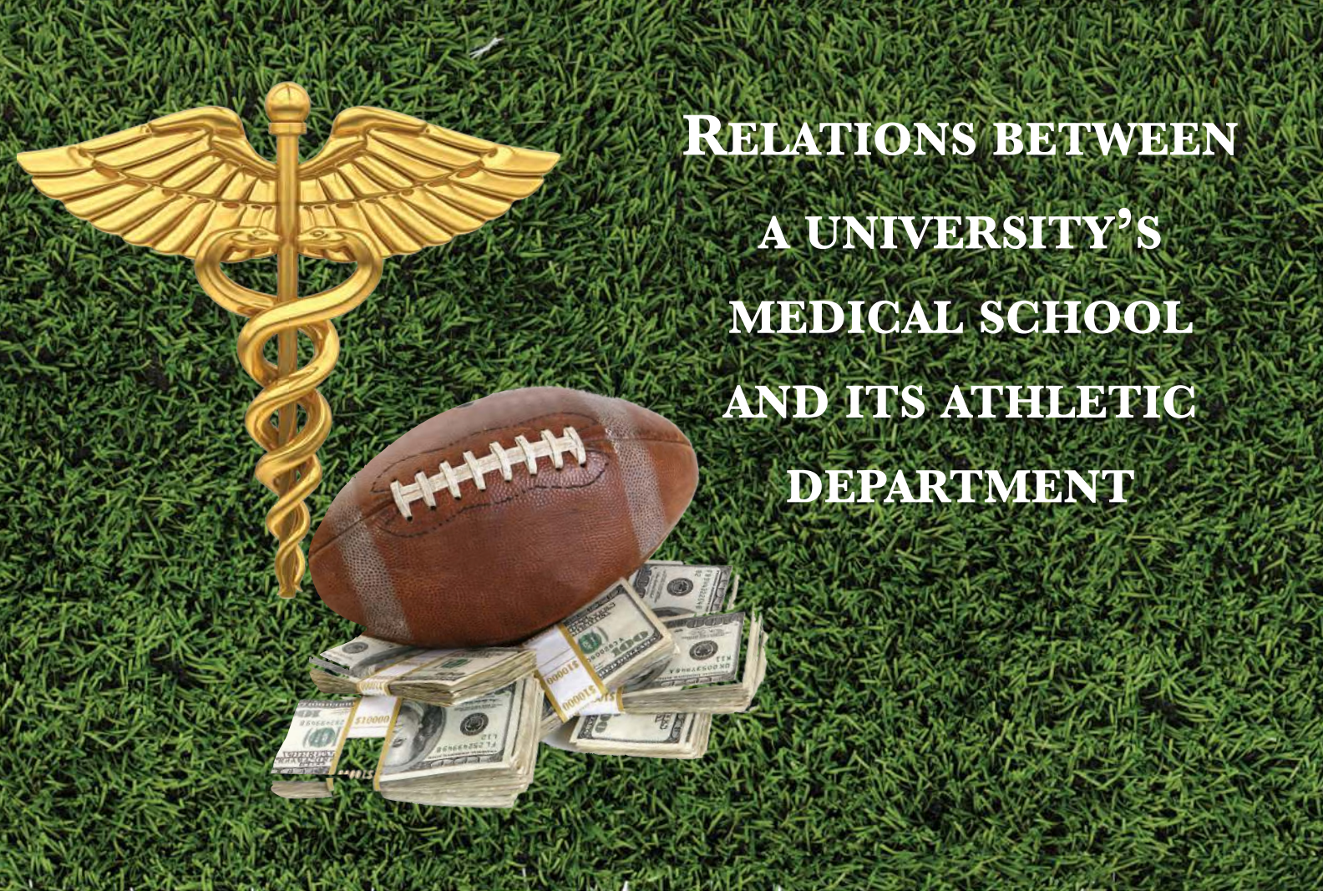

Relations between a university's medical school and its athletic department

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Most United States allopathic medical schools are part of a National Collegiate Athletic Association (NCAA) Division I university. The NCAA divides member institutions into three types:

- Division I schools generally have large undergraduate student bodies (>10,000), compete in a variety of sports, and distribute a considerable amount of athletic scholarships; except for the eight schools in the Ivy League which have no athletic scholarships.
- Division II schools have fewer students and fewer athletic scholarships.
- Division III schools have no athletic scholarships.

