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Repairing the Athletic Body

Treatments, Practices and Ethics

During the 1988 Seoul Olympics the British middle-distance runner Peter Elliott sustained an injury to his groin. In order for him to continue competing at the Games he was given a cortisone injection before each subsequent race. Even though he could now race, it meant that the injury would be exacerbated and it would eventually keep him out of athletics for more than a year. For Elliott the knowledge of the consequences of this injury was compensated with the silver medal that he won in the 1,500 metres.¹ The case in point highlighted not only some of the dilemmas that athletes faced regarding injuries, particularly how far can they push their bodies before they sustain serious injury but also that essentially elite sport is about excess rather than the cultivation of a healthy body. The bodies of professional sportsmen and women have a limited amount of ‘athletic capital’ that allows them to compete for a certain number of years. Any ‘athletic death’ is not only conditioned by the ageing process but also by the wear and tear inflicted on them through training and competition. ‘Body management’, therefore, and the recovery from both minor and serious injuries has been a crucial and accepted part of an athlete’s working life. These demands further highlighted the unique needs of this particular patient – the athlete – and the difficulties of the medical profession in treating them. George Sheehan, an American cardiologist and a runner who wrote a training book on the subject, believed that ‘the athlete is medicine’s most difficult patient’. He mused that:

Physicians who handle emergencies with *éclat*, who drive fearlessly into abdomens for bleeding aneurysms, who think nothing of managing cardiac arrest and heart failure, who miraculously reassemble accident victims, are helpless when confronted with an ailing athlete. They are even less able to counsel the athlete and [answer] his never-ending questions about health.²

Whereas the previous two chapters concentrated on enhancement, here we are more concerned with the enabling of athletic performance; how the day-to-day practices concerning injuries and their treatment have developed. As a site for medicine, sport has operated outside the control of the medical profession, if not the influence of medical professionals. Instead, individual sports have developed their own medical sub-cultures. Not only has this been evident in

the treatments and practices that athletes have experienced but also through the particular tensions that have revolved around the ethics of the practitioner-patient relationship within elite sport.

In conjunction with the sporting medical sub-culture that athletes have inhabited, we can also see the treatment of athletes' injuries in light of the shifting boundaries between orthodox and alternative medicine since the nineteenth century. In essence, since the nineteenth century, medical orthodoxy has been based on its political legitimacy while alternative medicine has been demarcated in terms of its political marginality. As Saks has argued, definitions of both are relative to their political importance and not necessarily 'objectively derived from the "scientific" or "non-scientific" status of the knowledge involved'.³ For example, the dismissal by doctors of some treatments as 'quack remedies' reflected the on-going professionalization of medicine as the medical profession attempted to marginalize 'alternative' practitioners. Alternative medicine had not officially existed in Britain before orthodox medicine came into being with the 1858 Medical Registration Act. As a consequence, herbalists, midwife-healers, bonesetters and others competed for custom with physicians, surgeons and apothecaries in an open market. Until then there was no national unified, enforceable legal monopoly of medicine despite the existence of various organizations for physicians, surgeons and apothecaries. Even after 1858 the market did not disappear. While in some European countries the doctor was under direct state bureaucratic control, in Britain there was a 'modified free field'. By contrast, the demand for the services of alternative healers in America, especially osteopaths, has been greater, reflecting the lack of a national health service and also a more liberal medical marketplace.⁴ The medical profession in Britain had been granted the right to self-regulate but the government did not award it a legal monopoly as alternative/unorthodox healers were still allowed to practice under the common law. However, it was now illegal for these practitioners to claim that they had any medical qualifications they did not possess. Instead, a *de facto* monopoly emerged that put alternative practitioners at a competitive disadvantage. In addition, specialization within medicine was not an inevitable process. Instead, it was a political one with each specialty struggling with one another in the pursuit of state recognition and funding.⁵ These tensions have also been evident in sport's medical marketplace.

As with the training of athletes, early methods for the treatment of injuries were initially carried out by trainers and coaches. They usually had little formal medical training and used popular forms of medicine to treat minor ailments.⁶ For corns and bunions, leeches could be applied to the feet while, following a couple of days of rest, the treatment of strains and bruises involved rubbing the injured area frequently with spirit embrocation, and then holding the leg under a cold water tap for as long and as often as could be tolerated.⁷ Boxing trainers, many of whom were former fighters themselves and predominantly from working class backgrounds, similarly used traditional methods that persisted

deep into the twentieth century. In preparation for fights, for example, trainers would 'pickle' the faces and fists of boxers to harden the skin against blows to prevent cuts.⁸ A common remedy for black eyes was the application of raw steak while to treat a boxer's cauliflower ear one trainer would 'bind a freshly roasted white mouse tightly over it'.⁹ During fights trainers used a variety of substances, some that doctors might have termed 'quack remedies', such as cow dung, spiders' webs, tannic acid and nitric acid, to stem the blood from cuts that boxers had suffered.¹⁰

In 1920s America the trainers of college football teams were from similar backgrounds to those in Britain. It was claimed that the trainer's role lacked definition because of the growing importance of the coach in the sport and they had been reduced to minor duties such as tending equipment as well as providing medical care under the direction of the team physician. The Carnegie report on *American College Athletics* noted that few trainers had 'any scientific training' and that 'tradition, superstition and prejudice have usurped the place that should be filled by scientific reason and knowledge'. It was said that,

the trainer's locker has become a quack cabinet overflowing with proprietary ointments, liniments, and washes, and his quarters a museum of old and new appliances for applying heat, water, light, massage, and electricity.¹¹

Sports medicine has also been shaped by national cultures and attitudes to medicine more generally. In Irish sport, for example, the tradition of alternative practices has persisted. For example, Billy Ritchie, the trainer of Glentoran FC in east Belfast, was a bonesetter and ran a successful sports injury clinic from his home.¹² Ossie Bennett, a self-taught masseur, worked with many GAA teams and athletes while Dan O'Neill was a farmer who also ran a busy bonesetting clinic. His clients included both athletes and animals.¹³ Sean Boylan, a manager in Gaelic football, was also a practicing herbalist. He was manager of Meath for twenty-three years and used various herbal remedies for the alleviation of players' muscle fatigue and other ailments. In 1988, a week before the All-Ireland Final replay, one player, Liam Harnan broke a bone in his shoulder. After applying a comfrey poultice and some physiotherapy, he was able to play without any injection.¹⁴

The British football trainer

One of sports medicine's most emblematic images has been that of the football trainer running on the field to treat a player with his so-called magic sponge.¹⁵ More than any other role, the football trainer has highlighted both developments in the treatment of athletes and the management of injuries. It also provides an insight into the history of the relationship between sport and medicine, especially with regard to physiotherapy, as well as on-going tensions

between orthodox medicine and alternative practices. While the image of the football trainer with his bucket and magic sponge has been both mythologized and derided, it is important to put his role into context. Football clubs were professional and commercial operations and generally sought the best available medical care for their players. However, the demand for medical care was also shaped by firstly, football's production process, which in turn was largely a product of the changing nature of the game's commercialization; and secondly, a footballing sub-culture that in Britain has been built on a practical tradition, placing the virtues of experience over those of qualified expertise.¹⁶

