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Management of medical confidentiality in English professional football clubs: some ethical problems and issues

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Objective: To examine the ways in which confidential matters are dealt with in the context of the relationship between the club doctor (or physiotherapist) and the player as patient in English professional football clubs.

Methods: Semistructured tape recorded interviews with 12 club doctors, 10 club physiotherapists, and 27 current and former players. A questionnaire was also sent to 90 club doctors; 58 were returned.

Results: There is among club doctors and physiotherapists no commonly held code of ethics governing how much and what kind of information about players may properly be passed on to managers; associated with this, there is considerable variation from one club to another in terms of the amount and kind of information passed on to managers. In some clubs, medical staff attempt to operate more or less on the basis of the rules governing confidentiality that apply in general practice, but in other clubs, medical staff are more ready to pass on personal information about players. In some situations, this raises serious ethical questions.

Conclusions: Guidelines dealing with confidentiality in practitioner-patient relationships in medical practice have long been available and have recently been restated, specifically in relation to the practice of sports medicine, by the British Olympic Association, the British Medical Association, and the Football Association. This is a welcome first step. However, if the guidelines are to have an impact on practice, detailed consideration needs to be given to ensuring their effective implementation; if this is to be achieved, consideration also needs to be given to identifying those aspects of the culture and organisation of professional football clubs that may hinder the full and effective implementation of those guidelines.

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The role of the club doctor in sport is sometimes likened to that of the "old fashioned family doctor", although this comparison is in many respects misleading. The relationship between doctor (or other health professional) and patient is normally underpinned by a number of fundamental assumptions: (a) the doctor's skill is used exclusively on behalf of the patient; (b) the doctor is not acting as an agent on behalf of anybody else whose interests may conflict with those of the patient; (c) the doctor may be trusted with private or intimate information which he/she will treat confidentially and not divulge to others.

However, these assumptions may 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 Bottomley¹ has noted, 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". But if the team doctor and physiotherapist are agents of the club, how can they simultaneously act as agents for, and on behalf of, the individual player as patient?

In the above context, one obvious area for potential problems relates to medical confidentiality. The Arsenal and England team doctor² has written that the rules of confidentiality governing relationships between the club doctor and players are not those that apply in general practice, but rather those that apply to the relationship "between an occupational physician and an employee of a company". In this respect, he noted that the physician "may be employed by the company primarily to serve its interest. There may arise, therefore, a conflict of loyalties . . .". A similar point has been made by Graf-Baumann.³ Writing as a member of the Sports Medical Committee of the Fédération Internationale de Football Association (FIFA), he has noted that: "Pressure from officials,

the media or even sponsors can lead to a conflict of interests", and he added that a "particularly sensitive problem in football and in all prominent sports is that of confidentiality and professional secrecy in dealing with information on an athlete's physical and mental condition". Mellion and Walsh,⁴ writing from an American perspective, have similarly noted that, in sports clubs, confidentiality is "often compromised" by the physician's relationship to the club and that "information is seldom held in the strict doctor-patient confidentiality".

How, then, do club doctors and physiotherapists deal with delicate issues involving doctor-patient confidentiality? For example, how much information about the players' health is communicated to the team coach or manager? Is such information confined to the players' injury status, or does it include information that the manager may want, but which would normally be considered confidential to the doctor-patient relationship, such as information relating to a player's lifestyle? And what do club medical staff do if they discover that a player is consuming large amounts of alcohol or is illegally using drugs? Are such problems handled within the confidentiality of the doctor-patient relationship, or do doctors feel that, as the club employs them, they are under an obligation to inform the manager about aspects of a player's lifestyle that may affect his performance? Although these questions have all been phrased in relation to the club doctor, they also apply equally, of course, to the club physiotherapist. The central focus of this paper is the way in which confidential matters are dealt with in English professional football clubs in the context of the relationship between the doctor (or physiotherapist) and the individual player as patient.

