season is over November 1st, and you can’t have an athlete waiting and sitting for the first treatment for two weeks.

Coach 3:
Well, you can’t, I don’t even want to wait three weeks to find out what it is [inaudible]. The doctor will know entirely what it is, but you can’t see the physio for another two weeks.

Coach 1:
And that happened a lot this year. Yeah, like they would see a doctor, and then wait, especially in October, two weeks for a therapist.

Interviewer:
And so during this time, they would continue playing if they could?

Coach 1:
Yeah, if they could.

When asked whether coaches vocalize their concerns about clinic and clinician accessibility, the coaches acknowledge that they can and do communicate their concerns with the clinicians ranging from the Medical Director to the head therapist to their assigned therapist.

What became evident though was a sense of frustration with the answers that the clinic gave to them, particularly that of budget constraints.

Interviewer:
Is there any room for you to take your complaints and say ‘Look, I need...’

Coach 1:
I think that you can go and talk, I have talked to them about that.... And to their defence, they’re also working within a budget that doesn’t allow them to have the things that we once had. And I think that’s the most difficult thing, to have something and then have it taken away. We used to have a full time therapist, at every practice and every game, and we’re used to that. And then all of the sudden, they took that away, is a budgeting thing.
So to then go and say to people in the clinic, 'Why can’t you this anymore,’ their answer is ‘Cause we don’t have the money to do that.’ So, is it their fault, I don’t know?

Coach 2:
I think that’s a problem... I find that whenever you do bring it up, that’s always the answer. And I find that that tends to be the answer a lot of the time to everything. So, ‘No we can’t do that cause it’s not in the budget. Well, if we had a bigger budget, we’d be able to do more.’ And I’m not sure completely... sometimes that’s something to hide behind, that ‘We don’t have the budget.’ And I think it’s a bit of a mystery as to what is suppose to be provided. It depends on the team as to what is provided. Like swimming gets certain things, you know, field hockey gets certain things, lacrosse gets certain things, there is some inconsistency.... So, I find it very mysterious as to what everybody is supposed to get... there’s a lot of confusion.

The issue of accessibility is mediated by a number of factors, some of which have been discussed, and which include the influence of coaches and/or team therapists – in other words, the personal connections that athletes and coaches make with the clinic and the clinicians (see Figure 3). These personal connections represent ways in which athletes can potentially ‘bypass’ the decision-making process in order to make contact with physicians and/or therapists.

Athlete 1:
But one huge benefit that the ___ team experiences having people who deal directly with track, so although it’s not a set out thing. So if you have an injury, on paper it says you have to wait like everybody else, but because you have people who are keyed into our team, you can just talk to them personally if they have a space open.

Someone murmurs:
A connection.

Athlete 1:
Yeah, a connection. And that’s just because there’s a close relationship with one of the people who work there.

Interviewer:
And does the whole team know that?

Athlete 1:
No, not the whole team. Um, I think it’s dependent on if the physios see if this person is a compliant patient, like this person is committed to getting better then they’ll say, ‘Yeah, I have a spot for you.’ But if they see someone who just shows up and then a month later complains of having the same injury, they probably would be like.... Also, I think it’s also based on how good the person is to the team. Also how long they’ve competed, different things like that. I can’t see this happening if the person’s just showed up.
Interviewer:
Does anyone else find that on their teams, that there’s a number of factors that go into...

Athlete 2:
No, it’d be across the board for us. Well we don’t have a connection in there, so it’s all the same.

Interviewer:
So do you guys deal differently with your injuries then? Do you just let it go?

Athlete 2:
Well, most of the people will go to the physio but they’ll have to wait. And it’ll make them [stay out of competition] for longer than they would’ve had to have been, or they’ll be doing physio but also [competing]. So same thing as you were saying in [mentions another sport], a lot of good a physio treatment does, if you go and [keep using your injured limb] another thousand times.

Athlete 1:
I’m not saying the ___ team gets a free pass, like you definitely have to wait. Like three days, I thought that was quite short. But when you actually get in there, ’cause our physio is at meets, you get treated at meets or you’re invited if you’re not competing that week, you can come and get treated while other people are competing. There are small ways of getting better treated. I may be biased, ’cause it’s worked really well for me but I know some people who just went elsewhere.

The coaches also spoke of having personal connections with the clinic, or using their authority or influence as coach to gain access to the clinic for their athletes. In this exchange, Coaches 1 and 2 both coach teams that receive primary field care coverage and have offices in the Athletic Centre, while Coach 3 only receives coverage during tournaments or playoffs and is a part-time coach.

Interviewer:
Just to go back to something, ___ mentioned that [this coach] had to go down and stand there...

Coach 1:
Oh I do, and I’m lucky too because [I’m in the building], but if somebody comes back and says ‘Oh, I can’t see the doctor until Monday, and this is Wednesday, and they have a [specific type of injury],’ well, sorry, [those injuries] have to be dealt with [in this sport] right away. So I’ll go and go ‘Look, we need this person, they got to go in, first cancellation you call me,’ and ‘Well I could squeeze them in right now, in the next fifteen minutes,’ ‘Thank you.’ And I go down there at least once a week.
Interviewer:
Same with you?

Coach 2:
I talk to __. We’ve worked that out, and this way it keeps us both, not on our toes, but we’re quite aware of who needs help immediately. And when the athlete does go down, and can’t see the doctor right away, then we talk and the athlete gets in there quite quickly.

Coach 3:
Well, the ideal situation of the system should be that any athlete that walks in there, they should treat without question. I mean get the file… and as an athlete, why would I walk into therapy if I’m not injured. When I see the athlete has to book an appointment, [fill out the paperwork], we’re so worried about the administrative, they forgot the sport. Instead of ‘You’re hurt, OK, where’s your file, start treatment, what’s wrong with you, let me make you feel better.’ And I know it won’t ever happen, ’cause we fill out all these forms for other people just to get treated. And I wish that that kinda system, athletes walk in and get the kid’s file...

Interviewer:
Have you ever tried to step in?

Coach 3:
I don’t because I’m part-time, I don’t want… you know, if I’m really stuck, I call __. We went to school together, but I try not to use that. When an athlete gets hurt, just go see a doctor or therapist. And I believe in that, it’s vital to sport.

Clearly, each of these three coaches have found ways in which to connect to the clinic, whether it is by demanding service at the counter, by relying upon the assigned team therapist, or by calling upon personal contacts during times when they are really “stuck.” Not all coaches may use these strategies, and as implied by the last coach, this may be a result of differences including whether they are full-time or part-time, new to University of Toronto as a coach, or whether they work in or near the Athletic Centre. For clinicians though, the fact that some coaches do resort to any type of strategy to get their athletes into the clinic is problematic.

Interviewer:
Do you find that some coaches are owed something by the clinic?

Clinician:
Oh yes. Oh yes, and historically they are the ones that were the only teams receiving field care.
Interviewer:  
So, those coaches who walk their athletes in, do they do it solely through you or through a particular therapist? Do you find that a problem?

Clinician:  
It has been at times. It has been and with respect to those coaches, I ask them not to, and tell them ‘You don’t need to bring them in yourself, they can come in on their own.’ They’re adults and [inaudible]. [There are those who] have the expectation that their athletes will be seen same day, same day nothing, same hour, as soon as they walk in. I don’t know what planet they’re on sometimes. We’re running a clinic that is open to the public and it works by appointment, welcome to the real world. Where do you find physicians and therapists who don’t have appointments, except in a sheltered world that is the exclusive territory of a team.

What is important about this is what influence these behaviours have on patient-athletes, and their sense of connection to the clinic. One answer as mentioned before by a clinician is that “athletes develop a sense of entitlement, in my opinion, as a function of their coach,” but we need to examine this in further detail.

Do athletes, and invariably coaches, feel a sense of entitlement, and do their attitudes towards the clinic as ‘their’ space and ‘their’ service have an impact on their sense of the clinic’s accessibility? While this may have been expressed implicitly through other discussions on the accessibility of the clinic, student-athletes and coaches did comment on this explicitly on a few occasions, often using the justification that intercollegiate athletes should receive prioritized service since the athletes are ‘sacrificing’ their time and energy to represent the university. As one coach stated:

I just would like to be in the position where our student-athletes can go down and see a therapist when needed, and get looked after almost immediately. And at one point, we were like that, and I don’t know what the physical situation is, the financial situation is, but these kids give up quite a bit of their time, energy, effort to represent the university at the highest possible level – at the CIAU level. And they should get at least treatment for injuries that is appropriate for them.
This notion of representation justifying priority service is echoed by a student-athlete in a focus group.

Interviewer:
And varsity should get priority?

Athlete:
Yeah, I think they should. I think depending on the season, depending on how compliant the athlete is, depending on a lot of these... Because the student is doing a service, like an academic student will, doing a research that will help the university to get known as an awesome school, the university will bend over backwards for that student.

Interviewer:
And the athlete is doing the same?

Athlete:
Yeah, there's a bit of representation there. So the priority should be there too. But realistically [the clinic wants] to decrease the amount of athletes who need the service, so...educational [programs would work]. Because once you're there, the problem's already there. Like we speak highly of them when we say 'Yeah, I could get back into practice right away if I could see them faster,' but you know that's not the case. Just 'cause you see someone, doesn't mean you'll be back at practice right away. So that may be deceiving.

What is interesting to point out is that this athlete, an individual on a non-contact sport, CIAU team, was the only athlete to point out that patient-athletes, and potentially coaches as well, may be "deceiving" themselves by putting such emphasis on the rehabilitative and restorative potential of the clinic. In another focus group, similar concerns were expressed in relation to the mandate of the Faculty.

Interviewer:
So do you think that varsity athletes should get priority?

Athlete 1:
I mean especially since it's already hard to get in.

Athlete 2:
It's our clinic.

Athlete 1:
Because it's already hard to get in there, it's crucial that athletes can help get the help they need.
Athlete 3:
It’s part of the mandate of the Faculty that student-athletes have the opportunity to have safe competition, and you know, make sure that they have the care available. But if they’re leaning more towards, trying to make money from other sources, ’cause they’re making money off us through our fees and stuff, but it just doesn’t seem to make sense. You’re jeopardizing the health of your student-athletes to get more OHIP dollars, it doesn’t make sense to me.

Interviewer:
But someone could also say that a student-athlete could also mean someone in intramurals or a rec program. Does varsity make a difference?

Athlete 3:
I think UofT students should get first priority, whether it’s varsity or someone taking a TaeBo class upstairs. I mean, intramurals, there’s high calibre intramural play. There’s equal opportunity for an injury to happen there as well. Those students should get first priority, along with varsity, before the public, I think. I think the theory is we have a high quality sports medicine clinic that is highly marketable in that sense. So why not open it up to the public?

Athlete 2:
Along with what he said, I agree about intramurals and everybody should get... But varsity I think is still... I think varsity should be at the top, ’cause, not to blow our own horns, but they’re the people that the alumni focus on and invest their money into.... I think that it’s a big deal, varsity sports. Schools are recognized for that sort of stuff.

Athlete 3:
And varsity athletes make the biggest time dedication and money dedication. And we’ve probably all experienced, you’ve got to buy ___ cleats, and you’ve got to buy your own suits and everything, and you have to probably buy all your equipment, I mean, varsity athletes pay a lot of money. And plus, they’re doing a big job to represent the university and to conduct themselves in the proper manner, etc., etc. I think that you have your point [looking at Athlete 2], and varsity athletes should probably be #1, especially for a sports medicine facility.

Athlete 2:
But you’re right, everybody deserves to get in, even the people up in the fitness classes. I think that any student in university has priority over the public.

For other athletes, particularly those who came from teams that did not receive primary field care coverage, there was a radically different perception about their sense of entitlement to the clinic and to clinic services. For a number of athletes, their sense of entitlement stemmed
from the nature of their injury – they felt entitled to be in the clinic if their injury was ‘worthy’ enough. As one athlete from a non-contact sport commented:

I’ve gone to UofT sports medicine for [my injury], and they did a little bit of exercise for it. But I always felt like a wanker being in there. ‘cause it’s all these people with broken arms and dislocated shoulders and I looked okay, except my neck was in so much pain… I’d feel bad ’cause I would walk in and be like ‘Okay, I can see that your ankle hurts and your shoulder hurts, but I look okay.’ I can’t really tell them, I can explain that it feels tight or it feels wrong, but I can’t really tell them exactly what sharp [motioning to her neck] pain is like…

S/he comments about an atmosphere or tone in the clinic that privileges only certain types of athletes with certain types of injuries. We must question how prevalent this feeling is amongst patient-athletes and what motivates such an atmosphere to develop and persist in the clinic, and be sensitive to these influences in regards to the accessibility of the clinic. One clinician acknowledges this in a part of his/her interview, and even points out some of the clinic’s initiatives in altering this perception.

Interviewer:
Do you find that that imbalance in terms of field care is reflected in how patients come to the clinic to deal with their athletes? For example, if they don’t have a professional at their practices like football does, do they…

Clinician:
Well, football is the only sport that’s like that. And then there’s a whole bunch of them that have the same coverage – full time therapist at home games, and students at away games and practices. And there are teams that have no field care presence. And we do see differences, but the extent to which that based on injury occurrence? I mean, after all, the sports that have no coverage are deemed low risk. And we no longer provide no coverage to any of the sports deemed to be at significant risk, like rugby or lacrosse, that have relatively little funding, but they are deemed to be at risk so they have a therapist. We see fewer of the athletes from teams that have no coverage at all, badminton, curling, golf, but that may be a function of them having relatively few injuries. I don’t know that though. I think that amongst them is a level of shyness of coming into the clinic and seeing athletes from one of the other teams lying on a table like ‘they own the place, and feeling that they don’t…
We actually implemented a new policy to try and reduce that to some extent. Something that was deemed both a positive and a negative thing was the use of what we call the high mat. We have, what is essentially a stretching bed that’s about ten feet squared covered in a blue naugahyde over some foam, and it served as a focal point for team gatherings and so you’d get some teams that after practice would come down en masse and grab ice
teams. However, the presence of an active and involved field care therapist, S/he continued: the athletes to games, but some of them come in, please... Amongst the clinic is sport. We do chic? So we put the message out there, but...curling...And as we’ve moved necessarily, out of necessity, because of financial constraints away from being a clinic that services primarily intercollegiate athletes to a clinic that services a broader population, we’ve had to tone down the intercollegiate presence so as not to intimidate the other clients. So, we’ve moved the high mat away from the whirlpools, and discouraged the teams congregating in that fashion. They still do to some extent, on some of the other tables, I mean we don’t deny them coming in to get ice packs and to ice down and stuff, but we try to keep the jocularity etc. down to a level where they are not dominating the clinic. And the new larger clinic design facilitates that, because if they gather around the whirlpool, most of the other clients can be at the opposite end of the clinic.

So it’s much better than it was, there was a period of time when we were shoehorned into the smaller room, that one intercollegiate team could dominate the clinic and scare everybody else off. That’s still and always has been, I think, to some extent, an issue for some of the teams that do not have field care such that the badminton athlete or the curling athlete, to use those two examples, comes in and thinks, ‘Well is this really my clinic? Can I come in here?’ Well, of course it is, in fact you don’t have to be a varsity athlete. We do our best to make that obvious, there are signs hanging saying it, it’s published in the Athletic Centre guide, in the athlete’s handbook, and so on and so forth. So we put the message out there, but nonetheless, I think there persists the myth that the clinic is for certain varsity sports.

S/he continued:

Amongst the funded and field care provided teams, I think how the athletes approach the clinic is primarily a function of their therapist. It really is, more than the culture of their sport. If they have an energetic and proactive, and all our therapists should be like this, but some of them are more then others. If they got a therapist who is on them, saying ‘You better come in, don’t let things linger, I want to know about it right away, please come in, please come in,’ then they come in. If they have a therapist who attends their games, and keeps their mouths shut, and then goes home, they’re not actively lobbying the athletes to come in, so I think there are differences based on that. In the situation like football where they have a therapist who’s with the team day in and day out, they can’t help but interact with the therapist.