A demand for football trainers had emerged after the FA had legalized professionalism in 1885. Initially, there were limited ideas on what comprised training for footballers and the first generation of football trainers was largely made up of ex-professional athletes and athletic and rowing trainers.¹⁷ Their job was initially divided up into a number of duties: day-to-day responsibility of the players; getting players fit; and treating their injuries. The only organization that offered training that would have been any use to a football trainer was the Society of Trained Masseuses, formed in 1894.¹⁸ Massage had been part of the British medical scene for many centuries but in the late Victorian period it had enjoyed a revival. Heggie has argued that this revival reflected wider trends in modernity and massage was part of the uptake of 'scientific' training and medical treatment.¹⁹ However, the Society was dominated by women and given the masculine nature of football it was unlikely that clubs would employ qualified female masseuses.²⁰ Athletic coaches in Britain, such as Harry Andrews and Sam Mussabini, were fulsome in their praise of massage's 'health-giving' qualities. Massage for athletes was also widespread in America and Australia. In addition, highlighting the huge trade in 'quack remedies' during this period, a niche market for massage liniments, herbal potions, patent pills and tonics opened up and was directed in part at the sporting world.²¹ In 1899, for example, it was claimed that every side that had won the FA Cup since 1893 had used Gratton's Embrocation.²² Although football and athletic trainers shared similar medical techniques, the Society of Trained Masseuses showed little interest in their work or recruiting them. Instead, it had been too concerned about establishing the Society's own professional credentials.²³

During the inter-war years the trainer began to take on a more physiotherapeutic role. In one newspaper article under the headline, 'Diplomat and Psychologist', it was said that a trainer 'must be a masseur [and] conversant with every form of modern electrical device'.²⁴ While massage was still part of the job, this change owed something to the legacy of physiotherapy from the First World War. Physiotherapy had enjoyed a 'good war', mainly because of the rehabilitation of disabled soldiers through physical therapy that placed an emphasis on active treatment.²⁵ The attitudes of the medical profession to physiotherapy began to shift and many orthodox practitioners had gradually come to accept its benefits. Physical medicine had also emerged as a specialty

amongst some doctors and there had been a move towards the use of electrical treatments. However, physiotherapy itself continued to occupy a subordinate status within medicine.²⁶ A larger body of expertise on the treatment of injuries had emerged during the inter-war years that incorporated physiotherapy. Dr Charles Heald, an advocate of physiotherapy and also the physician in charge of the electro-therapeutic department at the Royal Free Hospital, wrote a pioneering book entitled, *Injuries and Sport: A General Guide for the Practitioner*.²⁷ In addition, the surgeon, William Eldon Tucker, contributed an essay on 'Athletic Injuries' to *The British Encyclopaedia of Medical Practice*.²⁸ In the late 1930s the Football Association published its first coaching manual, which contained a chapter on the treatment of injuries.²⁹

During the inter-war period most football trainers came from the first generation of former players. Some had also gained medical experience during the war³⁰ and by 1938 it was claimed that the medical knowledge of a growing number of trainers was supported by diplomas in massage and physical instruction.³¹ The most famous trainer during the inter-war years was Tom Whittaker of Arsenal, then the most successful and modern club in England. After retiring from the game through injury in 1925, he was sent by the club 'to take a course of lessons' under the tutelage of Sir Robert Jones, the pioneering orthopaedic surgeon, in which he studied 'anatomy, massage, medical gymnastics and electrical therapy'. Whittaker was later the regular trainer for the England team.³²

Because they were now insured employees under the 1906 Workmen's Compensation Act (see Chapter 2), the medical care offered by clubs exhibited the characteristics of occupational health.³³ The bigger clubs, unsurprisingly, were able to afford the best medical facilities. Up to 1914 Aston Villa was the wealthiest club in the land and in that year it outlined proposals to build 'a special room for the doctor' to be fitted up with 'X-rays, radium and other modern appliances'.³⁴ The growing use of electro-medical apparatus, such as sunlamps, reflected how clubs were employing a more scientific approach to treating injuries.³⁵ Electrotherapy, hydrotherapy and exercise machines were the fashion at first, followed by the use of ultraviolet light treatment.³⁶ These new methods were employed in combination with what could be termed more traditional applications. One treatment for pulled muscles was for players to sit all afternoon with towels over their legs and pour boiling water over the towels. These types of practices continued after 1945. One player has described how during the 1950s he sustained a twisted ankle and had to keep dipping the ankle into a wax bath until it had a thick coating.³⁷

Paradoxically perhaps, while there had been a shift to more modern methods, it was during these years that the image and mystique of the football trainer and the magic sponge became firmly established, usually via the press, in the popular consciousness. The perception that was created had begun to raise concerns among mainstream physiotherapists who were then trying to

establish their own medical credibility and professional credentials. J.W. Mowles complained that the lay press were conveying to the public an image that 'trainers are great experts in dealing with all forms of injury at sport'. He particularly singled out 'the use of the magical wet sponge by trainers when dealing with injuries on the field of play; following its application, many players apparently helpless and crippled by injury are cured in a matter of seconds'.³⁸

Following the Second World War a growing, if small, number of football clubs began to hire qualified physiotherapists. Gradually, 'physiotherapist' began to replace 'trainer' as the term for the practitioner who dealt with players' injuries, although 'trainer' was still in use in the 1980s. In 1953 it was claimed that 7 out of the 92 Football League clubs had a physiotherapist.³⁹ An FA survey in 1961–2 revealed that 12 out of 45 clubs employed full-time qualified physiotherapists – or remedial gymnasts – with another 11 employed on a part-time basis; there were none at all at the 22 other clubs.⁴⁰ Moreover, with the expansion in coaching there was a growing division of labour within football clubs as coaches had responsibility for players on the training ground while the treatment room was the trainer's domain. Different attitudes to sports medicine within the sport had been underlined with the abolition of football's maximum wage in 1961 and the modification of its retain and transfer system two years later. The subsequent rise in transfer fees and wages saw players become increasingly valuable assets. These events accelerated commercialization within the game as well as stimulating the emergence of a football technocracy in which qualifications in coaching and medicine gained in importance.⁴¹ From the 1950s through to the 1970s *FA News*, an in-house journal, regularly published articles on the treatment of injuries as well as advertising products like ultrasonic therapy machines.