METHODS

These issues were probed as part of a broader study of club doctors and physiotherapists conducted on behalf of the Professional Footballers Association.⁵ Some results from this study have been published already, describing the constraints on players to continue playing while injured,⁶ and the qualifications, experience, and methods of appointment of club doctors.⁷ The present paper is based primarily on data collected by tape recorded, face to face interviews of between 30 and 60 minutes with 12 club doctors, 10 club physiotherapists, and 19 current and eight former players. Interviewees were given guarantees that neither they nor their clubs would be identified.

Doctors in the Premier League were more amenable to being interviewed, a fact that probably reflected their generally greater involvement in their clubs. However, this did mean that the sample of doctors interviewed was biased towards club doctors in the Premiership. Of the 12 interviews, seven were with doctors at clubs in the Premier League (one had recently left the club to return full time to general practice), two were with doctors at clubs in the First Division of the Nationwide League, two with doctors at Second Division clubs, and one interview was with a doctor in a Third Division club; one of the Premier League club doctors had also previously worked in a Second Division club.

Of the club physiotherapists, three worked in Premier League clubs, two in First Division clubs, two in Second Division clubs, and two in Third Division clubs; in addition, one physiotherapist had formerly worked in two football clubs (one Third Division club, one Premier League club) but now worked as a club physiotherapist in another sport. Nineteen current and eight former players were also interviewed in order to get the "patient's perspective".

The larger study also included a questionnaire which was sent to 90 club doctors who were not interviewed; 58 questionnaires were returned. This paper, however, draws primarily on data obtained from the 49 interviews with doctors, physiotherapists, and players.

RESULTS

The most general finding—and one that we believe is a matter of concern—is that there is among club doctors and physiotherapists no commonly held code of ethics governing the way in which confidential issues are handled, and there are considerable variations in terms of both the amount, and the kind, of information about players that doctors and physiotherapists pass on to managers. This lack of a common ethical code for dealing with confidential issues was particularly striking among physiotherapists, but, although there was more uniformity in terms of the responses of club doctors, there were nevertheless some concerns about the ethics of the behaviour of some doctors; a particularly striking example of unethical behaviour on the part of a club doctor is cited later.

Most club doctors are general practitioners,⁷ and many seek, insofar as it is possible to do so, to apply the rules governing confidentiality in general practice to their practice within the football club. Asked about how issues involving patient confidentiality were best dealt with, one doctor replied:

"I find this one very difficult because coming from a background in general practice obviously anything between a patient and myself is confidential, unless it's an absolutely extreme case . . . Whereas inside a football club, it seems like everybody else thinks they have the right to know what's going on before the player does and when I have had disagreements with managers it's usually been around this issue. There's also the question of the press, and I think that the right of confidentiality still holds. I don't see why it should be different because you're in a football club."

Asked about the appropriate way to handle a situation in which a player is drinking heavily, this doctor said:

"I certainly wouldn't tell the physio or the manager or the board unless he said that it was alright for me to do so. I don't think he would. [I would] see whether he would let me get the PFA [Professional Footballers Association] involved, or where he would accept help, just like in general practice . . . it's the same with drugs . . . I wouldn't tell the manager unless he told me to. I would consider that as a breach of my confidentiality if I told. I mean, that has happened to me [a player using drugs] and I have dealt with it like I would any patient."

This doctor summed up the problem of dual loyalties—to the club as employer and to the player as patient—in the following way:

"I've always considered myself the players' doctor. You know, it is more difficult because I am employed by the club . . . fortunately I haven't had the situation where the club would be at risk, but it would make it more difficult. But I would always try to get the player's consent before I involved anybody else."

Another doctor took a broadly similar line in relation to patient confidentiality. Asked about the best way to deal with a situation in which a player confided that he was drinking heavily, this doctor replied:

"We would sit down and have a talk about it. I have a very strong feeling about confidentiality with the players. If I tell somebody that they're telling me something in confidence then it doesn't go any further, and I'm sure there are things that I'll probably carry to my grave that people have told me as players that I wouldn't say to anybody unless they said, 'Yes, OK, I'm happy to talk about it'. So I would try to sort out with them what to do, between the two of us."