A number of the themes affecting accessibility are commented upon, including the views that some athletes have towards the clinic and its services as influenced by such factors as the presence of an active and involved field care therapist, and/or a “level of shyness” amongst some teams. However, also acknowledged is the fact that there are no clear reasons as to why student-
athletes from different teams access or do not access the clinic and its services. Regardless of motivation though, once contact is made, the patient-athlete and clinician enter into the space of interaction, as described in the following sub-section.

**Sites of Negotiation**

Once the athletes make contact with the clinic and the clinicians, they enter into the actual space of interaction by engaging in negotiations with physicians and/or therapists. While Figures 4 and 5 present possible ways of mapping out the interaction, each and every negotiation between patient-athletes and clinicians is varied and unique. Realistically, one image alone cannot encompass all the effects of such variables as time, place, class, gender, nature of injury, emotion, influence of others, race, dis/ability, or biography on the process of negotiation between two individuals. Therefore, these models present only one way of interpreting the negotiation process as seen from the research. While the relationship between the "culture of precaution" and the "culture of risk" will be discussed below, the rest of Figure 4 shows the two-relationship, between clinicians and athletes based on the exchange of information, and as influenced by the coach. While the coach and the physician have a two-way relationship themselves, the coach exerts greater influence on the athlete that is not reciprocated. Similarly, when the injury is "exceptional", the physician-patient relationship is also one-way.

Before examining the sites of negotiation in greater depth, it is important to remember that these negotiations between clinicians, patient-athletes and coaches occur within a "culture of risk" as indicated by the outer box underneath which the negotiation occurs. Yet, this "culture of risk" is not absolute. There is a counter-culture that is engaged in a dialectical relationship with the "culture of risk," a "culture of precaution" according to one clinician, which resists the influences that promote and tolerate injury as part of sport. As seen in the model with the dotted
Figure 4: Site of Negotiation – Physician

“Culture of Precaution”  ←  ‘Culture of Risk’

Exchange of information based on weighing of perceived risks vs. perceived benefits

Physician  ←  Coach  →  Patient-Athlete

Usual exceptions: Head/brain injury; severe acute trauma; perceived potential for catastrophic injury

Physician’s recommendation to patient-athlete
Figure 5: Site of Negotiation – Therapist

"Culture of Precaution"  "Culture of Risk"

Nature of Injury & Type of Rehabilitation

Coach

Patient rehabilitation and education

Therapist

Weighing of perceived risks vs. perceived benefits

Patient-Athlete

Involvement in rehabilitation; modification of treatment

Exiting clinician/patient-athlete interaction
arrow from the “culture of precaution,” the ‘culture of risk’ is in a dominant position (indicated by a solid line) conceptually as seen in the proliferation of injury-legitimating norms, but it is tempered by a concern for the health and safety of student-athletes in sport as expressed by all the major actors. Both Nixon (1992) and Walk (1997) also acknowledge in their respective works the paradoxical nature of comments made by coaches, clinicians, and athletes that support risk-taking and injury, and which also communicate concern and caution for the health and welfare of student-athletes. In this study, most clinicians were quick to point out that, on the whole, the athletes and coaches at this institution tended to err on the side of caution when it came to pain and injury, and that they did not heavily subscribe to stereotypical behaviours of denying, hiding or downplaying injury.

Interviewer:
Do you find that a lot, that people hide things from the clinicians?

Clinician:
If they do, they’ve done a really good job. I haven’t seen many cases where… and honestly I would like to say I’ve seen more and expected to see more, but I guess things are changing. People are smarter about things, and people are realizing that they’ve got careers after their university sports years. And they’d like to be able to do rec sports after.

This is echoed in some ways by an athlete who expressed tremendous concern for head injuries.

I don’t care if you lose a quarter of your points, this is dealing with somebody’s brain. It has a permanent influence on what happens later on. I mean, if it was a strained muscle that maybe you didn’t use so much. Like an injury’s an injury, but a brain injury is huge. You don’t mess around with that. You see a lot of that with hockey and rugby and stuff.

This supports the concept of a “culture of precaution” that resists, to a degree, the dominant ‘culture of risk’. An example of this is in the previous quote, where the athlete positions “a strained muscle,” as compared to a concussion, as an injury that can be “mess[ed] around with.” One could argue that this “culture of precaution” is an extension of the Faculty’s emphasis on healthy and positive sport participation. While the debate between musculo-skeletal and
neurological injury will be discussed later in this chapter, we do need to recognize and keep in the back of our minds, the dynamic tension between a ‘culture of risk’ and a “culture of precaution.”

In negotiating with physicians (see Figure 4), the key dynamic involved is the communication, interpretation and exchange of information between physician and patient-athlete, based on weighing the perceived risks versus perceived benefits of playing with injury. While this concept is also relevant and integral to the negotiation process between therapists and patient-athletes (see Figure 5), it is best exemplified within the site of negotiation with the physician. When asking physicians to discuss how they go about negotiating with patient-athletes, their answers always touch upon this weighing process as a part of the bargaining and negotiating they engage in.

Clinician:

First a process of diagnosis, and then as soon as I have a conditional diagnosis, unless it’s very sketchy or uncertain, like a 50-50 cross-out where I need to do some tests to narrow it down, and I’ll say ‘Look, I don’t want to give you a lot of advice until I get a clearer picture, so go get this test.’ And I don’t like to get sidetracked into the ‘what if’ discussions when it’s totally hypothetical. If its all leaning in one direction, there’s 70 or 80% probability that they have a torn ligament or a bruised joint surface or whatever, and there are some other possibilities, I’ll start discussing the major possibilities, I’ll say to them ‘There are several possibilities, but the most likely thing is this, and this is what it means.’ And then they start asking questions, and we’ll talk. Almost always the first piece of advice out of my mouth, in dealing with most types of injuries, is you have to modify your activity at least temporarily. They get into ‘Why? Why should I avoid running or jumping or playing squash or football?’ From that point, I’ve got my answer. I make my recommendations based on, from my perspective, perceived risk versus perceived benefit. But...I can’t evaluate the perceived benefit. The perceived risk is something I can put numbers on and describe it, but I still can’t evaluate the negative value of pain. For some people, pain is like water off a duck’s back, and for them, if the only risk is they are going to have pain for the rest of their life, they honestly, some people say ‘Well, if that’s all, hell, I’m getting out there.’ But like pain, well, ‘I don’t care about pain.’ Some people don’t care about pain, and who am I to say that they’re crazy. But I can tell them ‘You will have pain in your knee for the rest of your life,’ ‘Okay, thanks doc.’ Hey, if that was me, that would mean more to me than it means to some other people apparently. And tolerating pain is difficult, ‘cause it’s a subjective perception. Nonetheless, I can use terms like that. I can talk about it. But attaching value to the perceived benefit of participating, I find is a bit more difficult by. There’s
your overall health benefit, in terms of your cardiovascular health, your spiritual and mental health, and all the wonderful things that participating in sport does for you, so you need to weigh that against the probability and the value, negative value, of the perceived risks, versus the probability and perceived estimated value of the benefits.

Interviewer:  
And you’re giving this when those athletes are beginning to resist what you’re saying?

Clinician:  
No, I give this just about all the time with everybody.

What is important in this passage is the physician’s admission that s/he cannot put a value on the perceived benefits of playing, and of playing with injury. While physicians can offer statistics on the risk of furthering injury, they are always in conflict with the unquantifiable value of the perceived benefits. The same physician discussed this in greater depth later in the interview, when asked whether the timing of the season and/or nature of the competition influenced the ways in which patient-athletes negotiate with him/her:

Clinician:  
I do honestly believe that the equation, the balancing of risks and benefits, changes because the perceived benefits are increased while the perceived risks remain essentially the same. So whereas the risk and benefit of playing basketball on a sprained ankle in exhibition season, well, this is a no brainer, although if the athlete were to get cut… If they’re playing the exhibition game to make the team then there is a very great perceived benefit of playing and showing that they can play. I will explicitly discuss all this with athletes and so I’ll say to them, you know, I understand…say it’s an exhibition, I’ll say ‘There’s a slight risk that you could hurt yourself more, and you know, if this was the NBA finals, and you were being paid a million dollars to play this game, I think the benefit would outweigh the risk of tweaking your ankle, but you’re not getting paid, it’s an exhibition game.’ And they’ll say ‘Yeah, but I might not make the team.’ So okay, I understand that and I’ll support them in their decision, and ‘Let’s get some extra tape on there and let’s do our best to get you ready.’

Now I wouldn’t do that if their risk was catastrophic, so it’s always this weighing of risks and benefits. If it’s a significant risk, it’s their brain, their spinal cord, some tissue that doesn’t repair, like with nervous injuries, the tissue doesn’t repair itself. If you sever your spine, you’re in a wheelchair. At least in 2000 you are, maybe we’ll have some great research that’ll fix that but at the present time, you’re toast. Whereas if you tear a knee ligament, you can have it reconstructed. If you bruise your calf, it will fix itself. So I discuss that and explicitly support athletes to play hurt if the perceived risks that I try to help them understand from my perspective as a physician, are outweighed by the perceived benefits which include the exhilaration of competition, the camaraderie, being part of a team, making a team, you know, it’s been the goal of their life to play varsity
squash so they got to play. And you know, I understand that and I don’t, you know, fight hard against them when they express their value judgement that that is an important value to them. So that the perceived benefit of playing is huge. But yeah, I will frequently discuss what they perceive as a benefit to playing an exhibition versus the benefit of practicing versus the benefit of playing a regular season or even an important regular season game, so we’ll talk about that... so has the team made play-offs, yeah, does this game mean anything in the standings, no, why would you risk yourself? And try and help them see that, ’cause I try to get into their heads and figure out what is the perceived benefit of playing with this injury? Why is it you’re so desperate to play hurt? Is the coach riding you or do you want to or is the team riding you? And I mean if they have some reason why they want to do it for them, then I can’t argue with that, so I just do my job making sure they what the risks are.

Interviewer:
So it’s an informed decision?

Clinician:
Yeah, it should always be an informed decision based on perceived risks and benefits, and it’s their decision and not mine except in cases where the risk of injury is so great that I feel it puts the Faculty of programs in risk of significant liability, and it’s just not conscionable to allow someone to participate. And in those cases, I will go to the coach and say that this person can not participate. Advice of the medical director, and if the coach violates that, well, that’s on their desk and not mine.

S/he reiterates that if the perceived benefit of participating with an injury is strong enough for the patient-athlete, and the injury will not potentially be catastrophic, than s/he cannot argue with what they believe is a positive and beneficial part of their lives. Also emphasized is the importance of educating athletes about the perceived risks, and ensuring that they are making an informed decision to continue participating – a notion that touched upon in the next subsection.

Another clinician talks about the weighing process that s/he goes through with his/her patients, as well as with him/herself as the physician. Not only does s/he comment on communicating perceived risks and benefits with the patient-athlete, but s/he comments upon his/her understanding of the professional risks of negotiating with athletes who want to bargain.

Interviewer:
So, how does the bargaining happen?
Clinician:
Well, see that's interesting, because the bargaining begins in my head before they say anything. Because, and this is the same with any physician-patient interaction, if you look at how physicians who see patients with colds, when you do studies where you look at what's the physician's expectations of what the patient is coming for, and you do a separate evaluation of what's the patient's expectations of what they're going for, they often don't jive. The physician thinks that they're here to get antibiotics for their cold, and the patient's expectation is, to a certain extent that, they also want to know what do they have and what they need to treat it. And so, you start bargaining in your head, how much am I gonna be likely to give them, how forceful am I going to be fending off their desire for getting these antibiotics, and... So it's the same bargaining, and so as soon as I hear the story and they tell 'I got this injury and I have a meet in three weeks,' I'm already wondering what strategy I'm going to use to bargain with them, how forceful I'm going to be in my opinion, and I'm already calculating the risk in my head that if I let them hedge, what's the chance that they'll do some damage. And there's two sides to that, there's the one, the side that's the primary concern which is well how much damage are they going to do to themselves, and the second is, well if they do some damage to themselves, what's the chance that I'm going to get repercussions for that? Meaning I'm going to get sued, or I'm going to hear from the coach, or from the parents, or they're not going to.... The usual line I give them is 'You may not like my decision now, but you're going to be a lot less unhappy with me if you get a good result than if I let you go play sooner, and you end up with a bad result, and you say 'well, why didn't you say that this was a more significant risk.'

Interviewer:
What kind of athlete are those like? If you had to characterize the athlete who, essentially lies about in some situations, their condition?

Clinician:
To a certain extent, it's a knowledgeable athlete, 'cause they know the extent of the problem and they know the chance is good... Well, I guess there are two sides to it. One is they know the chance is good that they're going to be told they can't participate. So what they might do if they're being asked to come see us, is they'll downplay their symptoms. So, they won't give me the whole picture. So, when I ask them what they're able to do and how they can perform, they'll give me a much inflated picture of what they can do. Now usually, you can sort of see, well not always, but you can sometimes see a physical exam of their functional ability, something doesn't jive. The ones that tend to be the most disappointed are the ones who get caught off guard by their injuries, so they think that their knee sprain is a mild one, but they have a torn ACL. Um, those ones are less hard to convince that they need to stay off; 'cause once they try and do something, if they don't believe you, they know they can't 'cause their knee buckles and gives out or is too painful or swollen. And so, you may tell them they can't do it, and they believe they can, 'cause they're sort of in denial over their injury, and they go and use it and clearly they can't function. But, the ones that tend to be coming for bargaining, when it's the most highly competitive, towards the end of the year or towards the end of school/university eligibility. Where there's the last few or last competition, so they're willing to say... some of them are willing to say 'Well, it's my last competition, so I
don’t care what happens. After that, I can rehab for a year, who cares because this is the last one.’ And um, there is a different ability of elite athletes to perform with the same injury than someone who is not elite. So you also have to take into account what’s their skill level as compared to someone who is not very skilled. So what’s their risk and um...

Interviewer: How do you know all of this?

Clinician: How can you tell with one athlete? [Interviewer nods]

Clinician: Um, you don’t necessarily...you might...you get a sense of their denial of their injury to a certain extent by the degree of their bargaining in disproportion to the degree of their injury. Their belief that they can actually do what they want to do, when it’s clear to anyone...you know, how are you going to function? You’re talking about competing in a week and you can’t even walk without crutches. So, you know that they’re very competitive, they don’t want to believe that this injury is of consequence. You can clearly see that they’re not being realistic.

While none of the athletes mentioned considering liability in their negotiations, all the clinicians communicated this dual weighing process: weighing both the perceived risks and benefits of the athlete playing with injury, and the perceived risks (i.e., legal liability, negative reputation with athletes) and benefits (i.e., positive reputation with athletes) in offering recommendations.

As noted in Figure 4, the line of communication significantly changes when the injury is exceptional, such as when the injury is neurological in nature, severe, or perceived to be potentially catastrophic. In fact, where the limits of playing or not playing with injury can be shifted and blurred if the injury is musculo-skeletal in nature, there is zero-tolerance for playing with head/brain injuries in this institution. The policies of the clinic under study about head/brain injury are not a recent phenomenon, but they have taken centre-stage as increased public attention is paid to the significance and consequence of head/brain injury in sport, and as the clinic is involved in an innovative concussion study with the student-athletes. When the injury is neurological in nature, the patient-athlete is not in a position to negotiate or bargain with the
physician. In fact, as one clinician notes, patient-athletes are more likely to take risks with musculo-skeletal injuries than neurological ones.