Moreover, there was an influx of trainers now with a background in remedial gymnastics. The establishment of the School of Remedial Gymnastics at Pinderfields Hospital in Wakefield acted as a *de facto* training school for future football club physiotherapists.⁴² The college's first two principals, John Colson and William Armour, wrote a sports medicine text, *Sports Injuries and Their Treatment*,⁴³ while Armour ran the FA's treatment of injury course. The initial in-take at Pinderfields of 115 men formed the nucleus of the Society of Remedial Gymnasts.⁴⁴ They brought new approaches to handling footballers' injuries, which highlighted developments within physiotherapy more generally. Remedial gymnastics had largely been a product of the war and placed an emphasis on exercise-based methods for rehabilitation, especially for injured servicemen, amputees and paraplegics.⁴⁵ Remedial gymnasts brought a more active form of treatment for footballers' injuries. Similar developments were taking place in America as a number of athletic trainers became involved in 'corrective therapy' during the 1940s.⁴⁶ It signalled a shift away from the previous machine-oriented approach of those physiotherapists who were members of the Chartered Society of Physiotherapists. Importantly,

because of the physical nature of this technique, it was better suited to men than women.⁴⁷ Moreover, since William Armour was running the FA course, football trainers gained some knowledge of remedial gymnastics. Norman Pilgrim, Coventry City's physiotherapist from 1964 to 1974, had 'never [been] a great lover of electro-therapy'. He had trained under James Cyriax, a pioneer in manipulation,⁴⁸ and felt that treatment for sports injuries should be concerned with good manual techniques and the management of the injury's natural progress. Pilgrim also felt that too many trainers viewed ultra-sound machines and heat lamps as a panacea for all football injuries,⁴⁹ something that perhaps reflected a more general misplaced optimism in 'progress' and modernity in the post-war era. New techniques did continue to coexist with older practices such as the tradition where players, whatever the injury, had to attend a club's treatment room on Sunday mornings, mainly because 'something must be seen to be done'.⁵⁰

After the war there was a gradual if uneven incorporation of professional medical practices in football through the growing employment of qualified physiotherapists. With its recognition by the state under the Professions Supplementary to Medicine Act of 1960,⁵¹ physiotherapy had not only gained more credibility but it also gave further impetus in football to professionalize the marginalized role – in medical terms – of the football trainer. Moreover, through the growth in alternative medicine and growing criticism of the medical profession and biomedicine, there was a move towards greater consumer choice in medicine as people, including footballers, became more discerning and critical of the treatment they received.⁵² Ironically, by the early 1990s there was a move by alternative and unorthodox practitioners themselves towards professionalization and this allowed alternative medicine to initiate a process of 'exclusionary closure'.⁵³

The FA had actually started courses for trainers in the 1930s, although attendance was not compulsory.⁵⁴ By 1961–2, while 32 club trainers had attended the trainers' course, 11 others had not.⁵⁵ In 1958, in an attempt to improve the standard of care for footballers, the FA had decided to offer – rather than make compulsory – a three-year course leading to an 'FA Certificate in the Treatment of Injuries'.⁵⁶ It was hoped that the certificate would be recognized as a minimum qualification for trainers and 32 candidates enrolled on the three-year course in that year.⁵⁷ However, clubs fiercely protected their independence and did not want to appoint from a limited number of candidates imposed on them.⁵⁸ Personal contacts within football remained the main method of appointment for trainers.

Physiotherapy itself had been subject to an increasing professionalization through the formation of clinical interest groups. One of the earliest groups was the Committee for Research into the Treatment of Athletic Injuries, set up in 1949. The interest group, however, had little success in its aim of encouraging

sports teams to employ only chartered physiotherapists. By 1979 there was a total of 14 clinical groups within the CSP, rising to 25 ten years later. One of them, the Association of Chartered Physiotherapists in Sports Medicine (ACPSM) was formed in 1973 and viewed itself as being in direct competition with football trainers. In 1979 it had 275 members and a year earlier it had secured a place on the committee of BASM. In 1980 ACPSM members, in the style of a professional organization trying to establish a monopoly, campaigned to protect its title in the face of unqualified rivals like the 'sponge-and-bucket' men of the football world 'who were physiotherapists to the press'. The membership of the ACPSM had risen to 630 by 1989, highlighting how sports medicine was more generally becoming a growth area.⁵⁹

Some of the severest critics of non-chartered practitioners were actually chartered physiotherapists working in the game.⁶⁰ In 1982 Vernon Edwards, then doctor to the England football team, also commented,

The key person is the physio, but many have very little training ... I get anxious when non-qualified people dish out drugs like sweets to deal with aches and pains. It's amazing how few teams have anyone even trained in first aid. Injuries are sometimes treated by someone totally unqualified.⁶¹

This suggested that in spite of the change towards a more professional approach, football's amateur and voluntary traditions continued to linger. An FA medical committee, for example, had not been formally established until 1983, and even then its role was limited. Practical realities also meant that many in football considered those with experience of treating footballers' injuries were just as suitably qualified as chartered physiotherapists. In addition, like football club doctors (see Chapter 3) the pool of chartered physiotherapists with an expertise in sports medicine was limited. It probably meant that some 'old-style' trainers had more knowledge when it came to treating particular football injuries. Furthermore, it was argued within the football world that GPs did not have the experience of the bone and muscle injuries suffered in football and that the treatment they usually offered – strap it up and rest it for several days or weeks – did not match the demands of a professional sport in which clubs wanted players back playing as soon as possible.⁶²

Clubs, therefore, were still reluctant to surrender control over whom they could employ. Even in 2001 Alan Hodson, the head of the FA's Medical Education Centre, admitted that the FA had no control over who football clubs could employ.⁶³ As a result, the appointment of physiotherapists during this period continued to be through football's 'old boy network' and often in the gift of the manager.⁶⁴ While football club physiotherapists had professionalized the role, working conditions probably remained unattractive to women who made up the vast majority of chartered physiotherapists.⁶⁵ Amanda Johnson was one of the earliest female chartered physiotherapists to work in professional football

when she was recruited by Bury in 1989.⁶⁶ For male or female physiotherapists alike the job could be difficult. Johnson identified:

the virtual seven day week isolation from August to the end of May, the isolation from other professionals, the lack of appreciation and the fact that you are at the whim of a manager whose mood depends on the team's last performance. There is also the danger that, in the eyes of your fellow professionals, your job is of little importance in the real world and that your career is put on hold whilst you are employed by the club.⁶⁷

In addition, because of the volatile nature of football, reflected by an increase in managerial turnover, the physiotherapist's job also became more insecure. Laurie Brown was sacked in 1981 because Manchester United's new manager, Ron Atkinson, wanted to bring in his own staff. This was becoming increasingly common and Brown's successor was actually less qualified than he had been.⁶⁸ With the establishment of its Medical Education Centre in 1989, however, the FA's approach began to take a more professional approach. By 2001–2002 the Premiership and Football League demanded that all newly appointed senior physiotherapists had to be chartered. From 2003–2004 they were also required to hold the FA's post-graduate diploma in sports medicine.⁶⁹

Sports medicine practices

In addition to medics attached to sporting organizations, such as trainers and physiotherapists, a variety of practitioners offered specialist expertise, knowledge and services regarding athletes' injuries. It also highlighted the holistic nature of sports medicine because anyone with an appropriate medical qualification – what constituted appropriate was sometimes debatable – could claim an expertise in sports medicine.