This doctor indicated that he would encourage the player to talk to the manager, but that if the player did not wish the manager to know, then he could not pass on that information:

"I can't tell the manager . . . I think players, in order to come to you with confidences have to be very sure that they can really trust you because clubs are places where that kind of thing goes around in a flash and sometimes physios aren't as discreet as they should be about that kind of thing, and I see my role as being somebody who people can trust, things will go no further."

Although most doctors sought to apply within the club the same rules governing confidentiality that they applied in general practice, one doctor differentiated very clearly between his role as an occupational physician for the club, and his role as personal physician to the players. He said that, in the former role:

"in respect of what I do with [the players], I share the information with their employer. I also have a personal physician role which means that things that are said between the two of us are entirely confidential and I will not discuss them at all with anyone else unless I have their permission . . . if there is information that's coming to me that I feel compromises the position of the club, compromises the position of the team, that compromises the well-being of the club, I will say to them: 'Right. You've told me this now. This is something that I feel should be shared with the manager . . . and if you don't want me to share it, don't go into this any further. You're going to have to discuss this with somebody different'."

It's always been agreed between us that there are two roles that I have. It's not like a normal doctor-patient relationship."

One of the doctors cited above suggested that "sometimes physios aren't as discreet as they should be", and it is certainly the case that there was considerable variation between physiotherapists in terms of how they dealt with issues involving confidentiality. It might be argued that, in relation to such issues, physiotherapists have a particular ethical responsibility because, as one experienced physiotherapist pointed out, physiotherapists—perhaps more so than doctors, most of whom work only part time at the club—often get to know a great deal about players' private lives:

"I could tell you more about any player in the football club than the manager, chairman, coach together, because you work one-to-one with them. You get to know, not just the problems themselves, but the families that they have, the children . . . everything about them because you spend time with them and, you know, you're not prying, you're just asking questions all the time."

This particular physiotherapist was clearly aware of his responsibilities to the club—he said that, if a player had a problem that was affecting the team, then "it's better that the manager knew"—but he emphasised, in particular, his responsibilities to the players and, in this context, he adopted a position in relation to confidentiality that was not very far removed from that expressed by several doctors. He said, for example, that normally he would not tell the manager if a player was drinking excessively—"a manager's got enough to do without worrying about people who drink"—or if a player was using "social" drugs such as marijuana:

"I know an awful lot of things about players that needn't go any further. It's important it doesn't go any further . . . if you find something out, or the player tells you something in confidence and they ask you not to tell anyone, then you keep that confidence . . . they tell you an awful lot in confidence and if you went running to the manager with everything then you wouldn't probably find these things out."

A player at another club described how the physiotherapist not only did not tell the manager that a particular player was drinking heavily, but actually sought—as this player put it—to "protect" the player from the manager:

"I used to get changed next to [the player] and . . . at times when he was a bit worse for wear he'd come into the treatment room and [the physiotherapist] would protect him and maybe say he'd got a sore so and so and he couldn't train that day. Or sometimes, if [the player] had to go out training he would call him back over and say that there's a telephone call or whatever to get him out early. He would protect him that way."

Other physiotherapists, however, appeared to see their primary responsibility towards the club and to the manager, and some of these expressed a greater readiness to pass on information. Thus one physiotherapist, when asked what information he passed on to the manager, explained, without any further prompting:

"Most physios know more about their staff than anybody in the club, and if it was beneficial that the manager should know [something]—or essential that the manager should know—then I would tell him."

Asked whether he would inform the manager if a player is drinking heavily, he replied:

"The problem is that I'm employed by the football club. I'm employed by the manager and I'm supposed to be working with him and if I withhold information which he thinks he should have, then he would say that I wasn't working for the club or for him, so it puts me in a difficult position . . . if I didn't divulge what I knew and then it came out afterwards, we're in hot water . . . If I thought it was beneficial to the club . . . that he should know, then I would say."