Sometimes, I think if it’s something more musculo-skeletal related and I think they would take more of a risk. Just say someone had a, like it happens all the time, just last week, someone had a hamstring pull and I said ‘You can run this weekend if you want,’ she was a ___ athlete, or ‘How important is this weekend to you, because you have a risk of popping it completely.’ She said ‘I won’t [compete] at all this weekend, I’ll take two or three weeks off of competition ’cause this is not so important.’ So if it was play-offs, the end of the year, she’d probably take the risk and say ‘That’s fine, if I blow it now, then I have four months to recover and it doesn’t matter ’cause this is my most important competition.’

There is nothing here which implies that the clinician takes more risks in his/her recommendations to the athletes compared to situations where there is a head/brain injury, but it does provide yet another example of how there is a different mentality regarding musculo-skeletal injuries on the part of the participants. The clinician and the patient-athlete engage in an exchange of what is feasible, what is valuable, and what are possible complications with the hamstring pull – an exchange that would not occur in this same manner if the injury was a concussion.

While the clinicians believe in, and practice a zero-tolerance policy regarding head injuries, not all patient-athletes support this policy. One clinician cited s/he most often engages in negotiating and bargaining with patient-athletes over the subject of head/brain injuries, and that most of the patient-athletes do not understand and/or interpret their head/brain injury as significant, because it is not a physical or visible type of an injury.

Clinician:
In here, the pressure comes from the athletes who don’t want to have to sit. And the time that you get the most bargaining, or when I see a lot of bargaining, is with the head injuries.

Interviewer:
Really?
Clinician: Because, it’s not a physical... you see, they know their body really well. They know what they can do and what they can’t do. And some of them are in denial, and some of them are you know, pretty aware. They’ll say ‘I want to, but it’s only three days to the meet, and I know I can’t.’ You know, I tell them if I think that something is relatively safe, but not ready, we bargain and I say, ‘OK, before you can play, you have to practice.’ You know, I give them set goals so it helps them to see realistically... so if I think there is a big discrepancy between the injury and their perception of the injury and the reality of the function, so one of the bargaining tools is I say ‘Well, you might be able to play by this weekend.’ ‘Cause I’ve seen a lot of elite athletes where you see them and you think they can’t be able to perform, and they just can because their skill level is that high, or their neurological patterns are so well laid down that they can. So, if I think that if the injury has some risk, but they still may be able to function, I give them set goals they have to be able to maintain. So that way they can see that if they can’t even meet those goals, that playing could be not helpful.

Interviewer: Do you think that is a nature of sport type of issue? In terms of head injury thing...

Clinician: Well, so with head injuries, the difference is, it’s not a physical thing. So they’re not used to thinking of their head as a physical thing. It’s only recently that it’s become a big issue, I mean before, you got your bell rung, it was nothing, no big deal. Now, as we learn more about it, and we see the consequences of it more frequently, then it becomes a bigger issue. But to the athlete, it’s not, especially for milder head injuries, it’s not the same kind of physical pain as having an injury and not being able to function. They can still function, they might not perform as well, or they might think they’re performing as well, but it’s a different organ system that kinda gets... it’s hard to wrap yourself around when you’re an athlete. You just have a headache, your body works, just a headache, so what’s the big deal. So, there is sometimes more bargaining there. Especially when you tell them, you might be feeling well but you need to wait three weeks. And then you have to try to explain to them why that is, and what the risks are.

Clearly this is an issue that goes beyond this one project, in that it touches upon how head injuries are perceived in sport in general. There are shifting interpretations and definitions of what a concussion is - as one clinician noted standard medical practice has only recently, within the last decade or so, changed its definition of concussion as that which only occurred when there was a loss of consciousness. This re-understanding of head/brain injuries has resulted in shifting protocols and levels of caution, but this has not been a welcome change on all fronts in the competitive sport system. Even within this particular institution, although one particular
protocol has been established and published as the head/brain injury guideline, and a study has been implemented to review the protocol empirically, there is still a sense of ambiguity and frustration over what a concussion is and what is its course of treatment. This confusion and frustration is expressed by a coach, to the head nodding of others, in the focus group session, in response to a question as to whether any coaches experienced notable injuries on their teams in the previous year.

Coach:
One things that we’ve had, and I think the other sports have experienced it have, an increase in concussions or so-called concussions. I’m just wondering now if we are going to an extreme when it comes to concussions because, ah, every time someone gets hit, it seems there’s a concussion. And I don’t dispute the doctors, believe me [inaudible], but sometimes I wonder the length of time that people are now sitting out [inaudible]... in this area, the concussion study that we’ve started. We lost a lot of players to concussions this year.

Interviewer:
Now, who is making the call though that so and so is...?

Coach:
Well, I think the therapists are on site, they have the say in whether they have a concussion or not, the doctor can see how serious it is. It’s bit of a point of frustration with some of the coaches, you see so many concussions, and we may be just better educated or know that they are concussions, so I’m not sure, but that is an area of question [inaudible]. It just seemed that they always had a concussion.

Interviewer:
Did you have any specific times this year that that has happened...that you felt maybe there wasn’t a concussion?

Coach:
Well, I’m not a doctor so I can’t say that...I couldn’t say that it wasn’t a concussion but it just seemed like there was a number of concussions over the last two years. I’m not sure if, I can’t say, if I was always sure they were concussions [inaudible]. Sometimes a player can say, ‘Well I feel good,’ but the player still has something wrong with them.

This coach’s question about whether “we,” implying the Faculty, its intercollegiate program and the sport medicine clinic, are “going to an extreme when it comes to concussions,” is an example
of not only the tension between musculo-skeletal and neurological injuries as perceived by athletes and coaches, but also of the tension between the 'culture of risk' and "precaution."

While not incorporated into the models, clinician reputation as perceived by both patient-athletes and coaches does influence the negotiation process. This was particularly expressed by the coaches, in regard to the physicians, during a focus group session as a set of coaches started a dialogue about the nature of the profession.

Coach 1:
Like you would rarely get a doctor complaining about another doctor [Other coaches agree by saying no]. I mean that profession is very closed...

Interviewer:
And do you mean from the clinic here, or generally...

Coach 1:
I mean generally. I think the medical profession is a very closed one, not very anxious to admit they made a mistake.

Coach 2:
And they make mistakes.

Coach 1:
Yeah, they are human.

Coach 2:
But, I always ask the question of who the athlete has seen.

Coach 1:
Oh yeah, I always ask the question when they go down, who did you see [Other coaches also say Who'd you see?]. And if it's that one, then I say, OK, we need to go down and get a second opinion.

Interviewer:
Does everyone do that?

Coach 2 and Coach 3:
I do that.

Coach 4:
I'll do that from now on.
None of the coaches offer reasons as to why they make it their policy to ask their athletes who they have seen, but it is an important to them — this is a message that is picked up and reproduced by Coach 4. An athlete, who plays on Coach 1’s team, reiterates this in his/her comments.

Interviewer:
So, you’ve never gone back to the clinic for a new injury? [Athlete shaking her head no]
’Cause I was going to go ask who would you go see if you had an injury?

Athlete:
Well, definitely the second doctor. And it’s interesting ’cause any time anyone from our team gets looked at by the first doctor, our coach makes them go get a second opinion.

Once reason why the coaches do have such a policy could be related to their perception of the clinicians as being overly lenient or rigid in their recommendations. Few coaches discussed this explicitly, but did touch upon this implicitly when discussing controversial and unique injuries they have experienced with their teams. Often these experiences would become unique because one clinician would be lenient and allow an athlete to participate with an injury, only to then be disallowed by another clinician. Since those experiences are difficult to recount in this project due to identification issues, it is interesting to see how the issue of conflicting recommendations is interpreted by the clinicians themselves. For a number of clinicians, the different recommendations are naturally a function of experience:

Interviewer:
Do you think there’s a range of clinicians who work there, lenient versus very rigid in their...

Clinician:
I think it’s more a case of experience in this sort of sport setting. You’ll get people that come in that are good therapists, good clinicians, and they haven’t dealt with athletes or competitive athletics, or that kind of motivated type of individual. So they may be conservative, ’cause they’re playing it safe, and the more experience you have with a variety of injuries, you realized that okay, at this stage of healing, this person could go back into play with a brace or tape or something to stabilize. They’re not going to make it worse, they can still practice or participate with their team while continuing their therapy and rehab to get back up to 100%.
This was echoed by another clinician, who also suggested that clinical experience and a history with the coaches affects their reputation in terms of range of recommendations. Interestingly, this clinician also pointed out that s/he had never been approached by coaches about the perceived leniency or rigidity of his/her recommendations.

Clinician:
You know what, to be honest, I’ve never had a coach come to me and say, you know after I’ve told them that they have such and such an injury and they can’t play. I’ve had them come, and I can see them frustrated and venting, but they’re not coming to me and saying ‘Are you sure, you know, or can’t we hedge, or don’t you think he’ll be alright.’ And I’m not sure... I mean it’s not because I have such a wonderful relationship with the coaches and I’m buddy-buddy, and we’re talking all the time. Some of them don’t even know who I am, and I don’t know who they are. Maybe, it’s because I’ve been here long enough that they know me, and they know that I’m not real rigid. You know when they see me... with the athletes... and you know, I’ll let athletes go back where maybe the other people won’t, but I’ll keep them back if I think it’s really more serious. So you know maybe it’s a question that over time, they’re comfortable with the way I manage things, and don’t they see that I’m being ridiculously rigid about letting people, you know, sit when they should really be playing because it’s trivial. So they might get frustrated, but I can’t ever remember a coach coming in here and sitting down, so and so has such and such a knee and can’t they compete. Certainly, not from the point of view that we really need them for the team. No, I just don’t get that. I don’t really get that pressure here.

Interviewer:
Do you think that maybe, even internally, but between the coaches and athletes, that there is a ranking of the clinicians here?

Clinician:
Oh, I’m sure there is. Yeah, although I’ve never necessarily known a coach to tell an athlete to go see doctor so and so ’cause he or she is less rigid than doctor so and so, I have no idea if that goes on. It may go on amongst the athletes, but I haven’t really heard wind of it. I think, personally, ____ is probably stricter than I am, but I don’t know if the athletes necessarily...

Interviewer:
Stricter in the sense of...

Clinician:
Stricter in the sense of when they can go back, and when they can’t go back. In terms of applying guidelines and stuff that follow the letter of the law. Whereas, I mean, I know I’m a bit more flexible like with head injury routines, like if I see that they’re functional. I’m more of a ‘Let see how they’re functioning’ and ‘Let’s see how they manage’ and step-by-step evaluation person than I am a this amount of time you’re off.
The last comment is remarkable in that the clinician admits leniency, and offers, as an example, head injury protocols. This is indicative not only of the range of leniency/rigidity amongst the clinicians, but also that the established head/brain injury protocol, in effect a zero-tolerance policy, is also negotiable with some clinicians. This is obvious when we consider that all negotiations are dynamic and subject to a variety of influences, regardless of the nature of the injury, but it certainly does fly in the face of the mandate of the clinic.

Interviewer:
Do you find that there’s a range in the attitudes towards clinicians? ... do you find that there is a perception from athletes or coaches that there is a range of laxness or strictness?

Medical Director:
Well, I think so, and I’m just thinking because the apparent laxity or strictness of the different physicians’ recommendations really was only ever an issue with respect to concussions. I don’t think that any of the physicians have had a reputation for being more or less lax than the others with respect to their recommendations on ankle sprains and stuff like that. It’s been more of an issue with concussions, and we’re all singing from the same song sheet now. I have published a protocol for dealing with concussions, and have told the staff that they are required to follow that protocol. So we have essentially removed the individual differences in how physicians even approach concussions, so...

Even while an established protocol is being followed, there is very little chance of truly removing “the individual differences” in how clinicians approach any injury. This reinforces the view that, while we can attempt to analyse and investigate the negotiation process and offer a version of it for discussion, we are always dealing with a subjective process between individuals.

Turning to the negotiation process between patient-athletes and therapists (Figure 5), this model takes into account the fact that the interaction between patient-athletes and therapists often occurs over a longer period of time depending upon the nature of the injury and the type of rehabilitation, as indicated by the inner box. Similar to Figure 4, in Figure 5, the relationship between therapist and athlete revolves around the exchange of information, but also includes to a greater degree issues of patient education and the modification of treatment. Both individuals
are influenced by coaches – the therapists being able to dialogue (a two-way relationship), while athletes cannot. Since there is greater contact between therapists and athletes, greater frequency of interaction, other factors come into effect. Such factors include the modification of treatment by athletes, as well as the importance of clinician involvement and patient education.

Where both physician and therapist sites of negotiation revolved around the weighing of perceived risks and benefits, the issue of treatment modification was most readily apparent in discussion with the therapists.

**Interviewer:**
Did you ever have athletes who tried to modify the treatment that you prescribed?

**Clinician:**
Yeah, we had another [athlete], who had a fracture in...their thumb, and had a specific brace designed to stabilize it at a certain angle for best healing. But with this functional brace on, they could still...do things, but the brace was intact in a sport specific position so they can do what they need to do. And over the course of time that they were in the brace, it seemed to get shorter and shorter and shorter, cause they were cutting the brace back to allow more thumb movement and just stabilize at the one specific joint. But it made the brace less effective, the splint less effective than it should have been. As a result, [they] ended up with delayed healing and extra pain because of the extra trauma going on. So, that does happen.

**Interviewer:**
Did you treat [that athlete]?

**Clinician:**
I treated him/her after. Before it wasn’t my patient, but after the season, the physiotherapist was no longer with them, I took on the patient. It happened fairly close to right before OU’s started, so I’m sure [they] kept [their] brace relatively intact until [they] had to start playing with it, and then...started to trim it down.

The modification of the brace occurred during a peak period of the competitive season, but this example is valuable in how the patient-athlete modified the treatment. A patient-athlete offers another perspective on modifying treatment.

**Interviewer:**
You had so much rehab, did you ever try to modify the treatment?
Athlete:
No, but I definitely questioned things. I would never change it without asking him/her, I definitely talked to him/her about things like ‘This is really hurting’ or ‘I don’t think it should be hurting this much and I don’t think I should be at this level yet.’ Or ‘I think I should be doing more balance’ and stuff like that, but I never changed it without asking.

Interviewer:
And how did s/he respond to that?

Athlete:
Sometimes s/he would be like ‘Yeah, you got a good point.’ Other times, s/he’d be like ‘Yes, it’s going to hurt.’

For this particular athlete, modification was secondary to questioning, and the ability to question, different points throughout the treatment process, and exemplifies the dynamic nature of negotiation between patient-athletes and clinicians, and the continual exchange of information between the two individuals.

For this particular patient-athlete, recovering from a significant injury, the ability to question the therapist was of tremendous value to the relationship. Later in the interview, the patient-athlete noted other ways in which the therapist helped him/her during rehabilitation.

Interviewer:
And how did the therapist help you along in your rehab, other than the exercises?

Athlete:
We get along really well, personality wise, so we were always joking around, so that was awesome ’cause it was always fun to go in there, to a certain point obviously. And also it was neat, ’cause s/he also brought in the other therapists, like just s/he always let the other therapists know what I was doing just ’cause I was in there everyday, they were asking. And s/he was really good just in the fact that s/he always checked up on how I was doing emotionally more than anything, ’cause s/he could see physically how I was doing.

Interviewer:
Do you think that that helped you more than the physical stuff?

Athlete:
Totally. It kept me positive, and s/he was very good telling me ‘You’re falling behind right now. You should be at this level.’ And so emotionally that really helped me, ’cause there were a couple of weeks that I didn’t come in for as long as I should [have]. And
s/he got mad at me and s/he really took it personally as well, do you know what I mean. S/he took it on as a project for him/herself.

Interviewer:
It was like a big commitment to you?

Athlete:
Emotionally and physically s/he was committed.

This sense of commitment is seen as integral and valuable to how the athlete recovers physically and emotionally from a significant injury. While the physician-athlete relationship may offer the same commitment, the greater duration of time spent between therapist and patient-athlete places greater emphasis on the concept of clinician involvement.