The treatment of injuries and the services required naturally varied according to the severity of the injury. While in football much of this treatment was given in-house through the trainer, clubs did call on other services, such as ambulances and hospitals, when they were needed. As far as operations were concerned, there was initially limited expertise or knowledge of injuries commonly sustained by footballers, in particular, cartilage operations, and perhaps just as important, post-operative care. The first known cartilage operation, or meniscectomy, had been performed in 1883.⁷⁰ Even up to the 1930s it was one that footballers were loathe to undergo as it could signal the end of their careers.⁷¹ Some surgeons advertised themselves as specialists in football injuries. It was claimed that J. Ward, who practiced in both Bolton and Manchester, was 'England's greatest bloodless surgeon' and had cured footballers of loose cartilage and fluid on the knee, conditions that other doctors had pronounced incurable.⁷² By the 1930s West Bromwich Albion sent

their players for cartilage operations to a Newcastle surgeon, a Mr. Stewart, 'an authority on knee troubles'.⁷³ An American pioneer was Robert Hyland. Hyland acted as the team doctor for baseball's St. Louis Browns between 1914 and 1950 on a voluntary basis. He had trained as a surgeon and through his reputation athletes from all around the country, including Ty Cobb and Babe Ruth, visited his clinic.⁷⁴

Probably the earliest example of a sports injuries clinic, which offered athletes specialist treatment for sports injuries, was John Allison's 'Footballers' Hospital'. Initially a hydropathic baths, it was based at Matlock House, Hyde Road in Manchester.⁷⁵ Allison was a director of Manchester City and a Liberal councillor. For around twenty years, from the mid 1890s, many football clubs as well as Northern Union rugby clubs sent their players there for the treatment of leg and knee injuries. In general the image of hospitals had been changing from the mid-nineteenth century. A rise in outpatient demand saw a growth in hospital services outside the voluntary sector with more specialist hospitals created. Allison's hospital was part of this trend and surgery was part of the service, although the hospital was mainly used for rehabilitation purposes.⁷⁶ The resident surgeon at Matlock House was Walter Whitehead, who it was claimed had performed hundreds of operations on footballers, including those on cartilages. He also helped to devise machines to expedite recovery.⁷⁷ The hospital at one stage employed several nurses along with a retired Army surgeon, John J O'Reilly. Matlock House closed down after the First World War and there was no replacement.⁷⁸ Of course, many of the sporting injuries and conditions that were treated were relatively unremarkable in a medical sense. However, medics offered not only expertise for certain injuries that athletes suffered regularly, such as hamstring strains and cartilage problems, but also specific rehabilitation programmes as well as a more urgent service that the demands of sport dictated.

In England some athletes began to seek expertise about their injuries from football trainers who at least had experience in dealing with them. During the war Charlton Athletic's trainer, Jimmy Trotter, was able to use the club's electrical equipment to treat private patients.⁷⁹ Because of his and Arsenal's reputation Tom Whittaker had also run an informal sports injury clinic at their Highbury ground. Some of his patients were the tennis players Fred Perry and Bunny Austin, and Whittaker was actually the trainer for the victorious 1936 Davis Cup team. He also treated celebrities and public figures as well as other famous sportsmen. These included the cricketers Jack Hobbs and Douglas Jardine and the jockey Steve Donoghue.⁸⁰

Following the Footballers' Hospital, the next clinic that gained a reputation for treating sports-specific injuries was the Park Street Orthopaedic Clinic in London, which opened in 1936. It was headed by Morgan Smart and Bill (William Eldon) Tucker (1903–91), a former England rugby international forward. Tucker was later its director until 1980 when he retired and a founding

member of BASM, and in 1955 he was co-opted on to the BASM executive.⁸¹ It was said that, based on his experiences as a rugby player, he wanted to offer a medical service to sportsmen in addition to regular patients. His most famous patient was Denis Compton. Compton, who suffered from a persistent knee injury, was England's premier batsman in the early post-war era and had also played football for Arsenal. Tucker regularly treated the knee before removing the knee-cap altogether in 1955, enabling Compton to continue his cricketing career.⁸² Tucker also made himself available at weekends, which was invaluable to elite athletes. On one occasion, after he was called away from a Saturday dinner party, Tucker reset the dislocated shoulder of a jockey, Gay Kindersley, who he had previously operated on.⁸³ Tucker specialized in manipulation. In 1968 the cricketer Tom Cartwright was a patient whose reach, it was claimed, increased three inches following a Tucker massage. On his later visits Tucker gave him butazolidin tablets, which were usually administered to horses, to aid recovery.⁸⁴

The establishment of Tucker's clinic had coincided with a struggle within medicine between orthopaedics and physical medicine and the perceived unorthodox practice of osteopathy over professional status and medical autonomy. Osteopathy, it was claimed, was a holistic system of manipulation but because its treatments were similar it brought it into direct competition with these orthodox specialisms. Orthopaedics had rapidly gained respectability after World War One (see Chapter 3) while physical medicine had been tainted by a perceived association with non-medically trained bone-setters, although its marginal status was bolstered through its growing popularity. Unlike other medical groups, osteopaths did not seek medical patronage and were seen as a threat. There was a backlash in the medical press. It was claimed that osteopathy was not scientific and it was eventually denied state recognition.⁸⁵ In 1963 BASM strongly disapproved of the Golder's Green Athletics Clinic because osteopaths – who were not accepted as BASM members – practiced there.⁸⁶

Athletes were prepared to criss-cross the medical divide to find the treatment that they felt was best for them. From the 1960s footballers were becoming increasingly critical of the medical treatment they received and with the greater scepticism of medicine generally, they began to seek second opinions, including osteopaths. When he was at Manchester United, Denis Law had a long-running knee injury and in 1967 he decided to see an osteopath, which did not go down well with the club doctor and physiotherapist. However, Law found the osteopath's advice and treatment better than at United.⁸⁷ Law, because he was a superstar and confident of his own status, was able to ignore the club's medical advice and use other treatments without any fear of recrimination; players not as valuable and those not as experienced would have – and continue to – faced a different dilemma.⁸⁸