Division I has been tarnished by scandals. Players have died from head and spinal cord injuries, dehydration in football, and undiagnosed cardiac disease in basketball. Point shaving gambling scandals; sexual assault by players and coaches; allegations of cover-ups by campus and municipal police; verbal and physical abuse of players by coaches; grade manipulation; failure to graduate; and the pervasive influence of apparel companies and television money are all well known.[1-5] In the last decade, prominent examples of the detrimental effects of big-time collegiate sports have included the growing scientific evidence of brain injury from recurrent head trauma in football and soccer; the creation of no-show classes to keep athletes academically eligible; hiring strippers to entertain recruits and players; and federal indictments and a trial and convictions related to an FBI investigation of athletic shoe company money permeating college basketball.[1,4-8]

There are several lessons to be learned about the interaction between big-time college sports and the university's medical school.

Ethical issues

There are the ethical issues related to which physicians provide medical care for the players, and the terms under

which care is delivered. As a new medical school dean I was naïve enough to think that the players would receive their medical care from the members of my faculty. l was disabused of my childlike innocence by the athletics director. He informed me of the five- and six-figure fees paid for the right to treat collegiate athletes by private practice medical groups that competed with our faculty practice. In return, these private practices received stadium and arena signage, tickets, radio and TV advertising, and the right to put the team logo on their website, stationary, and clinic buildings. Big-time college sports is, in this regard, no different from professional sports.

College and professional teams have official shoes, soft drinks, pickup trucks, and the basketball coach's handsome suits are provided by a local men's clothing shop. So why not sell the right to be the official health care provider? If fans believe that a doctor is good enough for their favorite college team, then that doctor is good enough for them. Buying the role of official team doctor is a powerful marketing tool.[9]

Purchasing the title of "official health care provider" of a university's sports team for the purpose of gaining an advertising advantage over competing medical practices creates an ethical problem of dual loyalties: commitment to the patient versus preservation of the medical practice's financial interest in the agreement. In order to preserve the agreement with the university's athletic department, the medical practice needs to ensure that the coaches and athletic director are pleased. This desire-to-please in order to maintain the contract can conflict with the physician's primary obligation to the patient.[10-12]