Another physiotherapist who placed particular emphasis on his responsibility to the club said:

"I think if [a player's] breaking the law, i.e. taking drugs, whether performance-enhancing or whether they were just recreational, I think it's my duty to tell the football club. I work for the football club. And the players know where I sit. I'm not a player. I don't know who they've shagged, I don't know what they've drunk and I don't want to know what substances they're taking. They can do what the f*** they want. If they tell me, it will go back. And the players know that."

If they come to me confidentially and they're breaking the law, it will go back. If they're not breaking the law—I don't mind if they're out nightclubbing twice a week, I'm not judge and jury—but if the performance on the pitch . . . [if] they're not performing well or they're getting muscular irritations,

and I know their lifestyle's all over the place . . . I would go to the manager and say, 'Look, his lifestyle is in a right mess'."

Given the considerable variation in terms of the way in which physiotherapists—and also, to some extent, doctors—deal with issues involving confidentiality, it is perhaps not surprising that some players expressed considerable reservations about revealing confidential information to club medical staff. One player, asked whether he would be happy to discuss a confidential matter with the club doctor or physiotherapist, answered with an emphatic "No". He explained:

"Things get back. Things get back all the time. You can't say anything at a football club to anyone because basically they get back. There is no such thing as confidentiality at a football club. I found that out . . . something got back to a manager that I had said to a doctor . . . Well, it should be confidential . . . it was something [non-medical] I commented on . . . and it came straight back which I thought was a bit out of order. No, I wouldn't have confidence in anyone."

One ex-player, asked if confidential information about players was ever passed on by the physiotherapist, said:

"I think maybe that happened at [the club] sometimes, where you'd say So-and-so is the gaffer's eyes and ears . . . in the treatment room. I think the manager does have certain members of his staff to listen out to what players are saying in the treatment room . . . word quickly gets round who you should be careful of saying things to . . . players do tend to open their hearts out in there when they are on a bed for half an hour or more, or under a machine, and they just talk and things come out and, you know, really if the physio is hearing that type of stuff it should be for his ears only and really shouldn't go any further."

I mean . . . if he was a normal physio [and] he'd got a private practice, of course he wouldn't mention things his patients had said. It is a slightly different situation in a football club . . . because the manager's his boss and if the manager asks him something he might feel duty bound to tell him . . . So, with somebody in that position, it's not just a question of treating [the players] and whatever they say stays there."

Another senior player indicated that a particular cause for concern was where a new manager came to the club and brought with him his own "backroom staff", including the physiotherapist, from a previous club:

"When a manager brings in his own people, that is where there is concern because this person is relying on the manager for his job and he's not going to go against the manager."

He indicated that under a previous manager:

"Anything that was said in the physio's room went straight back to the manager. The manager had a huge input, even in the physio's room."

Players, he said, joked about this situation, but were very careful about what they said in the physiotherapist's room.

It was not, however, just in relation to physiotherapists that players expressed reservations about the degree to which information that they provided would be held in confidence, for some players also expressed reservations in this regard about club doctors and one player provided a striking example of unprofessional conduct on the part of the club doctor.

In this incident, the club doctor was clearly acting as an agent on behalf of the club, and used confidential medical information about a player to advance the interests of the club over and against those of the player. The player described what happened as follows:

"The club doctor, in my opinion, totally compromised his situation. I'd had [an operation] and my contract was up at the end of the season . . . I was approached by [three leading English clubs], Atletico Madrid, and Lyon. Three or four weeks later, when I was talking to these clubs, I got summoned to the club doctor's . . . the club doctor called me and said would I go round to his house . . . I arrived there and he was there with the surgeon who did my operation . . . the surgeon wasn't particularly happy about being there. He [the club doctor] said,

'You're thinking about leaving the club this summer?' I said 'Yes'. He said, 'Well, the surgeon has told us that you've only got another year at the most to play football. If we make that common knowledge, no club in the world would pay millions of pounds for you'. I said, 'Well, what are you telling me?' He said, 'Well, if you're thinking of leaving the club and we made that common knowledge, then . . . no-one would buy you'. So . . . I ended up agreeing a new deal to stay.'