Whereas for much of the twentieth century, osteopathy was a marginal practice in the UK, in the US it had been recognized as a medical specialty

since 1953. As a form of healing it shares similarities with chiropractic approaches, which are based on the idea that manipulation of the spine can relieve pressure on the nerves and thereby alleviate illness and pain. However, tensions have arisen over the status of chiropractors in American sport. In 1990 there were about 25,000 chiropractors in the States (in Britain there were just 350) compared to nearly 600,000 medical doctors (M.D.). Despite being licensed to practice in all fifty states, the American Medical Association (AMA) campaigned vehemently against chiropractors. Again showing how orthodox profession was keen to protect its turf, in 1963 the AMA's Committee on Quackery described chiropractic as an 'unscientific cult' and eight years later the committee's main mission was to eliminate it.⁸⁹ One particularly popular chiropractor, Dr. Leroy Perry, found himself ostracized from American sports teams as a consequence of his profession. His (satisfied) customers included athletes such as Alberto Juantoreno, Henry Rono and Dwight Stones as well as footballers, tennis players and baseball players. Despite a petition signed by several hundred American athletes and coaches before the 1976 Olympics requesting Perry's inclusion on the US Olympic Sports Medicine Committee, it was refused. A similar motion was rejected before the 1980 Olympics. Perry had attended the Montreal Games as a physician for another team and in spite of warnings by their own national medical staff, American athletes continued to visit Perry. Just as noteworthy as the tensions between orthodox and alternative practices was the reliance of athletes on Perry. A hurdler, Dedy Cooper said:

Everybody talks about Dr. Perry. *Everybody*. The first thing athletes ask at a meet is, 'Is Dr. Perry here?' If he's not some won't compete. Other doctors tell you, 'Rest.' Dr Perry fixes you up; he teaches you how to take care of yourself. We want him.⁹⁰

This rather embellished statement reflected how many athletes were and are still very superstitious. What athletes deem to work they usually keep on repeating. To a certain extent it betrays the underlying anxieties of athletes to stay healthy in an environment that revolves around short-termism.

Similarly, because he wanted to see his own specialist, during the 1982 Spain World Cup, England captain Kevin Keegan secretly flew to Hamburg for treatment on a back injury from Jürgen Rehwinkel. Initially, the manager, Ron Greenwood and the team doctor, Vernon Edwards, had refused but Keegan eventually flew to West Germany for treatment that allowed him to (briefly) participate in the tournament.⁹¹

Some forms of treatment have been perhaps more alternative than others. When he was England coach, Glen Hoddle used the services of a faith healer, Eileen Drewery. With headlines such as 'Voodoo Woman', it created a stir as well as cynicism in the media. Hoddle, for whom faith became an important part of his life because of Drewery, had frequently visited her from the age of 18. She had healed a hamstring injury, he claimed, and other subsequent

injuries with her techniques of the laying of her hands on the head and ‘other special centres of the body’ together with the use of ‘absent prayer’. Hoddle claimed that she cured his father of arthritis of the back after just one session and Richard Green, who was told his football career was over, was playing ten years after Drewery treated his back injury. Hoddle had been keen for his England players to see Drewery, and in the lead-up to the 1998 World Cup three quarters of England’s players visited her (Hoddle believed that his biggest regret for England’s World Cup exit was not getting Drewery out to France from the start). He claimed not to put any pressure on the players and that some flew from the north of England and abroad to see her. That players visited Drewery again partly reflects the anxieties of athletes over the fear of injuries and the need for them to be healed quickly, although to what extent those who did were there to please the coach is difficult to gauge. Many who visited Drewery were willing to ‘give it a go’. Tony Adams had suffered from a long-term ankle problem and had visited a number of medics. On his visit, Adams said, ‘I was open-minded about it, believing in taking help wherever I could get it, and was willing for it to work.’⁹² Drewery’s involvement with England ended following Hoddle’s sacking in 1998.

Some athletes have also resorted to homeopathic medicine, which continues to be opposed by elements of the medical profession. One doctor who has built his reputation on this practice has been Hans-Wilhelm Müller-Wohlfahrt. Müller-Wohlfahrt has been the club doctor at Bayern Munich but other athletes he has treated include Roger Black, Paula Radcliffe and Usain Bolt. At one stage in his career the golfer, Jose Maria Olazabal, suffered from rheumatoid arthritis in his feet and was barely able to walk. But following treatment from Müller-Wohlfahrt he won the US Masters again in 1999. Reflecting popular discourse, some of his methods have been deemed controversial. It is claimed that he has used ‘calves blood’ as well as a substance called Hylart that has been extracted from the crest of cockerels, which is said to lubricate knee injuries.⁹³ Reaction to his methods in Britain were mixed. They were criticized by BASEM while one physiotherapist condemned his treatments as ‘highly questionable on moral and ethical grounds’. Terry Moule – an osteopath ironically – added that there were questions over its long-term side-effects. However, Malcolm Brown, the then medical director of UK Athletics, was more relaxed and claimed that Müller-Wohlfahrt was ‘not a crank’. His treatments were actually not dissimilar to the anti-ageing treatments that had been administered in the form of injections of foetal animal cells into the buttocks of celebrities by beauty therapists at Clinique La Prairie in Montreaux since the 1930s. Despite criticism athletes used him because, as Colin Jackson has argued, ‘Athletes are not like normal people. Their bodies don’t function in normal ways. So normal medicine is not always the answer’.⁹⁴

Similarly, in 2009 it was sensationally reported that Liverpool had sent two of its players to Marijana Kovacevic, a ‘mystery horse placenta healer’ in

Serbia with the blessing of the club doctor. Footballers from all over Europe had visited her on the basis of recommendations of other players. Her treatment involved using fluids derived from horse placentas and electrolysis to rub on to the afflicted part of the body; in the case of Arsenal's Robin Van Persie, it was ruptured ankle ligaments. She had become so famous in Serbia that she was signed up by a football agency, no doubt so that the agency's injured players could be sent to her for treatment. In a short critique that echoed on-going debates between orthodox and alternative medicine, the *Independent's* health editor, Jeremy Laurance, argued that Kovacevic's treatment represented 'the triumph of faith over reason, the power of belief over evidence'. In other words, it had the effect of a placebo. Because the treatment would not do any harm – or anything – Laurance believed that team doctors would be unconcerned.⁹⁵

For major operations on joints, however, athletes have stuck firmly to biomedicine. Previously football clubs would use their network of consultants or local hospitals. Through their London connections, Arsenal, in the inter-war years could call on specialist orthopaedic surgeons, although other less wealthy clubs would rely on local hospitals. But with the increase in sport's commercialization, some surgeons gained first, a reputation, and then developed a specialty in operating on athletes. One such knee surgeon has been the American, Richard Steadman from Vail, Colorado. His sports medicine background had originally been in skiing and he claimed to have performed surgery on every US skier to win an Olympic medal between 1978 and 2002. He pioneered 'the microfracture technique' for knee surgery and his reputation has crossed the Atlantic for clients to include players from the National Football League and footballers in Europe. It has been estimated that Steadman earns approximately \$5 million per year. In comparison, sports surgery in Britain remains a fledgling industry with a top surgeon earning about £200,000.⁹⁶

Sports medicine practitioners and ethical dilemmas

One key area that has distinguished sports medicine from 'normal' medical practices has revolved around the fitness of injured athletes. Any relationship between doctor (or other health professional) and patient has been normally underpinned by three fundamental assumptions. First, the doctor's skill is used exclusively on behalf of the patient; second, the doctor is not acting as an agent on behalf of anybody else whose interests may conflict with those of the patient; and third, the doctor may be trusted with private or intimate information which she/he will treat confidentially and not divulge to others.⁹⁷ Because of the nature of sporting competition, authority over when an athlete should return to the field of play – both before and during the contest – has revealed acute ethical dilemmas between sports medics, management, coaches and players due to conflicts of interest and loyalty.