Figure 5 focuses on patient education, also communicated by physicians, but emphasized by therapists. For the therapists, the perceived value of their efforts lie not only in rehabilitating the athletes, but also in educating them about their bodies, their injuries, and the treatments that they are undergoing.

Clinician:
My position is patient education, huge. I talk to a few of the teams at the beginning of the year, again that’s my prerogative, I introduced myself so they know to come see me, ‘Any problems, come see me, no matter how small, and any questions about anything.’ At the same time, I go through their medical questionnaire, I go through that with them. ‘Have you said yes to any of these things,’ any major things, like head injuries, or anything that would preclude them from participating. And I say, ‘If you have this or this, before you even come to see me, go see a doctor. I won’t see you until you’ve see a doctor. You have to be cleared, I won’t let you see you unless you’ve been cleared. And if you’ve been here before, you know it’s standard, it’s not a big deal.’ And again, you have to explain to them why. ‘If you’ve had a head injury this past summer season, and you’re going to be playing in the fall season, get cleared because there’s something called post-concussion syndrome where you can die suddenly.’ And you really need to teach them why, ‘Oh, it’s not just a bellringer. Maybe I had more... I don’t want to put myself at risk.’ And they say ‘You know Eric Lindros may be leaving ’cause of head injury...’

Interviewer:
But do you ever risk creating a sense of fear or panic?

Clinician:
Yeah, unfortunately, that’s another thing. I try not to go that way ’cause people aren’t very receptive to it. If you use scare tactics, you’re not respecting their appreciation of
knowledge. If you say ‘Hey, these are your statistics,’ that’s the best thing. Arm yourself with statistics, and just say ‘These are the statistics. Here is your chance of this, this and this. You may not get it, but just get checked out just to be safe. It’s not worth injuring yourself for the rest of your life for just a game or a season.’ Ultimately you have to show that you’re giving them the necessary information to make a decision, but you give them the control to make the decision. If you just say ‘You can’t play or you’re gonna die if you get this.’ You’re not respecting their knowledge, and if you don’t respect them, they won’t respect you.

Coaches also influence the sites of negotiations between patient-athletes and clinicians (see Figures 4 and 5). The impact of these individuals on the negotiations is quite evident when asking clinicians and athletes how they perceive the coaches. As one clinician points out, much of his/her discussions with a coach about an athlete’s injury is in effort to prove to the coach that the athlete is actually injured and is not “dogging it.”

Clinician:
Yes, sometimes I’ll [talk to] the coaches. I’ll especially tell the coaches if I think the athlete won’t tell them or they won’t be honest. Or if I think the coach is hounding the athlete because they don’t believe the severity of the injury. See, I’m more likely to find a situation where the coach is bugging the athlete, that the coach thinks the athlete should be playing and thinks that they’re dogging it. And I’m calling the coach to support the athlete. I see that way more commonly here than I see the coach calling me to see if the athlete can play. If the coach knows that I’ve seen the athlete, and if I don’t think they’re ready, I don’t get pressure. But if the athlete hasn’t seen me or the coach doesn’t know the athlete has seen me, then the player tells me or I get the sense, that the coach doesn’t believe me, then I’ll say ‘Do you want me to write a note so that you can show them that you’ve seen me.’ ’Cause once the coach knows from me, I find that the athlete doesn’t complain from the pressure.

Interviewer:
Have the therapists ever said that the coaches have put the pressure on them?

Clinician:
Um [pause] I don’t know. I’m sure they get the pressure ’cause I’m sure the coach is asking them when, when, when…. That’s usually in the situation where it’s an equivocal kind of injury, where it’s not something that is so physically evident. Where they’re not walking around on crutches or they have a mild head injury that is not getting better, but they don’t seem that bad. They’re standing, walking around, joking with their teammates, and the coach’ll say well, ‘He’s doing so well,’ you know, and he’s still not all there. But he’s chatting it up and looks like he’s having a good time, and not running laps in the practice field, and the coach is going, what’s going on? And its in those less obvious situations, where I’m more likely to call the coach ’cause I know the athlete will get some pressure or the injury is not so evident.
For the Medical Director, the coaches are liaisons between the clinic and the patient-athletes and are targeted as such by himself and the head therapist. While previously we have seen that coaches complain about the services and accessibility of the clinic, the Medical Director offers another perspective on how involved some of coaches are in the medical coverage of their teams, particularly during the annual coaches-sport medicine meeting.

All the teams are there, or they should be and myself and the head therapist introduce ourselves, and give a blurb and there’s a blurb in the coaches’ handbook, and we tell them, the clinic is open to everyone, not just varsity athletes but it’s certainly open to all varsity athletes. And varsity athletes even have their own cueing stream in the clinic, so there are spots, in some sense, reserved to them. They are guaranteed 29% of the therapy appointments are block reserved for varsity athletes, not for a specific sport, but for varsity athletes. So we tell them that, having said that then [some of them] don’t have a therapist with the team day in and day out who can say ‘Hey, you look like you’re rubbing your knee a lot, why don’t you come in and see the doc?’ So then it’s up to the coach and the athlete, we tell them, now whether we should tattoo it on their foreheads? I don’t know, but we tell them. It’s hard to know because we’re just now implementing an injury tracking mechanism, and it’s going [to be] most difficult with those sports because we don’t have dedicated health care personnel to ensure that the necessary attendance rosters and so on are maintained that allow us to track injuries that we’ve identified. Where we have student therapists present, we’ll be able to implement injury tracking because it’s their responsibility to document both attendance at practice and injuries. So, we’ll get a sense of occurrences. So, you know, the relatively small number of golfers that show up at our clinic, is that a function of the fact that they have zero injuries or that they don’t come in? I don’t know.

Interviewer:
Do all the coaches come to that meeting?

Medical Director:
No. In fact, I think it’s a better turnout with part-timers than some of our full-timers. I mean some of our staff coaches don’t show up.

Interviewer:
Do you find there’s a difference between part-time coaches and full-time coaches in how they interact with their teams, and how that trickles down into the clinic in terms of philosophies of injury?

Medical Director:
I don’t think I could make that distinction on a part-time/full-time basis, I think it’s a personality thing. So you have part-time coaches who are injury conscious, and full-time coaches who are injury conscious, and part- and full-time coaches who want their athletes.
to play hurt and ignore their problems. I don’t know if that’s a function of part-time/full-time.

Interviewer:
Do you have coaches who resist you?

Medical Director:
Oh yes!

Interviewer:
Is it a sport thing?

Medical Director:
No, a coach personality thing. ‘Cause we’ll have coaches in the same sport, where the coach of [one] team is the one who is very aggressive about having people play hurt and the [other] isn’t.

Interviewer:
And so what do you do when these patterns are distinguishable?

Medical Director:
Well, there are some coaches who require more direct intervention by me. The therapists ask me to intervene and help, to assist them with my authority, to go to these problematic coaches and say ‘So and so cannot play, it’s against medical advice, they really shouldn’t play and if you let them play, you are going against the advice of the medical director, so if this person winds up getting injured and suing the faculty, it’s on record, in writing by this e-mail which I am sending and keeping a copy of, that you have been advised not to let them play.’

Interviewer:
And that usually...?

Medical Director:
Oh, that works.

Interviewer:
Has it ever gotten to point where you’ve had to go to a higher person, like the Dean?

Medical Director:
No, it has not. None of them have not followed my advice when I have asserted myself.

Interviewer:
So what happens to the team under that coach?

Medical Director:
Well...we’ve spoken to coaches, and said ‘You beat them in practice, you beat them up in training camp, too many sprains, too many whatever.’ And try to talk to them about
trying to save their teams.... They often throw their hands up and say 'Why are there so many injured people?' ‘Well gee, it might have something to do with your practice plans.’ ‘Well, we used to do this in the good old days, no one got injured with this practice plan.’ ‘Well, maybe they just didn’t tell you....’ They want to blame it on today’s athletes, not being hard enough workers, not being adequately conditioned, not following the regime or training or developing the necessary strength or so on. I don’t know — I get into arguments all the time, but the bottom line is when four or five of their athletes get [injured], they’re [doing] too much. Back off.

Interviewer:
And what do the athletes do?

Medical Director:
No, they are sometimes are the ones who in a somewhat apprehensively, shy way complain to me, ‘Coach is killing us. Would you please go to the coach and ask her or him to back off?’ I think the only time I was ever asked by an athlete to ask the coach to back off was during one of our coach’s rookie season, s/he was a novice coach and...s/he set [a] practice plan that reflected his/her ability, and none of [the athletes] could keep up with [it]. So they were all injured, and the captain asked me to speak to him/her, and I did, and s/he changed. And the team is now one of the least injured teams in terms of overuse injuries. So that was a happy story in that s/he was able to respond to feedback.

Interviewer:
Have you ever made that suggestion to [other teams?] [Medical Director: Oh yes.] And nothing has come of it? [Medical Director: No.] And have you ever considered doing something more concrete with them?

Medical Director:
Well, I guess my plan with respect to that is to implement quantitative injury tracking [to avoid only having] anecdotal, suggestive evidence. If we do see quantitative evidence that there are certain teams who are more often injured than teams that, based on published rates externally should be equally at risk of injury, and we look at it and there’s an anomaly in the data quantitatively, this particular program is getting beaten up, then yes, I’ll have evidence.

It is not unrealistic to suggest that there are a range of coaching styles and philosophies towards the tolerance of pain and injury all working within the same institution and faculty. The problem is that the attitude which tolerates pain and injury is not a function of a particular type of sport, or related to part-time/full-time status, but rather to the subjective and tricky concept of personality.

The influence of the coaches on the athletes is more significant than their influence on the clinicians, as explained in greater detail in the next subsection. For now, it is important to simply
show two different perceptions of coaches’ influences. For one athlete, the clinicians are a source of comfort as compared to the coaches.

I think in general, my experience [with the clinic] has been nothing but positive. If anything, I felt more comfortable going to them than coaches sometimes with issues that I had going on, ’cause they understood how athletes feel about not going to them in case of an injury.

For another athlete, the situation is quite different in that the coach promotes a “culture of precaution” on the team.

Athlete:
Well, I know with some people, like with a nagging, little type of injury, they’ll try to ignore it and will probably try to hide it from themselves...but it is an expectation and people live up to it, and take responsibility to dealing with their injuries.

Interviewer:
A team expectation?

Athlete:
Yeah, like a discussion at the beginning of the season about it. But then again, it has never been to the extreme, where if you’re injured you have to play. It’s just like, you should do whatever you can to get better. The same for academics, and stuff.

Interviewer:
Does that make a difference in how you and/or the team deal with the clinic? If your coach had a different attitude towards...

Athlete:
Yeah, well I probably would let more things slide, sounds like I already do probably, but even more...like with smaller injuries...[the coach] encourages you to see the doctors, and use the resources. Yeah, and like [the coach] is really good about communicating with people saying like ‘Whatever it is, take care of yourself.’ Everyone is expected to take care of themselves, and do what they have to be conditioned to play. Which could include not playing.

The coach’s attitudes on this team position the health and wellbeing of the athlete at the forefront, and this is communicated and understood by the athletes. It is safe to say that this team philosophy, as established by the coach, trickles down to how the athletes negotiate with the clinicians. What is interesting, and leads into the last stage of the negotiation process — exiting the clinician/patient-athlete interaction — is the responsibility of the health and wellbeing
being placed firmly in the hands of athlete. This positioning of the responsibility and the decision-making about playing with an injury is a theme that reoccurs throughout the final stage.

This subsection examined the actual space of interaction between patient-athletes, and sport medicine clinicians (physicians and therapists), taking into consideration the influence of coaches throughout the negotiations. Figures 4 and 5 show one way of interpreting the negotiation process, and both point to the dialectic between the 'culture of risk' and the "culture of precaution" that encompasses the entire negotiation, as well the weighing process that clinicians and patient-athletes engage in over the perceived risks and benefits of playing with injury. Interestingly, the communication patterns between patient-athletes and clinicians are significantly different in negotiating neurological or head injuries, as compared to musculo-skeletal injuries. Having discussed some of the factors involved in the actual negotiation process, the analysis of it must include an examination of the ways in which patient-athletes and clinicians leave the space of interaction, and exit the clinician/patient-athlete relationship.

**Exiting the Clinician/Patient-Athlete Relationship**

Figure 6 draws attention to the ways in which patient-athletes exit their interaction with sport medicine clinicians. Exiting interaction is again divided between physicians and therapists because of their potentially different relationships depending on the nature of the injury, and type of rehabilitation required. It is safe to say though that there is a fair degree of overlap between these two types of clinicians, and the different elements involved in exiting the clinician/patient-athlete relationship. For example, while the model addresses liability in relation to physicians and coaches, it was a key issue for all clinicians involved in this study.
Figure 6: Exiting Clinician/Patient-Athlete Relationship

Clinician’s notion of doing their job by informing athlete of risks/benefits and by putting responsibility in hands of athletes and/or in hands of coach

Physician

Recommendation

Acceptance/Compliance

Acceptance & Denial
(Modification)

Disregard & Denial

Patient-athlete

Influenced by how athlete views sport involvement (i.e., central or peripheral)

Coach

Relationship with therapist and/or other clinician(s)

Weighing the perceived risks vs. perceived benefits

Goal-setting & testing in relation to return to play

Return to competition/Potential and/or actual injury/Culture of risk
The primary objective of clinicians is to inform the patient-athlete of the perceived risks and benefits of playing with the injury, and to place the decision-making responsibility in the hands of the athlete and/or the coach. All the clinicians addressed this in one respect or another, but placing the onus of responsibility onto the shoulders of others was most clearly evident in discussions with the physicians. This was most evident when physicians spoke about negotiating with patient-athletes who were resisting their advice:

Athletes tend to be, unlike the general public, and that’s part of the nice thing of dealing with athletes, they are much more self-motivated. They are much more accepting of the risks involved in their sport, um, and they’re much more aware of their bodies. I mean so far, I haven’t had the problem where someone’s come back and said, ‘Well, why didn’t you tell me this could happen.’ ‘Cause usually what I’ll end up telling them is, if I see as the negotiations are going on that they’re just not happy with what I’m telling them and I think that they’ll ignore what I’m gonna say, then what I tell them is ‘You’re here to get my advice, you can ignore anything that I say and go and do whatever you want, but my job is to inform you of the risks and if you choose the therapy you want.’ So what I do is I put the burden on them, so they realize they’re making the decision for themselves and um, ’cause I can’t force a cast on them. Now, that works in the general public when you don’t have a coach or a system. The difference here is that I’m accountable to the athlete first, that’s the way I look at it, they’re my first priority. Um, but I’m also accountable to the school, ’cause I’m here working to a certain extent to protect the school from having an athlete play in a situation that would put the school at risk. So, if I think that they shouldn’t be playing and I tell them such, and I don’t think that they’re going to relay that to their coach, then because my responsibility also extends to the coach, I will them, ‘Well, I going to have to tell your coach that my recommendation is that you shouldn’t play.’ The coach can then decide, but the coach isn’t likely to go against what I have to say, and sort of put themselves out to the wind.

According to a physician, this process of informing both coach and athlete is most clearly seen with patient-athletes who resist the recommendations of the clinician:

But yeah, you get guys...or girls...who you know, you tell them what you think and it doesn’t matter. Their goal is to play, and so you end up with the situation where you just tell them... Because you negotiate to a point, and if you realize that you won’t be able to convince them that this is the way to go, then I decide my own point where I sort of think ‘I’m not getting anywhere here, I’ve tried to explain what the risks are....’ Which is my job, explain what the risks are, and they’re not agreeing with it, so then at that point, that’s when I resort to ‘You’re here for my opinion, you can make your own decision about whether you want to play or not,’ but in this environment, my fallback is always I just tell the coach. And so in the private world, all I can do is document that I’ve warned them of the risks and in this institution, there is some institutional backup for what I want
to do. So if I say they shouldn’t play and tell the coach that they’re not going to play, and then the athlete, they leave, they’re a bit powerless to do anything. Um, there are definitely athletes who don’t believe, so you could tell them that they’re at risk, and they shouldn’t play, and they can’t play, and these are the reasons why, and you try to negotiate and convince them, and they don’t want to hear it.