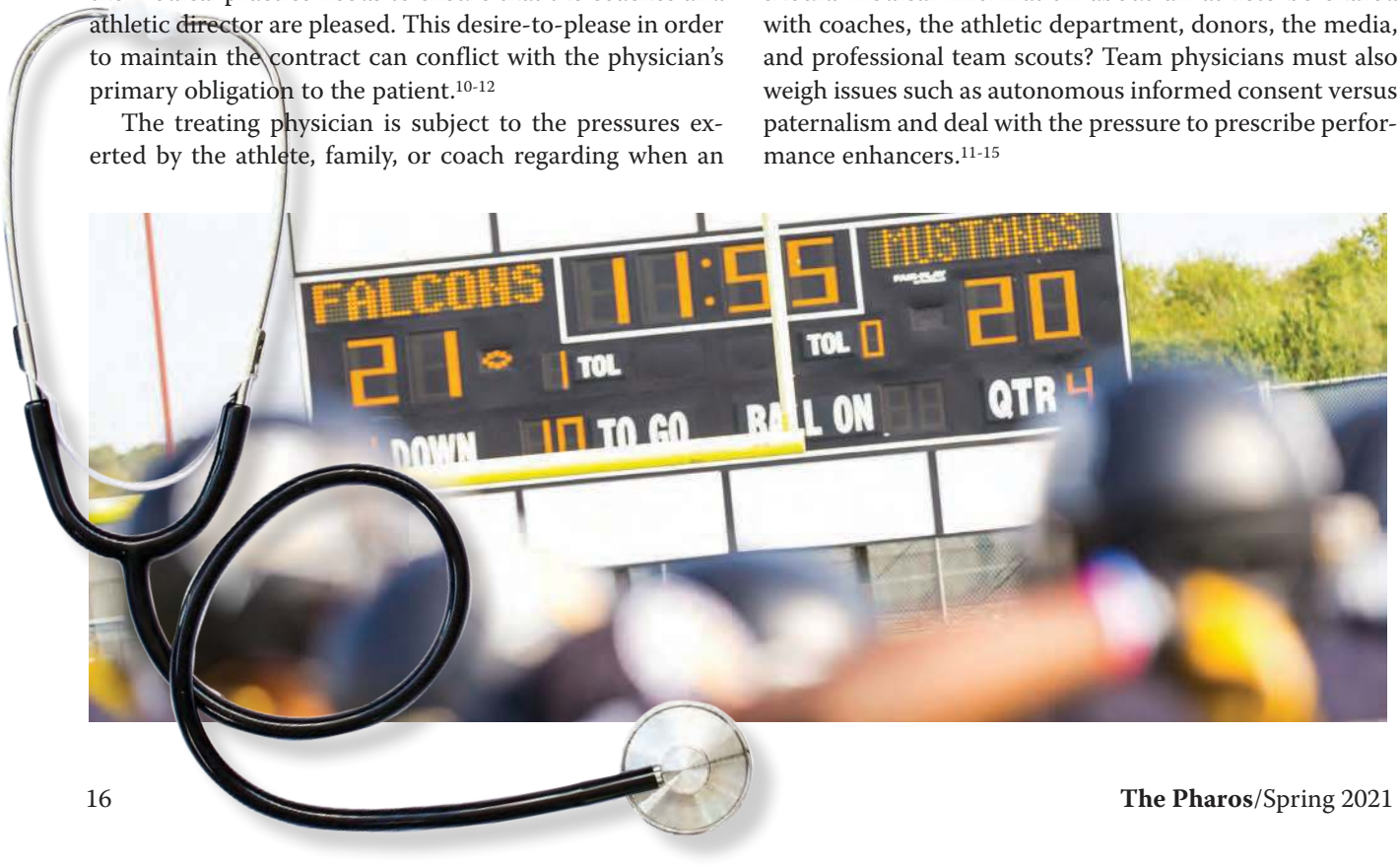
The treating physician is subject to the pressures exerted by the athlete, family, or coach regarding when an injured athlete can return to full competition and/or what medical or surgical interventions are recommended to restore the athlete to a competitive level. The physician faces the threat that he/she will be replaced if he/she does not support the wishes of the athletic department.

In fairness, this is not the only source of pressure. Peer-pressure from other members of the team on the student athlete to "play through the pain," or the desire of the student athlete to obtain a lucrative professional contract are also often involved.[10-13]

Doctors who purchase the right to care for college athletes are not the only ones giving medical advice. A recent federal trial revealed that athletic shoe companies can attempt to override a physician's best judgment regarding taping an athlete's ankle if the tape might obscure the shoe company's logo.[4-5]

Shouldn't the medical care of collegiate athletes be entrusted to the physician with the most competence rather than the largest checkbook? When a doctor comes to the aid of an athlete injured on the playing field, shouldn't the player have confidence that the physician was selected based on skill, and not out of a desire to market their practice?[6] Shouldn't the doctor's best judgment about how to tape an ankle supersede the wishes of the shoe manufacturer?

Team physicians must balance ethical issues related to the confidentiality of health information. To what extent should medical information about an athlete be shared with coaches, the athletic department, donors, the media, and professional team scouts? Team physicians must also weigh issues such as autonomous informed consent versus paternalism and deal with the pressure to prescribe performance enhancers.[11-15]



Many years ago, I sat in the audience while the team doctor of a university's football team addressed the county medical society. The physician explained how he "used time outs" to help the team win. If the team was doing well, and a player was injured, he ran out on the field and quickly got the young man off to the locker room. He didn't want to harm the team's momentum. However, if the opposing team was doing well he took his time attending to the injured player, allowing time for the opposing team to "cool off and get stiff to break their momentum." The crowd of doctors chuckled with understanding and approval. I was horrified. I was listening to a physician publicly declare that helping the football team win was affecting the manner in which medical care was being administered.