Any discussion of ethics within sports medicine needs to be seen in the context of a progressively more assertive medical profession, which has laid claim to making moral judgements based on their social and professional status. Rather than a neutrally conceived set of morals, the original intention of a code of ethics was political: to separate orthodox medicine from alternative practitioners.⁹⁸ On one hand, Victorian doctors were part of 'gentlemanly medicine', which promoted the values of the social elite; on the other, alternative practitioners were labelled charlatans.⁹⁹ For ethics particular to sports medicine, Waddington has provided a useful framework based on key areas of practice from his case study of professional football in England. The first one revolves around questions of informed consent. The second one is over 'return to play decisions' following injury and associated quality of care issues. The final area concerns issues relating to medical confidentiality.¹⁰⁰

In American football the potential conflict of loyalty of the team doctor has been brought in to sharper focus due to the brutality of the sport as well as its more commercial nature. In his sensationalized account of his time as a doctor at the Los Angeles Raiders (1983–89), Robert Huizenga was critical of the chief team physician, Robert Rosenfeld. Huizenga has suggested that Rosenfeld was acting more on behalf of the wishes of the owner – the megalomaniacal Al Davis – rather than for the health of the players. On occasions when Huizenga felt that players needed further examination before going back on the field to play because of a danger of paralysis, Rosenfeld had said to the player, 'You're okay, it's just a bruise.'¹⁰¹ Interestingly, in 1979 a legal representative for the NFL Player's Association remarked that of the 67 NFL injury grievance cases he had handled the team doctor had been a witness for the club and in opposition to the player in every single one. Where did the doctors' loyalty lie? Dr Bruce Ogilvie, who had worked as a consultant for a number of teams, commented:

It must be one of the most difficult of all medical roles. You can't be a team physician without becoming a red-hot jock yourself. I know for myself. My heart, soul and identification are with these players. The doctor is no different from me in that regard. But that places him in a very difficult position. He has to make judgements on readiness to play, medical treatment, diagnoses in situations of high stress – going down to the wire for the playoffs, going for the championship. In these situations you can't help but be torn.¹⁰²

In American sport more generally the role of the team physician was seen by some doctors as a way to advertise their services in private practice. An orthopaedist was generally the chief team doctor and he could use his position to obtain almost unlimited referrals of joint or muscle problems. In the 1990s orthopaedic operations averaged around \$3–4,000.¹⁰³ Moreover, during the 1990s doctors began to pay NFL teams and other sports franchises to work as team physician because it acted as a form of advertising for their main work. In 1989 the Jewett Orthopaedic Group had supplied the newly formed NBA

franchise, Orlando Magic, with team physicians and in return received arena advertising. The Jewett Group argued that, 'In this [medical] market, there are a lot of orthopaedic surgeons. A lot of them would be willing to be sponsors ... We want the world to know that we do take care of the team.' In 1995 there was a bidding competition to act as the 'official health-care provider' for the Jacksonville Jaguars. For the successful medical group it entailed purchasing luxury executive boxes, advertisements in programmes and donating medical supplies at a cost of around \$1 million.¹⁰⁴ The advertising of these medical wares highlighted more generally how American medicine was more market led when compared to Britain.

Ethical dilemmas have not been absent in English association football either. Medical tensions were brought into sharper focus during the second half of the twentieth century when the manager became a more powerful and dominant figure within clubs.¹⁰⁵ While a number of football doctors have remarked that they have enjoyed good relations with the managers they have worked with, they were also aware that the manager could over-rule their opinion concerning the management of players' injuries.¹⁰⁶ The pressure of games could also influence the judgment of managers over injured players. In 1961, during the half-time interval of one game, the Wolves centre-forward, Ted Farmer, discovered that he was urinating blood after being elbowed in the stomach. Despite an examination by the club doctor the Wolves manager, Stan Cullis, forced Farmer to play on. Cullis told the doctor, very forcefully, 'Wait 'til it comes through his backside before you take him off.' The doctor did not intervene any further.¹⁰⁷ Because they have been players themselves, managers think they know the mentality of players and that injuries or 'knocks' are not as serious as players think. Underpinning this idea is that players have to demonstrate a 'good attitude'.¹⁰⁸ When he was club physician at Leeds United (1961–75), Ian Adams resigned on four separate occasions because of arguments with the manager, Don Revie, over the fitness of players, i.e., Revie played them against Adams' advice.¹⁰⁹ Referring to modern sports medicine, Adams has said,

I wouldn't like to be a full-time [football club] doctor ... I would be very loathe to ... because your family depends on your employment, and I wouldn't like to have to depend upon the hysteria and stuff that's associated with the football club and possibly the change of manager.¹¹⁰

The employment status of the trainer further compounded the power of managers over these 'return to play decisions'. Trainers at English clubs have traditionally been unqualified to work in the NHS (see above) and have been dependent on football and managers as their only source of employment. As a result, a trainer, under pressure because of his employment situation, may have been forced to submit to a manager's demands over when to allow a player recovering from injury to be available for selection. With the increasing number of chartered physiotherapists working in football clubs there has been

greater potential for professional autonomy: if they left football at least they were qualified to work outside the game. However, working in football has also presented a challenge to a chartered physiotherapist's clinical autonomy because managers have still wanted some influence over decisions about the fitness of players.¹¹¹ 'That is the job' was the opinion of Norman Pilgrim, physiotherapist at Coventry City (1964–76). 'The job is standing up to managers; it's a big part of the job. I know people who are technically good at it but their managers just over-rule them all the time.' Pilgrim claimed he did not mind that side of the job, although managers and coaches at other clubs bullied physiotherapists into making the decisions they wanted.¹¹² One chartered physiotherapist, who worked for a First Division club in the 1980s and 1990s, has described how his manager would not even allow him on to the pitch until a senior coach, acting for the manager, had assessed the injury of the player. Another chartered physiotherapist at a First Division club in the 1980s stated that, although he and the club doctor agreed on most things concerning player fitness, the manager always wanted 'star' players to perform.¹¹³ When he was at Manchester United, on occasions Laurie Brown, ingeniously, put injured players in plaster as this sight would immediately dissuade the manager from being able to question his opinion. At other times he discovered that managers and players sought a second opinion on his diagnoses without informing him.¹¹⁴

Bloodgate

On 12 April 2009 the European Rugby Cup quarter-final between Harelquins and Leinster produced one of the most notorious examples of how sport, medicine and ethics do not mix. What was to become known as 'Bloodgate' led not only to a two-year suspension of the Harlequins' physiotherapist and a General Medical Council (GMC) enquiry into the club doctor's conduct but the club's director of rugby, Dean Richards, would receive a three-year ban from the game and the player involved, Tom Williams, was suspended from rugby for one year (reduced to four months on appeal).