The incident described by the player had taken place several years previously and, at the time of the interview, the player was still playing for the same club. The player said that he thought the club doctor was probably acting under great pressure, not in this case from the manager but from the club chairman, but he added that this did not excuse the doctor's behaviour: "He was probably under great pressure to do that, but he's done wrong".

DISCUSSION

There is considerable variation from one club to another in terms of the amount and kind of information about players that is communicated to the manager by doctors and physiotherapists. In some clubs, medical staff try to operate more or less on the basis of the rules governing confidentiality that apply in general practice, but, in other clubs, doctors and/or physiotherapists are much more ready to pass on personal information about players. This lack of uniformity in terms of ethical standards is a matter of concern.

Although this paper is concerned specifically with the situation in English professional football, there is no reason to suppose that the problems we have documented are confined either to football or to England. For example, as we noted in the introduction, Graf-Baumann³ has pointed out that confidentiality is a "particularly sensitive problem" not just in football but in all prominent sports, and Mellion and Walsh⁴ have similarly drawn attention to the fact that in sports in the United States confidentiality is "often compromised" by the physician's relationship to the club. Of course, the magnitude of the problem is likely to vary from one country to another and from one sport to another, perhaps depending on the importance attached to winning and the associated commercial, media, and other pressures to succeed, as well as other sport specific factors. Unfortunately there are almost no systematic data available that would shed light on these issues for, although there are numerous general statements of principle setting out guidelines for the behaviour of physicians working with sports clubs, our own study is, as far as we are aware, the only completed empirical study that has examined not how club doctors and physiotherapists ought to behave, in terms of general ethical principles, but how, as a matter of fact, they actually do behave in situations involving medical confidentiality.

In relation to this last point, it may be of interest to note that a study similar to the one reported here, but in relation to rugby union, is currently being undertaken by colleagues at the University of Leicester. The one early paper that has been published from this research⁸ does not deal with issues involving confidentiality, but preliminary results from the study do suggest that breaches of confidentiality may be less common in rugby union than in football. If this preliminary finding is confirmed, then it may be that it can be explained in terms of a variety of sport specific considerations, including the following: commercial and media pressures, although increasing in rugby, are less intense than in football; in rugby all club physiotherapists, unlike their counterparts in football, appear to be chartered; and in rugby there is considerably less movement of both players and managers/coaches from club to club, which may facilitate the development of more stable and perhaps more trusting relationships between players and management. Clearly what is needed are more detailed empirical

studies of the ways in which issues involving confidentiality are handled within the context of different elite/professional sports.

More or less concurrently with the research reported here, three major organisations have recently issued guidelines dealing with confidentiality in sports related contexts. The British Olympic Association (BOA)⁹ issued in 2000 a position statement on athlete confidentiality, and, in the following year, the British Medical Association¹⁰ issued advice for doctors working with sports clubs, which included a statement of doctors' responsibilities in relation to confidentiality. The medical committee of the English Football Association (FA) also introduced, in February 2001, guidelines relating to confidentiality for club medical and support staff.¹¹

All three documents emphasise the importance of maintaining confidentiality within the relationship between the doctor/physiotherapist and the athlete/player as patient. For example, the FA guidelines, which draw heavily on the BOA document, state that "the duty of confidentiality of [medical] staff to the player overrides the contractual obligations owed to the employer". It notes that managers/coaches may want to be informed about matters relating to a player's health, but states that such information should only be passed on with the consent of the player concerned.