Another therapist reiterates some of these same themes:

So I always put the onus on the patient, which mainly if it doesn’t work out, I say “Hey, you didn’t do your work. It’s not my fault. I told you what you needed to do, and you didn’t do it”. And I don’t feel bad anymore either if they don’t get better, ’cause I told them what they need to do to get better. Same with varsity athletes going back, I say ‘If you go back, you’re gonna get hurt, or you have an increased chance of injury.’ I don’t feel bad anymore because I’ve already given them the risks, they made their decision, if it’s a high enough risk, I advise against it ‘I don’t think you should play.’ Having said that, the coach and the player have the ultimate say. I can advise the coach that he can’t play, but I don’t think I ever, this year at least, gotten into a situation where I’ve said ‘No, you can not play’ and the coach has disagreed or the player disagreed. ’Cause generally, I would like to think that I did my job that they understand why they can’t play, and then they agreed. That could be why I haven’t encountered that situation here.

Informing the patient is a clinician’s job – no physician or clinician in any medical discipline can order an individual to do anything unless they feel that the patient is at risk, places others at risk, or is incompetent. What is interesting here is that in this context – intercollegiate sport and sport medicine – that power to ‘order’ a patient-athlete to participate or not participate rests in the hands of the coach. Although the clinician suggests that both “the coach and the player have the ultimate say,” that decision and the ability to make that decision does not rest equally in the hands of the athlete and the coach. Whereas a clinician cannot ‘bench’ a patient-athlete because of injury, a coach can. Thus, during moments of resistance, the clinician is motivated to inform not only the patient-athlete of perceived risks and benefits but also the coach. Incidentally, all student-athletes sign a waiver at the beginning of the season allowing the sport medicine clinicians to do this, and in return, all the clinicians must inform the patient-athletes that they intend to speak with the coaches. This last point was clearly seen in discussion with a physician about a unique incident that drew administrative and legal attention.
...['C]ause my view of it, and it still is and we can talk about case law later, that physicians do not make decisions about return to play. We give advice. The advice is given to athletes and to coaches, and the athletes and coaches make the decision. The American courts would think that the athletes make the decision, but in fact, there are very few cases where the athlete challenges the coach’s right to decide who plays. So in fact it’s the coach who makes the decision, ’cause if the doc says to the coach, ‘So and so shouldn’t play,’ even if so and so says ‘I refuse to follow the advice and I’m putting my uniform on,’ if the coach says ‘Park it on the bench,’ the athlete parks it on the bench. So, it’s kinda interesting that physicians do not have the authority or the right to tell someone they may not play, but coaches do. However coaches do not have the knowledge they should have to make those decisions based on injury, so they rely on advice from the doctor. So, there’s a triangle there between the athlete, the team official and the physician, and the physician gives the advice to both the team and the athlete, and the athlete makes their decision as to whether they are willing to participate and the coach makes the decision as to whether they will participate. That’s my view of it.

What this clinician acknowledges deals directly with the amount of real ‘power’ held by clinicians in comparison to that of coaches, and the perceived ‘power’ of the clinicians based on their expertise and knowledge. His/her mention of case law touches squarely upon what has been implied in the previous examples and throughout the negotiation process – liability.

Liability and the risk of being liable are key issues for both clinicians and coaches. In many ways, we can interpret all the actions of both these individuals as efforts to not be at risk or liable. As one clinician suggests:

I would say that UofT doesn’t [foster a ‘culture of risk’], if anything it’s the players themselves. If anything, UofT is a lot more protective ’cause it’s the biggest university in Canada, we’re doing the concussion project, we’re very protocolled, very strict guidelines. If anything, they are more strict on things and they don’t push people to play, if anything they push people not to play. So they’re overprotective in some sense, just because…there’s no better way of putting it…but they’re covering their ass. To be in such a big university, with so many administrative levels, you have to cover your ass and have protocols set out. Whether or not people follow them, I mean, we’ll see, but in general, from what I see, people follow them to the hilt. Definitely the senior therapists who have been around for a while, and who have been, I wouldn’t say reprimanded, but who have been counseled on being strict and I’ve seen people be counseled on not being strict enough.
For this clinician, the sense of being "overprotective" and "covering their ass" is a function of the clinic’s location within an educational institution, bringing us back to the importance of context – chiefly the administrative levels of the institution (cf. Figure 1).

The sense of accountability to 'higher ups' is echoed in conversation with coaches, although for them the first administrative level is perceived to be the physicians. In fact, the amount of power held by the clinicians as perceived by the coaches has tremendous impact on the decisions they make about playing or not playing injured athletes. One could argue that, for some coaches, the decisions they make about injured athletes has more to do with their response to the fear of being held liable, then with safeguarding their athletes’ health and wellbeing. An example of this involves a coach who explains why s/he does not want to receive field care only during playoffs/championships.

I don’t have any problems with [any of the therapists]...I think that they are well beyond me and qualified, but the delivery system has to change. Those people can not just come and show up at OU’s and CI’s. That’s the problem. [The clinician] calls me a week before, and says ‘Oh, I want to come to OU’s and CI’s.’ I don’t want you to come, it’s not that I don’t like you. You don’t know the athletes, how can you come to treat these guys when they’re hurt? I don’t want her to come and say ‘Oh, he’s hurt or she’s not competing.’ You know, what am I there for? You know she can call above me, that person’s not going to compete, and I’m not going to go against her because it’s gonna be my head too if he gets hurt or she gets hurt. So, I don’t want that person to come just to those two meets. If she wants to come, come all year, and see the athlete...each individual athlete pain tolerance, and how they each deal with their injury...

Another coach reiterated this concern about liability when describing how s/he was approached by a clinician after one of his/her athletes was told s/he could not play because of a head injury:

Coach:
Ah, at the end, when she was told she couldn’t play. Well, there was nothing they could do about it. It was the doctor’s decision so they were like, they came up to me and said ‘Well, it’s up to you.’ And I said, ‘Well, it’s not up to me.’

Interviewer:
The doctor said this?
Coach:
No the therapist. She was a full time therapist, and she came to me and said ‘Well, you can think about and we’ll let you make the decision,’ but I said ‘I’m not making the decision, I’m not a doctor.’ If a doctor said that they think she had a concussion, then she’s not playing. ’Cause if she gets an elbow, if she gets another one [while competing], and she already had a first one, maybe, and there’s a problem, I’ll be the one liable. So, I made sure she didn’t play.

While we cannot assume that the coach is not concerned for the health and safety of the athlete, there is no evidence to support that in this brief passage, the primary focus is on liability and accountability, and then health concerns. As a final example, we see coaches acknowledge that they, at times when they are not convinced that the clinicians’ recommendations are valid or reliable, they still follow those recommendations because of liability.

Coach 1:
And you always side on the side of caution, ’cause we’re there to make sure the kids are healthy and safe.

Coach 2:
You can’t overrule a therapist [Another coach agrees ‘No!’], even if it’s the stupid therapist on the road, you can’t say ‘Well, I think you’re wrong.’ You can’t do that.

Interviewer:
Have you ever said, you know, this is no good. I’m not doing this...

Coach 2:
Thought it, never did it, but thought it.

Coach 1:
Thought it.

It is not unrealistic for coaches, or even clinicians, to be concerned about liability, particularly in a North American culture that is, as Grayson (1999) calls it, “litigation hungry.” But it does influence the ways in which decisions are made about the health, wellbeing and safety of the patient-athlete. While the patient-athlete is not completely powerless and does have choices available, the overall impact of that ability to choose is lessened in the face of the relationship between the coach and clinician regarding issues of liability.
As noted in Figure 4, the actual negotiation occurs dynamically and almost equally between clinicians and patient-athletes. Where previous theories of physician-patient interactions would place emphasis and power on the physician, this context elicits a different power relationship. While the clinician has the advantage of a large degree of perceived power—arguably a function of the social, historical and political power bestowed upon them as a result of the professionalization of medicine—clinicians are not in a position to order a patient-athlete to accept their recommendations. The fact that physicians can only offer advice or recommendations is indicative of what real power they have in this context. The patient-athlete also wields a certain degree of power in that s/he can accept, modify, or refuse the advice of the clinician (see Figure 6). While previous examples have been given of the acceptance and modification of recommendations, we can look to the ways in which athletes perceive that they could disregard and deny the clinician’s recommendations. In response to a question of what the athlete would do if the clinician told them they could not participate in the championships, this student-athlete acknowledges that the only person to make such a decision is the coach.

Athlete 1:
You don’t have to listen to them. They’re not your coach. That’s how I feel about that. That’s the first thing I’d say to that, ‘You’re not my coach.’

Athlete 2:
They’re always gonna be conservative anyway.

For clinicians, the ways in which athletes respond to their recommendations is a function of the importance they place on their sport involvement. We saw one example (see pg. 106) when a clinician, speaking with reference to an athlete facing early retirement, referred to sport involvement (in relation to the rest of their life) as “the icing on the cake, it’s not the cake.” In contrast, another clinician gave an example of a case where the patient-athlete chose not to leave his/her sport despite receiving numerous concussions and being recommended to retire:
Yeah, play through pain, nothing serious is gonna happen to me, if I don’t play what am I gonna do. I actually got more of that sense that [the sport is] something that sustains him/her, and if s/he doesn’t play, then what is s/he gonna do?

The centralized position of sport in the athlete’s life has a radically different influence on the types of decisions some athletes make despite the recommendations of clinicians.

Another athlete, referring to the relationship between athlete, coach and clinician, touches on the amount of decision-making responsibility placed into the hands of the athlete, and the potential danger of such a practice:

Athlete:
Well, I think there’s always a bit of give and take, like a three-way relationship between the health care provider, the athlete and coach. And so, I mean I’ve never seen [the coach] objecting to the physio or [stepping] in. ’Cause I think there has to be an awareness as to like the physio looking at the coach and [saying], ‘You know this athlete better than I do, and you know how much this athlete pushes themselves outside of the...boundary.’ And [both coaches and clinicians] need to be aware of what the athlete is actually saying versus how they’re feeling too. There’s a lot of subjectivity I think. But as long as there’s open communication, like if the athlete is saying I can run or whatever it is, that desire can be overruled based on a severe injury. But for some of the less obvious ones, I think the coach has to be really attentive to that, between [inaudible]. I think that it’s really pushed at UofT, that it’s up to the maturity of the athlete. It’s kinda assumed that the athlete knows enough about their sport and enough about their injury, to make the decision and the choice not to.... Where it gets scary is when they assume that, and that the athlete doesn’t really see the need to take care of themselves.

Interviewer:
What makes you assume that? The clinic?

Athlete:
Or the coach, or the clinic. They just assume that if the injury got really bad, the athlete would stop.

Interviewer:
And where do you think this idea comes from?

Athlete:
I think it’s tied into efficiency. A physiotherapist doesn’t see somebody enough, so they kinda have to rely on the fact that this person is going to be responsible for their condition. They can’t walk them by the hand, and [inaudible]. I think there’s an element of saying ‘Okay, we have so much to treat people, how much can we really ingrain into this person to stop.’ Or ‘We told you once, and we can’t watch you...we’re not your babysitter.’
And then on the other hand it's the coach's responsibility to teach and really make sure that athletes know that their work doesn't depend on if they do well or not, rather if they're able to walk well in twenty years. But I think that sometimes the athlete assumes 'Oh, the coach really wants you in,' like what's up with that. But the coach needs to be, I don't know, a balance of 'I want you to push yourself but it's not the end of your world.'

When assumptions are made that the athlete is responsible, mature, and aware enough to make such decisions, s/he finds it "scary." This is not to suggest that athletes should be treated like children – they are adults and have a right to be treated as such. But we need to question whether placing the burden of responsibility on the shoulders of athletes is fair considering that athletes may be immersed in a 'culture of risk', and make their choices under influences from their coach, teammates, and even themselves. The question is reinforced when we compare what a clinician says about convincing patient-athletes to follow his/her recommendations with a description of an actual incident with a concussed patient-athlete:

Interviewer:
So [the coaches have been] very supportive of your decision? Does that make a difference then in how you would diagnose or interact with the athlete knowing that there's this support from them?

Clinician:
Yeah, you can say what you want. I don't think it would make a difference anyway, because if the coach would disagree, the coach would disagree. It's up to the athlete to make up her mind about what she wants to do. Because we can only give advice if they're competent, we can't say 'You can't play.' But if the coach says 'I'm not gonna put you on, then I'm not gonna put you on.' So, um, but if the coach says 'I'm gonna put you on,' and the athlete doesn't want to go on, then there's nothing you can do either. So if you had a difficult coach, you'd have to emphasize to the athlete that they can't play.

Interviewer:
So you can only advise, or can't order, for lack of a better word?

Clinician:
No you can't order. The only time that we can actually insist on any type of care is with psychiatric or we feel the person is not competent to make decisions, which we can't say, so we can only advise.
The situation experienced by some athletes is evident in this account by an athlete of the experiences of his/her teammate when s/he was concussed during playoffs, and needed to continue competing in order to help the team maintain their playoff status:

Interviewer:  
So, if it was the beginning of the season, and s/he had a concussion, s/he wouldn’t...?

Athlete:  
S/he wouldn’t have [competed]. S/he’s alright now, but s/he’s still getting treatment.

Interviewer:  
S/he’s getting treatment now, for the head injury?

Athlete:  
Yes.

Interviewer:  
Oh, I see. But when that happened, did the therapist step in and say...

Athlete:  
S/he told her, this is a possible concussion, but [pause]

Interviewer:  
It was left up to him/her...?

Athlete:  
It was left up to him/her.

Interviewer:  
And what did your coach say?

Athlete:  
S/he really didn’t give much of an option.

The last sentence sums up the situation that some athletes are placed in. Even though theoretically clinicians claim to place the onus of responsibility on the patient-athlete and the coach, and the coaches claim that they follow the advice of the clinicians out of fear of being held liable, the reality in some situations is radically different and potentially devastating for the patient-athlete. Having said that, while most of the situations and stories outlined in this study did not have such negative results, this is an area where there is a need for more research.
Finally, how do patient-athletes leave the clinician/patient-athlete relationship with therapists? Although this was expressed by a number of physicians as well, most therapists characterized the ways in which they allowed patient-athletes to return to competition as ‘goal-setting and testing’ (see Figure 6). As one therapist noted:

I’ve had patients who are overly protective, and I say to them ‘Just go and start playing. Don’t worry about it. Don’t come back until you hurt yourself again.’ I’ve occasionally had people who are overprotective which is good ‘cause you know they’re not gonna be foolish and hurt themselves, but at the same time, my job is to get them back as soon as possible. So there is a converse... I had a varsity player who hurt their ankle, was really afraid and wearing an aircast for like 3 or 4 weeks, and I was like ‘There’s no way you should be wearing that for that long, get it off, get walking.’ S/he started to feel a lot better, ‘cause s/he was starting to move again, felt a lot better psychologically, s/he was ‘Oh yeah, I was hoping to get in this season,’ s/he played half a year. It took him/her a while to get back into it, but I laid out everything for him/her, ‘As long as you do this and this, you’re fine.’ And s/he went through a progression really quickly and I was like ‘Hey, there you go.’ I’ve had situations where you can get off and get back into it as soon as possible, and they’ll be like ‘Well, can I try this?’ and I’ll be like ‘Sure, try this. If it hurts then you can’t, if it doesn’t then you can keep going.’ Progressing the levels again, and they see that. And that again is what functional rehab is for, give the athlete confidence that they can hit each level until they reach their potential, as opposed to, you never throw someone back into activity ‘cause that’s when you hurt yourself. You’re going to be encountering a lot of uncertain situations, and they just won’t know until it actually blows out on them or gives out on them. And even if it doesn’t, they won’t have that certainty so they’re not gonna be as effective. So again, patient education, showing them that they’re not okay or that they are.