During the game Harelquins had been losing and wanted to put on a specialist goal-kicker with only a few minutes to go. However, they had used up all their substitutions and could not replace anyone unless a player had a blood injury. Thus, Williams was pressurized by Richards to fabricate one. During a break in play he was given a blood capsule by the physiotherapist, Steph Brennan – under Richards' instruction – and bit on it to look as if it had been a blood injury i.e., they tried to cheat Leinster out of the game. Williams said that he felt under pressure from Richards who he claimed as coach was a very authoritarian figure. It was later revealed that Harelquins had used this tactic on four previous occasions. The capsules had been purchased from a joke shop to be used for this particular purpose. On this occasion their opponents

became suspicious and another match official also claimed it was fake blood. Williams in desperation then asked the club doctor, Wendy Chapman, to cut his lip with a scalpel for evidence of real blood. For Chapman this went against her medical principles as a doctor her job was to heal not inflict injuries.¹¹⁵

Williams later signed a prepared statement from Richards about the incident and lied to the European Rugby Cup's disciplinary committee when called as a witness (at the first disciplinary committee meeting Williams had been represented by the club's legal team rather than independent lawyers). There were further consequences. Williams intended to appeal against his original ban but was pressurized by the club to only partly disclose so as to limit the damage. The club subsequently admitted that it had breached its duty of care to Williams and offered him financial inducements for his co-operation. Following the resignation of Dean Richards just before the appeal, however, Williams fully disclosed the evidence.¹¹⁶

What were the consequences for Harelquins' medical staff? Chapman, an accident and emergency consultant, also lied to the hearing about her role. She had initially gone with the club's view of events and said that Williams' injury was genuine. She was suspended by the GMC, which described her actions as 'dishonest, likely to bring the profession into disrepute and wholly unacceptable'. The GMC though later allowed her to practice medicine again. For physiotherapist Steph Brennan the consequences were similarly problematic. He had been due to work with the England team but was banned from rugby for two years and so was unable to take up the post. The following year Brennan was struck off by the Health Professions Council for misconduct but won an appeal and instead received a five-year caution.¹¹⁷

However, the incident further highlighted how in sport situations can arise where medical practitioners can be placed in difficult situations that clash with the 'normal' doctor-patient relationship. Instead, this episode highlighted sport's peculiar relationship with medicine. Following the incident James Robson, the Scotland doctor who had accompanied five Lions tours, continued to claim that, 'The overwhelming majority of medical people involved in the care of sports people are underpaid and overworked, they are there for the love of it.'¹¹⁸ Moreover, it also reflected the whole idea of the professional athlete as someone who is essentially 'unhealthy' because of the stresses placed on their bodies, and that this also has had implications for the working practices of medics.

The patient's view

Much of the history of medicine has been written from the perspective of medicine. How have athletes – as patients – reacted to the medical care they have received? This brief section provides some insights into the motivations of athletes as 'abnormal' patients. Paula Radcliffe, for example, has claimed

that her pain threshold has been higher than her husband allowing her to endure more pain in some of her treatment with her physical therapist Gerard Hartmann. He used very deep and penetrative tissue work and massage to stimulate quicker recovery of the injured area. But as Radcliffe stated, 'his patient must be able to withstand a reasonable level of pain'. Her husband, Gary Lough, could not. On one occasion when he watched on while Radcliffe was undergoing intensive treatment, he had to leave due to the distress it was causing her. She said, 'The pain was as bad as anything I had ever experienced when working with Gerard, but I welcomed it.'¹¹⁹

Of course, context again is instructive, especially for footballers. How often footballers have played when injured has differed from player to player and has perhaps been because of their own perceptions of what constituted an injury. Players have had other motivations for playing through injury, such as wanting to take part in an important game. There were other concerns for some. One player once hid an injury because he feared losing his place in the team; another said that he did not want to let his teammates down. Similar sentiments were also expressed by players in the NFL. The main reason though for playing with an injury was financial. A soccer player from the 1960s and 1970s remarked that the 'money in our day was not like today. With a little bonus and appearance money, it was nice to see it in your wages at the end of the month'.

From a small survey of former players covering the period from the 1940s to the 1980s, it seems that most former players were relatively happy with the treatment they received, although this raises questions over the perceptions they had of the treatment they expected and with what they were able to compare it. Some players were more critical. One player from the early post-war years has described how he sustained an injury during a game but after being 'strapped-up' he played on as no substitutes were then allowed.¹²⁰ The strapping was left on even when he had a bath and was not removed until the following morning. It also took his skin off as the trainer had used the wrong side of the tape. The injury was subsequently diagnosed as damage to a cruciate ligament. Someone who played in the 1980s for lower league clubs was critical of the post-operation care he received following an ankle operation and felt this was due to the physiotherapist who was 'inadequately qualified'. A goalkeeper who played during the 1960s and 1970s for clubs throughout the league, though fortunate enough not to sustain any serious injuries, commented that 'physiotherapy didn't seem that sophisticated and attention to injuries on the field seemed clumsy at times – magic sponge and strong smelling salts seemed the answer to most problems!' One player from a top club in the 1970s and 1980s 'felt [that the] medical side was always lacking; physios were lacking knowledge and expertise'.