In considering these guidelines, perhaps the first point to note is that, as an editorial by Macauley and Bartlett in this journal¹² pointed out, the BOA position statement does not involve a statement of any new principles but "draws together and explains the implications of the Codes of Conduct that already exist among medical and scientific support staff". In this sense, these documents simply reaffirm what has long been the general understanding, of both patients and medical practitioners, in relation to such issues: that when a patient provides information to his/her doctor that information will, save in exceptional circumstances (for example, where information is required by due legal process), be treated confidentially. As the General Medical Council succinctly puts it: "Patients have a right to expect that [doctors] will not disclose any personal information . . . unless they give permission".¹³ This is of course also the standard position expressed in books on medical ethics (see, for example, Phillips and Dawson¹⁴). Perhaps most interestingly, guidance on ethics for occupational physicians—and the club doctor can be regarded as a particular kind of occupational physician—was one of the first issues addressed when the Faculty of Occupational Medicine was founded in 1978, and, in the most recent edition of its *Guidance on ethics for occupational physicians*,¹⁵ the Faculty reiterates the long established position that the consent of the patient is required—again save in exceptional and defined circumstances—before access to clinical information is granted to others.

The fact that three major organisations—the BOA, the BMA, and the FA—have all recently felt the need, specifically in relation to sports medicine, to restate ethical principles that are generally well understood both within and outside the medical profession does suggest a growing concern about the way in which issues involving confidentiality are dealt with in sport. The research reported here indicates that, at least in relation to professional football in England, that concern is justified. In this context, the FA guidelines represent a welcome first step. They are, however, precisely that: a first step for, as Macauley and Bartlett have correctly pointed out, "creating these [guidelines] is relatively easy; implementation is more difficult".¹²

In this regard, there are several potential problems which are likely to be encountered in implementing the guidelines. The most obvious, perhaps, relate to the increasingly intense commercial, media, and other pressures for clubs to achieve success on the field of play. These pressures are experienced particularly acutely by the club manager, whose position within the club is a notoriously insecure one and whose tenure is often very short; one index of this insecurity is that, of

the 92 clubs in the English Premier League and the Nationwide League, no fewer than 20 replaced their manager in the first three months of the 2001–2002 season. These intense pressures on managers to achieve success in the short term, and the associated insecurity of their position, have a number of consequences for the relationships between managers, players, and medical staff which are likely to make it difficult to implement fully and effectively the FA guidelines.

In the first place, these pressures on managers to achieve success on the field of play mean that, as the FA guidelines put it, “managers may feel that they should be informed about any problems relating to their squad”. Our own research leads us to state the problem in considerably stronger terms, for it is clear not only that managers generally do feel that they have a right to be informed about problems relating to their players but, rather more worryingly, this view is not uncommonly shared by club physiotherapists and doctors. In other words, a culture of medical confidentiality is much less well established in professional football clubs than in most other contexts in which medicine is practised. Successful implementation of the guidelines will thus require a shift in football club culture which may not be easy to achieve.

A further problem is associated with another, related aspect of the culture of professional football. As we have documented elsewhere,⁶ professional footballers are subject to strong constraints to “play hurt”, that is to continue playing with pain and injury. In this connection, one of the things that managers look for in a player is that he should have what, in professional football, is regarded as the “right attitude”, and one way that players can show that they have the “right attitude” is by being prepared to play with pain and injury. A closely related aspect of football culture is the idea that players who are unable to play because of injury and who can therefore make no contribution to the team on the field of play may be seen by managers as being of little use to the club and may be stigmatised, ignored (some managers simply do not speak to players for the duration of their injury), or deliberately “inconvenienced” in other ways, for example by being required to arrive at the training ground earlier than players who are fit and by being kept behind long after the other players have left.⁶

These often unsympathetic attitudes towards injured players on the part of some managers can be understood, at least in part, in relation to the constraints on managers mentioned earlier. They do, however, raise obvious difficulties in relation to the effective implementation of the FA guidelines. One such difficulty relates to the fact that the guidelines indicate that information should not be released to managers unless players have signed a consent form. But what does signing such a form imply? Does it simply imply permission to reveal information about a player’s injury status? Or, given the particular conditions characteristic of the culture of professional football clubs, will signing a consent form be taken to imply that a player agrees to the release of information relating to more personal matters, such as his lifestyle, which may influence his performance on the field of play? And if managers demand such information, to what extent are club doctors, and perhaps more especially club physiotherapists, in a position to effectively resist such demands? Such questions are, perhaps, particularly pertinent in relation to physiotherapists who have a longstanding personal relationship with a particular manager to whom they may feel they owe their job and, secondly, to non-chartered physiotherapists who have a qualification that is not recognised outside of the football context, who may therefore have difficulty in finding another job should their contract be terminated and who may therefore be in a weak position to resist such pressure from managers.