For this clinician goal-setting and testing are woven into patient education. For another, they are ways of helping athletes to reintroduce themselves back into their sport and team:

Clinician:

‘[An athlete] was having shoulder problems, and part of our evaluation, part of what s/he wanted to do was play. S/he wanted to get back into ___. Initially, s/he had loss of strength and loss of range, so once s/he had her strength and once s/he had her range, I said ‘Well, okay, if you think you can [compete], you have to take me down.’ I basically say ‘Don’t hurt me,’ but basically ‘Put me [through the paces], and if you take me down and there’s no pain, then you can try to return to activity.’ So we go through that sport specific patterning with him/her, and s/he got me tied up, and it didn’t hurt. And s/he was able to do it at slower speeds and higher speeds, and so I was ‘Okay, try practicing. See how it feels in practice situations first before you go back into [competition], and then you can go from there.’ Another situation I had was a rugby player... who was recovering from knee surgery. And part of return to practicing criteria was sport specific tasks. So [the athlete] had good range and good strength, so we went to the gymnastics
room, where the mats are set up, and went through tackling. So [they] had to tackle me, I had to tackle [them], to see if not only physically, but psychologically, if [they] were ready to be hit, tackle and absorb forces and things like that. And we probably spent 20 minutes in the room going through scrummaging, we were twisting each other up in scrummage type positions, tackling stuff, and then I made [the athlete] run the pit a couple of times to tire [them] out, and we did it again. And [the athlete] was able to successfully do that without any pain, [they] felt confident, [they] felt strong, and then we said ‘Okay.’

Interviewer:
Why do you say psychologically?

Clinician:
Well, because there’s an apprehension sometimes that physically you’re ready to go, but mentally you’re still visualizing the mechanism of injury or you may not feel comfortable pivoting or rotating or going through a sport movement pattern because you feel you’re unable to because you may get injured again. So there’s patterning that has to be developed, so part of the rehab is getting them to try those specific actions that they have to do, so their proprioception is okay to do that. Psychologically, if I’ve been bounding, running, jumping or doing things, I know I can do this. But if their mechanism or part of their apprehension is ‘What if I get hit?’ and they’ve been hit or had contact, and you put them into the game, then their play suffers cause they’re not going into contact or they’re avoiding a specific aspect of the game that they should be doing, cause they’re mentally worried that they’re gonna get hurt because they haven’t tried it, then that’s gonna affect their mental play as well as their physical play. By going through some of that ahead of time, and then saying ‘Well, now you can go and try practice where you’ll get more of these experiences, I’ve just gone through your practice scenarios, then you can go back into the game.’

This particular clinician shows not only the importance of setting and testing sport-specific goals as part of their patient’s rehabilitation, but also his/her level of involvement and commitment with the patient’s return to competition, a characteristic that is highly valued by the patient-athlete during a time when they feel quite vulnerable.

This final model examined the exiting of the clinician/patient-athlete relationship, and touched on such themes as the clinicians’ duty to inform and place the decision-making responsibility in the hands of athletes and coaches, as well as the importance of liability, and the threat of being liable, to both clinicians and coaches. For the patient-athlete, exiting the relationship includes the ability to accept, disregard or modify the recommendation as offered by
the clinician, but these decisions are often made as they are entrenched in the ‘culture of risk’, and under pressure from coaches, teammates, and even themselves. Furthermore, as seen most clearly in discussion with therapists, exiting the relationship also entails a tremendous degree of goal-setting and testing, characterized by communication and patient education that is highly valued by patient-athletes.

In concluding this chapter, it cannot be emphasized enough that the previous discussion reflects one way of interpreting the negotiation process between sport medicine clinicians, patient-athletes and coaches. It offered two macro-level areas, the spheres of influence and the cyclical nature of sport medicine within the ‘culture of risk,’ with the latter subdivided into the micro-level stages of negotiation — making contact, sites of negotiation, and exiting the clinician/patient-athlete relationship. It can also not be emphasized enough that the negotiation process — regardless of which stage we wish to examine it — is highly influenced by the context within which it occurs, and by the subjectivity of the individuals involved. This adds complexity to the study of this topic and to this project and demands further research, since while the context and its influence on individuals can be changed, the actual interaction between clinicians, patient-athletes and coaches — the content of the negotiation — remains beyond the control of any state, institution, organization, policy or individual. In turning to our conclusions and recommendations, we must then be sensitive to the fact that we can only modify, and hope to improve, the context within which these negotiation occur.
CHAPTER 6
CONCLUSIONS and RECOMMENDATIONS

This chapter briefly summarizes some of the major findings and arguments, and offers recommendations for maintaining and improving the process of negotiations among sport medicine clinicians, student-athletes and coaches in Canadian intercollegiate sport. We begin by returning to Pipe’s (1998, p. 40) statement that “[a]s sports medicine [clinicians], we have unique ethical responsibilities concerning the athletes in our care…. It is easy at times, when caught up in the pressure of competition, to lose sight of the full range of responsibilities…. Our primary responsibility is to protect athletes’ health and well-being as defined most broadly.” One must ask how well these “unique ethical responsibilities” are represented in this institution?

On one hand, the evidence from this project indicated that a ‘culture of risk’ does exist amongst the student-athletes, supporting research that documents the use of particular “neutralization” strategies that “[suppress the] effect” (Young & White, 1995, p. 53) of pain and injury, and which rationalize the ‘culture of risk.’ This rhetoric was employed not only by patient-athletes, but also by sport medicine clinicians, indicating that the clinicians are influenced by, and influence a ‘culture of risk,’ and thus negotiate with athletes within that context.

Furthermore, there are no clear-cut answers as to how clinicians understand, negotiate, and deal with the ‘culture of risk’ with their patient-athletes, just continuous weighing of the perceived risks and benefits of playing and/or not playing with pain or the risk of further injury. This study does point out some of the ways in which clinicians explicitly and implicitly supported the ‘culture of risk,’ particularly during important times of the season and/or important competitions, when dealing with athletes from different types of sports, or even with different levels of talent among intercollegiate athletes. It is important to emphasise that the clinicians are working within a competitive sport environment in which, at times, health is under-valued in
relation to performance. The clinicians are influenced by the ‘culture of risk’ and influence this in return, thus emphasizing the dynamic nature of responses to pain/injury in varying contexts. The fact that pain, perceived risk, and health are subjective concepts further complicates, or rather, makes more dynamic, the ways in which clinicians negotiate with patient-athletes.

However, Pipe’s unique ethical responsibilities are also evident in a number of ways. Clinicians expressed a concern regarding the accessibility of the clinic, acknowledging that changes are made in order to make the clinic atmosphere more inviting and equitable to student-athletes from all types of sports. Similarly, a number of clinicians remarked about a “culture of precaution” that resisted the influences of a ‘culture of risk,’ and expressed a great deal of concern for the ongoing health of student-athletes. This was clearly seen in the non-negotiation of head injuries, as well as in the involvement, care and goal-setting involved, on the part of clinicians, in bringing patient-athletes back to competitive levels. The evidence indicated the nurturance of patient-athletes when vulnerable, and an emphasis on patient education. These are but a few examples of the ways in which these clinicians have undertaken their ethical responsibilities, and must be recognised as the strong expression of a culture of care.

In examining how clinicians deal with the dual, and potentially conflicting, roles of patient and competitive intercollegiate student-athlete, clinicians emphasized the differences between CIAU and NCAA athletes, and stressed that the former system places greater focus on athletics supplementing academics. The clinicians felt that this positioning of sport as secondary to education greatly effected the ways in which student-athletes viewed their injuries, lessening the pressure for athletes to play with pain. The focus on education re-emphasized the importance of context, and the ways in which context influences the ways in which pain, injury, and risk are negotiated between clinicians and student-athletes.
In Chapter 5, the negotiation process was examined and interpreted through the use of six visual and theoretical models to plot the course of the negotiations. Furthermore, the role and influence of the coach in the negotiation of treatment was examined in greater detail.

The first model examined the different factors that influence the interaction between the clinicians, athletes, and coaches, beginning with the larger, ‘societal’ understanding of the ‘culture of risk,’ and narrowing to the core of the project, the space of interaction between patient-athletes, clinicians and coaches. The second model examined the cyclical nature of sport medicine within the ‘culture of risk,’ and considered some of the ways in which other participants, particularly coaches, understand and are complicit in the re/production of injury-legitimating norms. This is important since coaches are seen mediating not only the relationship between student-athletes and sport medicine clinicians, but also the relationship between student-athletes and health/medicine in general.

The cyclical nature of sport medicine within the ‘culture of risk’ suggests a series of stages that the actors followed, including: making contact with the clinic and/or clinicians; the actual sites where negotiation occurred; and exiting the clinician/patient-athlete relationship. A number of conclusions can be drawn from these themes.

- The issue of accessibility weighed heavily on the minds of both student-athletes and coaches, with some athletes acknowledging that the greatest effort in negotiating with the clinicians was in accessing them. Accessibility was mediated by a number of factors such as the presence or absence of a team therapist for field care, personal connections to the clinic and/or clinicians, and a sense of entitlement to the clinic as expressed by some athletes and coaches.

- While student-athletes, coaches and sport medicine clinicians negotiated within a ‘culture of risk,’ it operated in a dialectic with a “culture of precaution” – a culture that prioritised health and wellbeing. Participants were quick to point out that on the whole, athletes and coaches at
this institution tended to err on the side of caution when it came to pain and injury, and did not necessarily subscribe to stereotypical behaviours of denying, hiding, or downplaying injury.

- Once contact was made between the patient-athlete and clinician, the communication, interpretation and exchange of information between clinician and patient-athlete revolved around the weighing of perceived risks versus perceived benefits of playing with injury. For clinicians, this included the weighing of professional risks during negotiation. This weighing process was most visible with musculo-skeletal injuries, whereas neurological and head injuries were usually dealt with through a zero-tolerance/zero-negotiation policy.

- A primary objective of clinicians was to inform the patient-athlete of the perceived risks and benefits of playing with injury, and to place the decision-making responsibility in the hands of the athlete and/or the coach. While no clinician could ‘order’ a patient to follow a recommendation, in the intercollegiate sport context the power to ‘order’ a patient-athlete to participate or not participate rests in the hands of the coach. Liability was a significant issue for both clinicians and coaches, and the threat of being liable was the most cited reason as to why coaches would not countermand the clinician’s recommendations. But even though, theoretically, clinicians claim to place the onus of responsibility on the patient-athlete and the coach, and coaches claim that they follow the advice of the clinicians out of fear of being held liable, the reality in some situations is radically different and potentially devastating for the patient-athlete. While patient-athletes are expected to follow clinician recommendations in their decision-making, they make those decisions within a culture that tolerates pain and injury, and at times under pressure from their coaches, teammates, and even themselves.

While this study represents the first Canadian analysis of the process of negotiation between sport medicine clinicians, patient-athletes and coaches, and further in-depth analysis is
required, some recommendations are possible in order to maintain and improve the sport medicine-intercollegiate sport system at this institution.

Limitations and Recommendations

Since this project is one of the first attempts to locate and examine the negotiation process between patient-athletes and clinicians, it would be “premature” (Walk, 1997) to recommend policy-related transformation. One of the limitations of this study was the limited nature of policy analysis, thus future studies must access and investigate the ways in which policy works in creating the sport medicine/sport medicine clinic context, and the effect of policy on the structure within which negotiation occurs. However, we must understand that while policy can structure the context of negotiation, it can only influence the content of negotiation. Having said that, we cannot underestimate the role of regulation and policy is changing the attitudes and actions of individuals towards injury, an example being the increasing awareness of the consequences of concussions, and the subsequent creation of guidelines and policy in regards to the non-negotiation of head injuries.

The recommendations that can be made as a result of the findings of this project include:

- Greater support for long-term quantitative and qualitative injury tracking throughout the intercollegiate program, as well as the Faculty of Physical Education and Health, to document rates and incidences of injury per sport and per team. As one of the clinicians noted (see pg. 177), an injury tracking mechanism would help the clinic in tracking the rates of injuries in the intercollegiate program, as well as the ways in which different teams access the clinic and its services. Data could also be used to identify sports and teams whose injury rates are excessive.
• The development and implementation of a training course(s) in risk awareness for coaches. This course would be designed to help coaches recognize overconformity to the sport ethic amongst their athletes, their own role in promoting and/or tolerating risk, pain and injury, as well as ways in which to positively deal with and communicate with injured athletes.

• The continued development and acknowledgement of the rights of student-athletes regarding their personal health and safety, to be outlined in the Varsity Handbook. This document would explicitly outline to student-athletes their health rights as an intercollegiate athlete, in relation to the coach and the clinician, as well as offer suggestions and highlight resources to help them in their decision-making. A pain, injury, and risk awareness seminar could also be created, in conjunction with the Varsity Handbook, to emphasise to student-athletes the choices, options, and resources available to them when they are injured and when they are most vulnerable to a culture that normalises pain and injury.

• Furthermore, the hiring of a neutral medical (ombuds)person to act on behalf of all athletes, coaches, and sport medicine clinicians. This person would work with the David L. MacIntosh Sport Medicine Clinic, the Faculty of Physical Education and Health, as well as the intercollegiate program, in researching and developing appropriate injury-related policies, and addressing sport medicine/intercollegiate sport concerns.

These are some initiatives that can be taken to maintain and/or improve the negotiation process, as well as facilitate further research in this area. The clinic and the clinicians have a pivotal effect on the way intercollegiate sport is conducted in this institution. The sport medicine clinic is not just a service, but rather, is valued as a space where physical vulnerability can be exposed, and where healing does occur. Ultimately, even though the negotiations that occur between clinicians, patient-athletes, and coaches are fluid, dynamic and show some evidence of the ‘culture of risk,’ the core process remains centred on the desire to heal.
REFERENCES and APPENDICES


Appendix I:

Faculty of Physical Education and Health
University of Toronto

Mission Statement

To develop, advance and disseminate knowledge about physical activity and health, through education, research, leadership and the provision of opportunity.

Our Values

What matters are our students and members, for without them we have no purpose.
What matters is that we act with integrity in everything that we do, earning the respect of our community.
What matters are opportunity, personal growth, and satisfaction in an environment that thrives on diversity.
What matters are co-operation, consideration and respect among ourselves, for without these values there is no team.
What matters are ideas and ideals — and the recognition that we all have our own to contribute.
What matters is being the best. And then improving.

Guiding Principles

As representatives of the Faculty and the University of Toronto, it is essential that all staff act with integrity and respect for others. The following are a few of the more important guiding principles...

- Create a welcoming environment: One that is positive and receptive to everyone you come in contact with.
- Provide an education of the whole person, mind and body, in an intellectual, spiritual, social and physical environment.
- Enhance inclusivity by welcoming and accommodating diversity. Make ALL people regardless of race, culture, religion, sexual orientation, ability or gender feel welcome.
- Understand and promote the continuum of opportunities. We offer a breadth of programs which encourages all levels of ability to enjoy physical activity and learning.
- Know that the Faculty incorporates the interfacing of research - teaching and best practices.
- Discover the variety of student leadership opportunities, available in the Faculty, for all U of T students to develop important life skills.

(Source: 1999 - 2000 Staff Resource Guide & Handbook, Faculty of Physical Education and Health, University of Toronto).
Appendix II:

World Medical Association Declaration on Principles of Health Care for Sports Medicine

Adopted by the 34th World Medical Assembly, Lisbon, Portugal, September/October 1981; and amended by the 39th World Medical Assembly, Madrid, Spain, October 1987; and the 45th World Medical Assembly, Budapest, Hungary, October 1993.