One particular treatment continues to prove controversial. Cortisone was part of the post-war pharmacological revolution. This particular 'wonder

drug' acted as an anti-inflammatory treatment and was primarily used for rheumatoid arthritis. By the 1950s football clubs were using it to alleviate the injuries of players. Cortisone has the effect of disguising pain for three to four hours, and when injected it was converted into cortisol and influences the nutrition and growth of connective tissues. Its use on players though has varied from doctor to doctor with some refusing outright to inject. In the 1960s their use had been more liberal. Denis Law claimed that at Manchester United he and other players regularly received injections to mask the pain in the short-term; there was little consideration of the long-term consequences.¹²¹ Similarly, Ian St. John was placed in a similar situation when he was at Liverpool.¹²² A greater awareness has developed amongst athletes over the consequences of using cortisone. However, as Martin Roderick has outlined, the dilemmas that doctors and players have faced over the use of cortisone and other anti-inflammatories has continued into the twentieth-first century.¹²³

Legal implications

Because of the sums involved, issues regarding the law and insurance have become more complex for practitioners. One post-war development that did indicate greater interest by football clubs in insurance and legal matters was medical examination of transferred players. These began in Britain during the 1960s although European clubs had introduced them before then. 'Medicals' were a consequence of the rise in transfer fees following the abolition of the maximum wage and more complex insurance arrangements. Although now normal, they are not compulsory nor has there been an established protocol for them or any uniformity between clubs.¹²⁴

Medical examinations for college footballers with intentions of playing in the NFL have taken place at the annual week-long Scouting Combine since the 1982. The Combine includes physical as well as medical evaluations as the main objective is for the team's many coaches and medical staff to sift out the best prospects in preparation for the NFL Draft. Physical tests include a 40-yard dash and bench press repetitions. However, evaluating the health of players has proved problematic, giving a new twist to the doctor-patient relationship. During his interviews of players Robert Huizenga found that players would categorically deny anything was wrong with them. Whereas patients would usually come to his practice and spell out the seriousness of their complaint, at the Combine the patients said nothing and he had to figure out who was lying.¹²⁵

There is no such equivalent in English soccer and perhaps reflects a more scientific tradition within American sport where greater emphasis is placed on statistics. Early medicals in English soccer were routine affairs but gradually became more sophisticated through the use of MRI scans. A doctor and/or

physiotherapist would usually ask the player of any past history of injuries, although unsurprisingly players would sometimes keep information from them as it could prevent the transfer. One of the most famous transfer cancellations because of a player failing a medical was that of Asa Hartford's proposed move from West Bromwich Albion to Leeds United in 1971 for a potential club record fee of £177,000.¹²⁶ It had been found that Hartford had a small hole in his heart, and it was felt by the Leeds medical team that he may have been susceptible to heart failure due to the stress of playing.¹²⁷

The collapse of Ruud van Nistelrooy's transfer from the Dutch club PSV Eindhoven to Manchester United in 2000 highlighted the new financial risks involved in large transfers. The fee had been £18.5 million, then a British record, but was cancelled because of doubts raised over his knee after his medical. Armed with this knowledge, United's insurers had refused to underwrite a policy unless the club agreed to a clause ruling out seeking compensation for any injury resulting from his weakened knee. As a public limited company with shareholders to satisfy, as well as the prospect of paying van Nistelrooy £42,000 per week without playing, the club did not want to take the risk and called off the deal.¹²⁸

One outcome of these increasingly complex relationships has been legal action brought against sports medics and clubs by footballers who feel that they received poor treatment which has led to medical complications. In 1998 the former Sunderland player Keiron Brady sued the club on the grounds of medical negligence. He had argued that the club had failed to take appropriate action when he reported pain in his right leg despite his complaints in training. Later he was diagnosed with a rare medical condition, a blockage of the popliteal artery in his right leg, which eventually curtailed his playing career.¹²⁹ In this case, however, the club was found not to have breached its duty of care to the player.¹³⁰

In American sport legal actions regarding medical care have had a longer history and more expensive outcomes. The first athlete to sue the medical staff of a team was Dick Butkus in 1974. He successfully sued the doctors of the Chicago Bears over repeated injections of cortisone and other drugs to his knees and was awarded \$600,000.¹³¹ After his playing career ended in 1987 Kenny Easley sued the Seattle Seahawks' trainer and team doctors for what he said was an overuse of Advil that exacerbated his kidney disease and led to total kidney failure. The case was settled out of court. In 2002 Jeff Novak was awarded \$5.35 million for malpractice against Stephen Lucie, a former team doctor of the Jacksonville Jaguars. But instead of the club the player sued the doctor's employers, Jacksonville Orthopaedic Institute, who had been hired by the Jaguars.¹³² In addition, there is the potential ticking time bomb for sport in general of the disabling impact of injuries later in life and the financial consequences that this may bring through further legal action. When in 1995 Marty Barrett, then of the Boston Red Sox sued the team physician, Arthur

Pappas, over the treatment he had received, the question of the allegiance of the doctor to the team or to the health of the athlete was brought into even more sharper focus: Pappas, uniquely amongst team doctors, was also an owner of the club.¹³³ In 1995 his four per cent stake was estimated to be worth \$10 million.¹³⁴

For doctors the increase in sport's commercialization has had ramifications for their legal and insurance status. In 2003 Canadian sports doctors had their insurance cover removed by the Canadian Medical Protection Association because the financial risks they were now undertaking were too great. It left doctors exposed to litigation for misdiagnosis from entire teams of athletes who were on potentially multi-million dollar contracts.¹³⁵ Similarly, in Britain the Medical Protection Society refused to offer indemnity to any doctors employed by Premier League clubs from April 2008. Members of the Medical Defence Union though did continue to receive an individual professional indemnity insurance covering medical negligence to a limit of £10 million for every claim.¹³⁶

Conclusion

Getting an athlete fit for competition continues to be the nub of the relationship between sport and medicine. Yet this relationship has also been subject to a wider context. Not only has the science changed in the treatment of injuries but this has also been set alongside a change in the nature of sport, especially the growth of commercialization and competition. Whilst there has been change there has also been continuity in the sense that athletes continue to want to compete when injured or it may be more correct to state that they are always injured in some form such are the demands that elite sport places on the body. Hence participation remains a process of 'body management', albeit a unique one with regard to sport.

Footballers in England have been considered assets since the legalization of professionalism in 1885. Because clubs recognized their economic value they employed trainers to maintain fitness and treat common injuries as well as establish links with local hospitals and surgeons. However, this investment gradually increased with the game's changing economic context. With the establishment of the Premier League in 1992, there was an exponential rise in the medical facilities and back-up at top football clubs. Whereas in 1992 a top-level football club may have had a part-time doctor, a physiotherapist who was a 'mate' of the manager, supported by one or two assistants, fifteen years on this situation had changed radically. In 2005 Arsenal, for example, had a medical team of eight excluding doctors. These included fitness coaches, masseurs and four physiotherapists. All held professional qualifications in the field of sport and exercise medicine and can also be seen in light of an on-going process of excluding and marginalising alternative and unorthodox practices.

However, criticism by players of the treatment they have received has continued. Although there has been a greater investment in medical care, there has been an increase in the expectations of the players themselves who are probably better educated in terms of what they know about injuries, the limits of their bodies and just health matters more generally. Commercialization has also increased the independence of top players and loosened their reliance on and ties to clubs. Even in the lower leagues many players (clandestinely) seek second opinions on injuries and their treatment.¹³⁷ At the centre of this tension has been the manager or head coach. Sport's unique demands have placed extra pressure on medical practitioners – and has been seen with 'Bloodgate' – can affect their judgement in making decisions contrary to established medical practice.