It is also necessary to ask one other question: what happens to players who refuse to sign a consent form? Will their right to withhold their consent be recognised and accepted or, given

Take home message

There is in professional football clubs considerable variation in terms of the amount and kind of personal information about players that is communicated to club managers by medical staff. This lack of uniformity in terms of ethical standards is a matter of concern. The Football Association Medical Committee has recently issued guidelines governing confidentiality but successful implementation of those guidelines cannot be assumed and this process will require careful monitoring.

the culture of football and the unsympathetic attitudes of some managers towards injured players, will their refusal to give their consent be taken as an indication that they are uncooperative, not “team players” or, quite simply, that they do not have the “right attitude”? Such questions remain to be answered. In the light of these questions, there is clearly a need for the implementation of the guidelines to be carefully monitored; without such monitoring there is a danger that they may become simply one more policy document to gather dust.

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- 15 **Faculty of Occupational Medicine.** *Guidance on ethics for occupational physicians*. 5th ed. London: Faculty of Occupational Medicine, 1999.

..... **COMMENTARY**

This paper examines the dilemma facing the football club doctor/physiotherapist when they are presented with confidential information, often given in good faith by a player. The doctor/physiotherapist is employed by the club, and the authors of the paper have questioned whether, in this role, they are working in the interests of the club or the player. Traditionally occupational health doctors are responsible for the interests of the organisation that employs them. Their role is concerned with issues such as fitness for employment, the safety of staff in the work place, and the immediate care of individuals taken ill or injured at work. Primary medical care

is the responsibility of general practitioners who work independently.

Health professionals working in a football club should demarcate their occupational health role from that of the player's primary care provider. If football clubs feel the need to employ a general practitioner to supply primary medical care, this care should be supplied in a confidential setting. The two roles are different and no attempts should be made to merge them.

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EDUCATION PROGRAMME.....

British Association of Sport and Exercise Medicine in association with the National Sports Medicine Institute

Education programme 2002

General Sports Medicine
Lilleshall National Sports Centre, 21–26 April.

Diploma Preparation
Sheffield Centre of Sports Medicine, April–May.

Current Concepts: Lower Limb Rehabilitation
DSMRC Headley Court, Surrey, 10–11 May .

Intermediate Sports Injury Management and Medicine—Lumbar Spine, Thorax, Groin, Pelvis, & Hip
Lilleshall National Sports Centre, 7–12 July .

General Sports Medicine
Lilleshall National Sports Centre, 22–27 September.

Practical Sport and Medicine Meeting
Club La Santa, Lanzarote (families & non-delegates welcome; deadline 17 July, 2002), 3–10 October.

Diploma Preparation
Location and date to be confirmed, October.

The Queen's Golden Jubilee & Post Commonwealth Games BASEM Congress
The Low Wood Hotel and Conference Centre, Windermere, 10–13 October.

Intermediate Sports Injury Management and Medicine—Lower Limb
Lilleshall National Sports Centre, 17–22 November.

Current Concepts
Topic, location, and date to be confirmed, December.

Education programme 2003

Intermediate Sports Injury Management and Medicine—Head, Neck, and Upper Limb
Lilleshall National Sports Centre, 16–21 February.

General Sports Medicine
Lilleshall National Sports Centre, 27 April–2 May.

For further details of these courses please contact Mr Barry Hill, The National Sports Medicine Institute, 32 Devonshire Street, London W1G 6PX, UK. Tel: 020 7486 3974; Fax:020 7935 0402; email: barry.hill@nsmi.org.uk; www.nsmi.org.uk