The WMA has drafted and recommends the following ethical guidelines for physicians in order to meet the needs of the sportsmen or athletes and the special circumstances in which the medical care and health guidance is given. Consequently,

1. The physician who cares for sportsmen or athletes has an ethical responsibility to recognize the special physical and mental demands placed upon them by their performance in sports activities.

2. When the sports participant is a child or an adolescent, the physician must give first consideration to the participant’s growth and stage of development.

2.1 The physician must ensure that the child’s state of growth and development, as well as his or her general condition of health can absorb the rigours of the training and competition without jeopardizing the normal physical or mental development of the child or adolescent.

2.2 The physician must oppose any sports or athletic activity that is not appropriate to the child’s stage of growth and development or general condition of health. The physician must act in the best interest of the health of the child or adolescent, without regard to any other interest or pressure from any other source.

3. When the sports participant is a professional sportsman or athlete and derives livelihood from that activity, the physician should pay due regard to the occupational medical aspects involved.

4. The physician should oppose the use of any method which is not in accordance with professional ethics, or which might be harmful to the sportsman or athlete using it, especially:

4.1 Procedures which artificially modify blood constituents or biochemistry.

4.2 The use of drugs or other substances whatever their nature and route of administration, including central-nervous-system stimulants or depressants and procedures which artificially modify reflexes.

4.3 Induced alterations of will or general mental outlook.

4.4 Procedures to mask pain or other protective symptoms if used to enable the sportsman or athlete to take part in events when lesions or signs are present which make his participation inadvisable.

4.5 Measures which artificially changes features appropriate to age and sex.

4.6 Training and taking part in events when to do so would not be compatible with preservation of the individual’s fitness, health or safety.

4.7 Measures aimed at an unnatural increase or maintenance of performance during competition. Doping to improve an athlete’s performance is unethical.

5. The physician should inform the sportsman or athlete, those responsible for him, and other interested parties, of the consequences of the procedures he is opposing, guard against their use, enlist the support of other physicians and other organizations with the same aim, protect
the sportsman or athlete against any pressures which might induce him to use these methods and help with supervision against these procedures.

6. The sports physician has the duty to give his objective opinion on the sportsmen or athletes' fitness or unfitness clearly and precisely, leaving no doubt as to his conclusions.

7. In competitive sports or professional sports events, it is the physician's duty to decide whether the sportsman or athletes can remain on the field or return to the game. This decision cannot be delegated to other persons. In the physician's absence these individuals must adhere strictly to the instructions he has given them, priority always being given to the best interests of the sportsman's or athlete's health and safety, and not the outcome of the competition.

8. To enable him to carry out his ethical obligations the sports physician must see his authority fully recognized and upheld, particularly wherever it concerns the health, safety and legitimate interests of the sportsman or athlete, none of which can be prejudiced to favour the interests of any third party whatsoever.

9. The sports physician should endeavour to keep the patient's personal physician fully informed of facts relevant to his treatment. If necessary he should collaborate with him to ensure that the sportsman or athlete does not exert himself in ways detrimental to his health and does not use potentially harmful techniques to improve his performance.

10. In sports medicine, as in all other branches of medicine, professional confidentiality must be observed. The right to privacy over medical attention the sportsman or athlete has received must be protected, especially in the case of the professional sportsmen or athletes.

11. The sports doctor must not be party to any contract which obliges him to reserve particular forms of therapy solely and exclusively for any one sportsman or athlete or group of sportsmen or athletes.

12. It is desirable that sport physicians from foreign countries, when accompanying a team in another country, should enjoy the right to carry out their specific functions.

13. The participation of a sports physician is desirable when sports regulations are being drawn up.

Proposed Guideline #14:

14.1 Doctors involved in sport have an ethical and legal duty to provide competent professional services and to ensure that they practice medicine to a high standard with appropriate facilities.

14.2 The doctor has an additional ethical responsibility with regard to the prevention of injury by advising that appropriate equipment is worn by players, the environment is safe, and vulnerable individuals do not participate in an event where there is a risk of aggravating a primary injury or sustaining a second, invariably more serious, injury.

14.3 If a doctor recognizes a pattern of events leading to an injury, he has an ethical duty to draw this to the attention of the players, coaches, and legislators, in hope that this pattern can be broken and the injuries minimized.

14.4 On occasion, the doctor may be faced with a situation where an injury has resulted from violence outside the rules of the game. This may occur as a result of careless or thoughtless play, but may be the result of deliberate cheating, recklessness or violence and, in these circumstances, the doctor has a duty both to treat the injured player and to protect other players from similar violence by informed liaison with the relevant official in the event club or sport and the individuals concerned (NB while preserving professional confidentiality through anonymity).
Following the gross transgression of medical ethics during the Second World War, the World Medical Association (founded largely at the instigation of the BMA) restated the Hippocratic Oath in a modern style, this being known as the Declaration of Geneva. Upon this, an International Code of Medical Ethics was based.

Declaration of Geneva

At the time of being admitted as a Member of the Medical Profession I solemnly pledge myself to consecrate my life to the service of humanity.
I will give to my teachers the respect and gratitude which is their due;
I will practise my profession with conscience and dignity;
The health of my patient will be my first consideration;
I will respect the secrets which are confided in me;
I will maintain by all means in my power the honour and the noble traditions of the medical profession;
My colleagues will be my brothers;
I will not permit considerations of religion, nationality, race, party politics or social standing to intervene between my duty and my patient;
I will maintain the utmost respect for human life from the time of conception; even under threat, I will not use my medical knowledge contrary to the laws of humanity.
I make these promises solemnly, freely and upon my honour.

As cited in Grayson, E. (1999). Ethics, injuries and the law in sports medicine (pp. 6-7; 146-149). Oxford: Butterworth Heinemann, Reed Educational and Professional Publishing Ltd.
Appendix III:

Code of Ethics of the Canadian Medical Association
Approved by the CMA Board of Directors, October 15, 1996
As found on the CMA website (http://www.cma.ca)

Preface

The Canadian Medical Association accepts the responsibility for delineating the standard of ethical behaviour expected of Canadian physicians and has developed and approved this Code of Ethics as a guide for physicians.

The Code is an ethical document. It sources are the traditional codes of medical ethics such as the Hippocratic Oath, as well as developments in human rights and recent bioethical discussion. Legislation and court decisions may also influence medical ethics. Physicians should be aware of the legal and regulatory requirements for medical practice in their jurisdiction. However, the Code may set out different standards of behaviour than does the law.

The Code has been prepared by physicians for physicians. It is based on the fundamental ethical principles of medicine, especially compassion, beneficence, non-maleficence, respect for persons and justice. It interprets these principles with respect to the responsibilities of physicians to individual patients, family and significant others, colleagues, other health professionals, and society.

The Code is not, and cannot be, exhaustive. Its statements are general in nature, to be interpreted and applied in particular situations. Specific ethical issues such as abortion, transplantation and euthanasia are not mentioned; they are treated in appropriate detail in CMA policy statements.

Physicians may experience conflict between different ethical principles, between ethical and legal or regulatory requirements, or between their own ethical convictions and the demands of patients, proxy decision makers, other health professionals, employers or other involved parties. Training in ethical analysis and decision making during undergraduate, postgraduate and continuing medical education is recommended for physicians to develop knowledge, skills and attitudes needed to deal with these conflicts. Consultation with colleagues, licensing authorities, ethicists, ethics committees or others who have expertise in these matters is also recommended.

The Code applies to physicians, including residents, and medical students.

General Responsibilities

1. Consider first the well-being of the patient.
2. Treat all patients with respect; do not exploit them for personal advantage.
3. Provide appropriate care for your patient, including physical comfort and spiritual and psychosocial support even when cure is no longer possible.
4. Practise the art and science of medicine competently and without impairment.
5. Engage in lifelong learning to maintain and improve your professional knowledge, skills and attitudes.
6. Recognize your limitations and the competence of others and when indicated, recommend that additional opinions and services be sought.

**Responsibilities to the Patient**

Initiating and Dissolving a Patient-Physician Relationship

7. In providing medical service, do not discriminate against any patient on such grounds as age, gender, marital status, medical condition, national or ethnic origin, physical or mental disability, political affiliation, race, religion, sexual orientation, or socioeconomic status. This does not abrogate the physician’s right to refuse to accept a patient for legitimate reasons.

8. Inform your patient when your personal morality would influence the recommendations or practice of any medical procedure that the patient needs or wants.

9. Provide whatever appropriate assistance you can to any person with an urgent need for medical care.

10. Having accepted professional responsibility for a patient, continue to provide services until they are no longer required or wanted; until another suitable physician has assumed responsibility for the patient; or until the patient has been given adequate notice that you intend to terminate the relationship.

11. Limit treatment of yourself or members of your immediate family to minor or emergency services and only when another physician is not readily available; there should be no fee for such treatment.

Communicating, Decision Making and Consent

12. Provide your patients with information they need to make informed decisions about their medical care, and answer their questions to the best of your ability.

13. Make every reasonable effort to communicate with your patients in such a way that information exchanged is understood.

14. Recommend only those diagnostic and therapeutic procedures that you consider to be beneficial to your patients or to others. If a procedure is recommended for the benefit of others, as for example in matters of public health, inform your patient of this fact and proceed only with explicit informed consent or where required by law.

15. Respect the right of a competent person to accept or reject any medical care recommended.

16. Recognize the need to balance the developing competency of children and the role of families in medical decision-making.

17. Respect your patient’s reasonable request for a second opinion from a physician of the patient’s choice.

18. Ascertain wherever possible and recognize your patient’s wishes about the initiation, continuation or cessation of life-sustaining treatment.

19. Respect the intentions of an incompetent patient as they were expressed (e.g., through an advance directive or proxy designation) before the patient became incompetent.

20. When the intentions of an incompetent patient are unknown and when no appropriate proxy is available, render such treatment as you believe to be in accordance with the patient’s values or, if these are unknown, the patient’s best interests.
21. Be considerate of the patient’s family and significant others and cooperate with them in the patient’s interests.

Confidentiality

22. Respect the patient’s right to confidentiality except when this right conflicts with your responsibility to the law, or when maintenance of confidentiality would result in a significant risk of substantial harm to others or to the patient if the patient is incompetent; in such cases, take all reasonable steps to inform the patient that confidentiality will be breached.

23. When acting on behalf of a third party, take reasonable steps to ensure that the patient understands the nature and extent of your responsibility to the third party.

24. Upon a patient’s request, provide the patient or third party with a copy of his or her medical record, unless there is a compelling reason to believe that information contained in the record will result in substantial harm to the patient or others.

Clinical Research

25. Ensure that any research in which you participate is evaluated both scientifically and ethically, is approved by a responsible committee and is sufficiently planned and supervised that research subjects are unlikely to suffer disproportionate harm.

26. Inform the potential research subject, or proxy, about the purpose of the study, its source of funding, the nature and relative probability of harms and benefits, and the nature of your participation.

27. Before proceeding with the study, obtain the informed consent of the subject, or proxy, and advise prospective subjects that they have the right to decline or withdraw from the study at any time, without prejudice to their ongoing care.

Professional Fees

28. In determining professional fees to patients, consider both the nature of the service provided and the ability of the patient to pay, and be prepared to discuss the fee with the patient.

Responsibilities to Society

29. Recognize that community, society and the environment are important factors in the health of individual patients.

30. Accept a share of the profession’s responsibility to society in matters relating to public health, health education, environmental protection, legislation affecting the health or well-being of the community, and the need for testimony at judicial proceedings.

31. Recognize the responsibility of physicians to promote fair access to health care resources.

32. Use health care resources prudently.

33. Refuse to participate in or support practices that violate basic human rights.

34. Recognize a responsibility to give the generally held opinions of the profession when interpreting scientific knowledge to the public; when pressuring an opinion that is contrary to the generally held opinion of the profession so indicate.
Responsibilities to the Profession

35. Recognize that the self-regulation of the profession is a privilege and that each physician has a continuing responsibility to merit this privilege.

36. Teach and be taught.

37. Avoid impugning the reputation of colleagues for personal motives; however, report to the appropriate authority any unprofessional conduct by colleagues.

38. Be willing to participate in peer review of other physicians and to undergo review by your peers.

39. Enter into associations only if you can maintain your professional integrity.

40. Avoid promoting, as a member of the medical profession, any service (except your own) or product for personal gain.

41. Do not keep secret from colleagues the diagnostic or therapeutic agents and procedures that you employ.

42. Collaborate with other physicians and health professionals in the care of patients and the functioning and improvement of health services.

Responsibilities to Oneself

43. Seek help from colleagues and appropriately qualified professionals for personal problems that adversely affect your service to patients, society or the profession.
Appendix IV:

Varsity Handbook

Section 5. Health Care

Doping Policy of the CIAU

Position Statement of the CIAU on Doping

1.1. The CIAU is unequivocally opposed to the use by athletes of any banned or restricted substance or methods in contravention of its rules and the rules of the National and/or International Sport Federations, the International Olympic Committee, and the Federation du sport universitaire.

1.2. The CIAU is unequivocally opposed to any encouragement of the use of such substances and/or methods by individuals in positions of leadership in university sport (i.e. coaches, athletic staff, medical practitioners, sport scientists, administrators, etc.) or by the athletes themselves. The provision of, or administration of banned or restricted substances and/or methods to athletes is also forbidden.

For further information, visit the CIAU website at www.ciau.ca.

Drug Education Seminar

It is mandatory that all CIAU athletes attend a Drug Education Seminar. This must take place prior to competition. CIAU athletes not attending a Drug Education Seminar cannot compete.

Pre-participation Medical Screening

1.1. Medical Questionnaire

All athletes trying out for varsity teams must have a medical questionnaire completed and checked by the designated team therapist. Please note that there are two different forms to be completed: one for the first year varsity athlete and one for the returning athlete varsity athlete. A player is not allowed to play in a game or practice with the team until he/she has submitted a medical questionnaire for that year.

Medical forms may be picked up in the David L. MacIntosh Sport Medicine Clinic.

Medical forms must be signed by the student and a witness and then returned to his/her coach, the clinic or the designated team therapist.
1.2 Pre-Season Concussion Screening

As part of our continued effort toward excellence and best practice, the Faculty of Physical Education and Health has implemented an important new health and safety initiative for sports where there is a significant risk of concussion and brain injury. The idea is to obtain base-line neuropsychological data on all participants to inform treatment in the case of injury.

The policy requires every student athlete engaged in intercollegiate sports for which there is a significant risk for concussion, to complete a mandatory brief neuropsychological (NP) assessment prior to the start of their athletic participation. These sports are: baseball, basketball, field hockey, football, ice hockey, lacrosse, mountain biking, rugby, soccer and volleyball. This policy will help us ensure effective treatment of concussion/mild traumatic brain injuries, recommend evidence-based return-to-play guidelines (in conjunction with ongoing research on concussions) and protect the academic and professional careers of your future leaders. **The test must be completed prior to your first competition.**

**DAVID L. MACINTOSH SPORT MEDICINE CLINIC**

The David L. MacIntosh Sport Medicine Clinic is open to anyone with sport or exercise related injuries or inquiries.

Sport physicians, orthopedic surgeons, athletic therapists, massage therapists, physiotherapists and a chiropractor professionally staff the clinic.

Appointments with the physicians may be made by calling the clinic receptionist at 978-4678, or by booking in person. There are a limited number of acute injury spots for varsity athletes each day. Students with non-exercise related health care concerns should consult Health Services (St. George Campus) at (416) 978-8030, Health Services (Mississauga Campus) at (905) 828-5255, and Health & Wellness Centre (Scarborough Campus) at (416) 287-7065.

Patients must see one the clinic’s sport physicians prior to receiving therapy or other follow up care. Acute care visits with the therapists will be arranged according to the therapist’s schedule.