As a medical school dean you have to be careful what you wish for. If your faculty practice is either chosen or buys its way into caring for Division I athletes, will the medical school absorb the cost of the doctors covering weekend games and road-trips with the team? Is this travel more important than doing research, applying for grants, and publishing papers? Dealing with these issues requires sober consideration.

Philanthropy

It is hard to raise money for the medical school when donors are also potential donors to athletics. Some donors would prefer to see a plaque with their name in the basketball team's weight room than give money for medical student scholarships or an endowed chair. When the athletic department can hand out tickets on the 50 yard line for a bowl game, even the most charismatic medical school dean is at a disadvantage.

The overall fund-raising value of intercollegiate athletics to the medical school is debatable. At some universities, the coaching staff helps raise money for the university's hospital and its programs. At other universities the medical school is expected to pay a speaker's fee for a personal appearance by a coach. There is a commonly held belief that victories by the football or basketball teams translate into larger donations from grateful alumni, and for public universities, more budget allocations from the state legislature. This conventional wisdom is, for the most part, not supported by objective data.[16]

The big game

When it comes to getting the attention of the university's central administration, members of the state government at a publicly supported university, and the local press, it is impossible to compete with athletics. The "big football game" with tens of thousands of fans packing the stadium, national television coverage, tailgate parties, and press coverage occurs every week. As the basketball season ramps up, the football team is on its way to a bowl game. The basketball team plays once or twice a week as it moves toward March Madness.

Everyone on campus wants to discuss the upcoming game, go to the game, and rehash the game. It is often difficult to get central administration's attention focused on the medical school. Some members of the board of trustees have more interest in the team than the hiring of a new chairman of a clinical department. It's also tough to get the attention of the university's leadership when a coach or athlete has committed an indiscretion and as a result, the campus lawn is covered by TV trucks reporting the story.[1,4]

Costly endeavors

An institution can only direct its resources and energy toward a limited number of priorities. Every endeavor has opportunity costs. In recent years, some universities have focused on transforming from a "commuter school" to a residential undergraduate program by striving for recognition, in part, through intercollegiate athletics. Playing football on weeknights to gain TV exposure, building new sports facilities on the edge of campus to become the "front porch of the university," and/or opening a downtown basketball arena to rival the NBA are among the methods to achieve prominence—often at extraordinary financial costs.[4,17]

Finding solutions

The medical care of collegiate athletes should be vested in a physician free of outside influence. The best interests of the patient should be foremost. Neither the use of medicine to attract sponsorship dollars for the athletics department nor manipulating medical care to win games should be tolerated. Several specific solutions have been proposed.

- Team physicians for collegiate players should be employed by the intercollegiate athletic conferences rather than by individual schools.[10]
- Physicians should be required by law and/or conference policy to affirmatively disclose their financial relationships and conflicts of interest to the players. Arthur Caplan, PhD of New York University has argued for a "Miranda-style warning" to be given to athletes. It states, "You have the right to a physician of your choosing. You have a right to decline my

care."[10,18] In practical terms, a Miranda-style warning is of more use for professional athletes. If professionals are approached by a physician who has paid the professional sports team for the right to act as team doctor, they are often in a financial position to seek second opinions by physicians of their choosing. College athletes, in contrast, are limited to receiving their medical care by the doctor who bought his/her position from school. The athlete is young, often far away from home, and not in a financial position to seek medical care elsewhere.[11]

- The contracts between physicians and athletic departments should explicitly assert the doctor's authority to make decisions free from the interference of coaches.[10] A good place to start is the AMA's Code of Ethics: "The professional responsibility of a physician who serves in a medical capacity at an athletic contest...is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even the injured athlete that he or she not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations." [12]
- Eliminate athletic shoe contracts that interfere with medical decision-making.
- Refuse to allow medical school faculty practice plan money to be allocated to athletic department practice facilities more luxurious than the NFL and NBA.

College sports are about playing games. There is no reason why 17- to 21-year-olds should die or be placed on the pathway to premature dementia and the corruptions of gambling, prostitution, substance abuse, and sexual assault because of playing a game. There is, after all, a good reason why we call it playing a game.

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