Most medical services for Canadians are covered by provincial medical plans. International students receive coverage through the University Health Insurance Plan (UHIP) and other University of Toronto students are covered under university plans such as ETFS; the clinic accepts these plans directly. Clients who have other private medical care plans will be required to play for their medical services at the time of their appointment. There may also be additional charges for materials used in treatments that are not covered by medical care plans. Please remember to bring your provincial health card to your appointment.

**Attendance Policy**

Attending appointments is important for effective care of your injury. Accessibility to medical and therapeutic services is hampered if patients arrive late or do not arrive for their scheduled appointments. The Macintosh Clinic staff do not wish to penalize individuals seeking help at
this facility; however we feel steps must be taken to ensure fair accessibility of services to all patients.

No Show / Same Day cancellation Policy for Students

Charges for all missed appointments or cancellations without 24 hours notice will be invoiced to your account, emergencies notwithstanding. This fee is $10.00. The clinic reserves the right to withhold therapy if you have an outstanding balance. Payment may be made by Interac, cash, cheque (payable to the University of Toronto), VISA, or MasterCard.

Hours of Service
Clinic hours are subject to change, please call 978-4678 or check the MacIntosh Clinic bulletin boards for updates.

Academic Session (September 11 to December 11 and January 8 to April 12):
Monday to Thursday 7 a.m. – 7 p.m.
Friday 7 a.m. – 5 p.m.
Saturday 9 a.m. – 1 p.m.

New for 2000
The clinic has undergone significant change this year, for a variety of reasons primarily in response to long-term demand for more service, and changes in OHIP regulations. The changes for this year include:
• Expanded space (we have increased from 1,100 to 2,400 ft2 of floor space)
• Expanded hours of operation (including Saturday, early mornings and more evenings)
• The clinic is now open to the public

Appendix V:

A Brief History of the David L. MacIntosh Sport Medicine Clinic

What is now called the David L. MacIntosh Sport Medicine Clinic is, to the best of our knowledge, the evolution of the oldest dedicated Sport Medicine facility in the world.

It began during World War II. The then Director of Health Service, who was also on staff at Toronto General Hospital, enlisted volunteer help from the orthopaedic staff of the hospital. These surgeons occasionally visited both the old Men’s Health Service building, and the Hart House lockers, to see athletes injured playing sports at U of T. After the war, in 1947, this service was formalized as the Hart House Surgery. It was open in the evenings on weekdays during the academic fall and spring sessions. Any U of T students or staff with athletic injuries were welcome. It was staffed by the then future Professor and Chair of Orthopaedic Surgery, Dr. Dewar.

In 1951, Dr. Dewar enlisted Dr. David L. MacIntosh from his department to provide medical services at Hart House. From ’51 until ’78, it was the “Mac and Wally” show at Hart House, where Dr. Mac and his erstwhile assistant, the late Wally Purdue, tended to the needs of the injured. During this period of time, the very humble Dr. MacIntosh gained world fame for his discoveries related to torn anterior cruciate ligaments. Dr. Mac was the first in the world to describe the “pivot shift” manoeuvre, still the “gold standard” test for diagnosis of ACL injury. In the late ‘50’s, he performed and published the first-ever successful ACL reconstruction (attempts to repair or reconstruct this ligament had been failing since the 1870’s).

In 1978-79, the Men’s and Women’s Athletic Association merged to become the Department of Athletics and Recreation. When the new Athletic Centre opened, the Hart House Surgery moved over to the Warren Stevens Building to share space with the Athletic Therapy staff at DAR. Dr. MacIntosh and his Fellows, residents, and students continued to see patients in the evenings in this new facility, which was called the Athletic Injuries Clinic.

This clinic, located in Room 62 in the basement of the Warren Stevens Building, was really designed primarily for taping and hydrotherapy, and not for a full spectrum of therapy services or medical consultations. Dr. MacIntosh and his successors, however, did not let that dampen their enthusiasm for seeing patients in the new space (which was, after all, an improvement on the room in Hart House). One of Dr. MacIntosh’s outstanding protegés, Dr. John C. Cameron, who spent many an evening with Dr. Mac in Hart House, joined him on staff in the AIC in 1981.

Dr. MacIntosh retired from active duty at the clinic in 1984, and Dr. Cameron was then the only physician/surgeon at the clinic. He decided to ask Dr. Doug Richards, who was at Health Service, and was the team doctor for the Varsity Blues Men’s Ice Hockey team, to join the clinic staff for 2 or 3 evenings per week.

In the late 1980’s, a motion was passed by DAR Council recommending that the clinic be renamed in Dr. MacIntosh’s honour. This was eventually passed on the UA Board, and the clinic was officially renamed in 1980.
In 1990, the DAR hired Doug Richards directly to work in and manage the clinic. Up until that time, the medical staff were paid by Health Service, and seconded to work in the clinic. A financial arrangement between DAR and Health Service allowed OHIP revenue generated by the Health Services' doctors to offset the cost of their salaries and that of a physiotherapist who accompanied them to the clinic in the evenings.

Over the next eight years, with the direct operation of the clinic by DAR/FPEH, the scope of the service was greatly expanded. Hours of operation were extended, massage therapy and chiropractic were added to the services provided, and the athletic and physical therapy staff were increased.

Between 1989 and 1998, the clinic's services to AC members has increased from 5,000 client-services per year to approximately 18,000. This has been accomplished with less than twice the original amount of subsidy through athletic fees, reducing the subsidy-per-service by almost 50% while providing more than 3 times as many services.

In 1990, the DAR committed to expansion of the clinic, which would involve either relocation or renovation of the basement of the Stevens building. It quickly became clear that many other aspects of the facility required renovation, and a Facility Development Team was struck to look at overall renovation plans, of which the clinic's expansion would be a part. This team quickly identified equalisation and renovation of women's and men's lockers as the top priority. Through a long process chronicled elsewhere, we have successfully renovated the lockers, and eagerly anticipate the next phase(s) of the overall renovation of the Athletics and Physical Education Centre.

In January 1996, Dr. Richards requested of DAR Management that a formal review of the clinic’s operations be initiated. This resulted in a Task Force on DAR (now FPEH) Health Services, which is about to recommence the task.

Adapted from a source provided by D. Richards, August 2000.
Appendix VI (i):

University of Toronto  
Faculty of Physical Education and Health  
Informed Consent

Project Title: Healing the Body in the Culture of Risk, Pain and Injury: The Paradox of Injury in Competitive Intercollegiate Sport within the Canadian Sport Medicine Delivery System

Investigator: Parissa Safai  
Supervisor: Prof. Peter Donnelly

The purpose of this research is to investigate how sport medicine physicians and therapists negotiate with varsity athletes when dealing with injury, pain or risk. The participant will be interviewed for approximately 60 - 90 minutes, where they will be asked questions regarding their opinions, experiences and thoughts on this subject. All interviews will be taped, however the names of the participants will not be recorded. Only the investigator and supervisor will have access to the tapes, and at the completion of the study, tapes will be destroyed. Any quotations used in the research paper will be anonymous, and descriptions of any events that are likely to reveal the identity of participants and/or other individuals will be disguised. If the participant experiences any distress brought upon by the information they disclose during the course of the interview, they will have the option of terminating the interview. This research will form the basis for development of discussion and recommendations intended to guide clinician-athlete negotiations.

This is to certify that I, ________________________________ agree to take part as a volunteer in this project on the condition of confidentiality. I understand the data will be kept in strict confidentiality by the researcher and her supervisor. However, I understand that if there is any mention of unethical and harmful situations, the researcher is obligated to pass along the details to her supervisor for further review. I understand the potential risks, and feel comfortable with them. I give permission to be interviewed and recorded on tape. I understand that I can view a copy of my transcripts, and at the completion of the research the tapes will be destroyed. I understand that the research may be published, but that my name will not be attached to the study. I understand that I have the right to refrain from answering any of the questions posed, and I can terminate the interview at any time at my discretion. Likewise, I am aware that I can choose to withdraw from the study at any time with no penalty and without consequence to the provision of health care/rehabilitation.

I have been given the opportunity to ask any questions that I see fit and all have been answered to my satisfaction. I have been offered a copy of this form to keep.

Participant  
Witness  
Researcher

Date  ___________________________
Appendix VI (ii):

University of Toronto
Faculty of Physical Education and Health
Informed Consent

Project Title: Healing the Body in the Culture of Risk, Pain and Injury: The Paradox of Injury in Competitive Intercollegiate Sport within the Canadian Sport Medicine Delivery System

Investigator: Parissa Safai
Supervisor: Prof. Peter Donnelly

The purpose of this research is to investigate how sport medicine physicians and therapists negotiate with varsity athletes when dealing with injury, pain or risk. The participant will be part of a focus group for approximately 60 - 90 minutes, where they will be asked questions regarding their opinions, experiences and thoughts on this subject. All focus groups will be taped, however the names of the participants will not be recorded. Only the investigator and supervisor will have access to the tapes, and at the completion of the study, tapes will be destroyed. Any quotations used in the research paper will be anonymous, and descriptions of any events that are likely to reveal the identity of participants and/or other individuals will be disguised. If the participant experiences any distress brought upon by the information they disclose during the course of the interview, they will have the option of terminating their involvement in the focus group. This research will form the basis for development of discussion and recommendations intended to guide clinician-athlete negotiations.

This is to certify that I, __________________________________ agree to take part as a volunteer in this project on the condition of confidentiality. I understand the data will be kept in strict confidentiality by the researcher and her supervisor. However, I understand that if there is any mention of unethical and harmful situations, the researcher is obligated to pass along the details to her supervisor for further review. I understand the potential risks, and feel comfortable with them. I give permission to be part of the focus group and recorded on tape. I understand that I can view a copy of my transcripts, and at the completion of the research the tapes will be destroyed. I understand that the research may be published, but that my name will not be attached to the study. I understand that I have the right to refrain from answering any of the questions posed, and I can terminate my involvement in the focus group at any time at my discretion. Likewise, I am aware that I can choose to withdraw from the study at any time with no penalty and without consequence to the provision of health care/rehabilitation.

I have been given the opportunity to ask any questions that I see fit and all have been answered to my satisfaction. I have been offered a copy of this form to keep.

Participant ___________________________ Witness ___________________________ Researcher ___________________________
Date ___________________________
Clinician Interview Guide
[Follow-up questions represent sample ‘probes’ and ‘examples’]

Demographic and background material: Who they are; their professions; their work status (i.e., FT/PT); what teams they are affiliated with, if any; what are their personal sport background/ experiences; why sport medicine as a career

Negotiations with Athletes:
- What was the worst injury you ever had to treat, or heard about? [How did you handle it?]
- Have you ever had to treat ‘problem’ athletes? [e.g., athletes who avoid clinicians or treatment, athletes who are in denial regarding their injury, athletes who do not comply with treatment] [How did you deal with them? What were the circumstances for your involvement?]
- Under what circumstances do athletes try to change what you prescribe as treatment? [e.g., last game of career, play-offs, last game of career] Under what circumstance would you ‘give in’ to their requests? [Describe a ‘typical’ negotiation with an athlete]
- Has the nature of the sport, or type of athletes who plays in that particular type of sport affected the way you deal with the patient or how a patient deals with you? How? Why?

Negotiations with Coaches:
- Have you ever had to deal with ‘difficult’ coaches? [What were the circumstances? What were the consequences?]
- Have you ever dealt with ‘supportive’ coaches? [How did these situations differ? What were the circumstances?]
- Under what circumstances do the philosophies/actions of the coach interfere with your work as the medical personnel?
- Does the nature of the sport make a difference in coaches’ attitude towards you?
- Does the nature of the injury (i.e., severe acute trauma vs. chronic injury) affect how you deal with the coaches? [Under what circumstances (e.g., last game of career, play-offs, last game of career), would you ‘give in’ to a coach’s request to keep a player in the game?]

Negotiations with Other Clinicians and Administration:
- Does the nature of the faculty and its structure affect the way the clinic works, and/or how the staff interacts?
- How does education (whether it is working with scholar-athletes or being in an environment that stresses education) affect your work as a medical clinician in intercollegiate sport?
- Do you have any recommendations for transforming how athletes deal with pain and injury?
- Do you have any recommendations for how clinicians should negotiate with patient-athletes?
Appendix VIII:

Patient-Athlete Interview Guide
[Follow-up questions represent sample ‘probes’ and ‘examples’]

Demographic and background material: Who they are; what team they play for; how long they have been playing and what levels; what are their personal sport experiences

Personal Injury Experiences:
- What was your worst injury experience, or what have been the worst injury stories you have heard/seen?
- How did you recover from the injury? [Were drugs, surgery, rehabilitation required? How long did it take? Who did you see for treatment? What did they prescribe?]
- What were your immediate reactions to being injured? [How did you feel at the time?]
- Rather than the physical effects, how did the injury affect your emotional side? [Did it affect your personality, the way you think about yourself, or your relationship with other people?]

Negotiations with Clinicians:
- How did the injury affect your relationships with the clinicians? [How did the clinician deal with you as a patient and an athlete? Did they understand your situation? What did they say? What did they do?]
- Do you think you would have received different treatment or been treated a difference way if you weren’t a varsity athlete?
- When you were injured, did you try to modify the treatment/rehabilitation prescribed to you by the clinicians? [What did you do? Why?]
- If you had a chronic injury, under what circumstances would you decide to see a sport medicine clinician when injured? [Why? When? (e.g., start of season, playoffs, final, etc.)]
- Have you ever hidden an injury or downplayed its seriousness from a clinician? [When? Why?]

Negotiations with Coaches:
- What is your coach’s philosophy towards pain and injury? [Do they say anything out in the open to the team or is it an ‘unspoken rule’? Why?]
- If you’re injured, how do you act around your coach? [Why?]
- How does your coach interact with the clinicians (e.g., support them or resist them)? [When? Why? Does that make a difference in how you deal with the clinician?]

Discussion of Team and/or Sport Philosophy:
- Is there a team philosophy about pain and injury [(e.g., “are you hurt or are you injured?”)]
  How does the team know about it? When does it come out? Why?]
- Is there a team philosophy about sport medicine clinicians [(e.g., “don’t tell [clinician] because they will pull you out of the practice/game/season”)] How does the team know about it? When does it come out? Why?]
- Does the nature of the sport (non-contact/contact/collision) make a difference in how you respond to pain/injury, or how you suppose to respond to pain or injury? How? Why?]
Appendix IX:

Focus Group General Question Areas

Demographic Background and Introductions: who they are; what sport and for how long, etc.

Experiences of Injury and Pain:
Examples:
- Worst injuries (personal, other people, athletes) and/or rehabilitation experiences
- Stories they have heard about serious injuries
- What sport medicine clinicians were involved and nature of their involvement

Overconformity and The Sport Ethic:
Examples:
- Athletes’ philosophies regarding pain and injury (e.g., “are you hurt or injured”, “suck it up”, being honest about injury, etc.) Why?
- Discussion of factors that come into effect regarding pain and injury, e.g.:
- Importance of timing in season (start of season, playoffs, finals)
- Ability to play through pain (i.e., can it be covered-up effectively)
- Importance and need to be part of team at all costs
- Coaches’ philosophies regarding pain and injury (e.g., explicit messages vs. implicit messages on pain and injury tolerance, etc.). Why?
- What would coach do if s/he suspected or believed an athlete was injured? Examples?
- Discussion of factors that come into effect regarding pain and injury, e.g.:
- Importance of timing in season (start of season, playoffs, finals)
- Position played and need for that particular athlete (i.e. star vs. 2nd string)

Negotiations with clinicians:
Examples:
- Athletes:
  - Under what circumstances would you see a clinician when injured, and why?
  - Why would you not see a clinician?
  - Under what conditions would you modify treatment, and why?

- Coaches:
  - Under what circumstances would you consult with a clinician on an athlete’s condition, and why?
  - Under what circumstances would you support or resist a clinician’s proposed course of treatment, and why?