Healing the Body in the “Culture of Risk”:
Examining the Negotiation of Treatment Between
Sport Medicine Clinicians and Injured Athletes
in Canadian Intercollegiate Sport

Parissa Safai
University of Toronto

This case study examines the relationship between the “culture of risk” and the negotiation of treatment between sport medicine clinicians and student-athletes at a large Canadian university. The evidence acknowledges that a “culture of risk” was reinforced under certain circumstances during negotiation, but was also tempered by the existence of a “culture of precaution” that worked to resist those influences. The dialectic between the cultures of risk and precaution reveals some of the tensions inherent in negotiations between clinicians and patient-athletes, and helps to complicate the notion of a “culture of risk.” Another aspect (one that has rarely if ever been examined) of the negotiation of treatment is also considered—the promotion of “sensible risks” by clinicians to injured athletes.

In describing his personal experiences with injury, Sabo (1989) encapsulates much of the research on the culture of pain for men and women in competitive sport when he acknowledges that, “my pain—each individual’s pain—reflects an outer world of people, events, and forces. The origins of our pain are rooted outside, not inside, our skins” (p. 84). Pain and injury tolerance in sport warrants in-depth investigation not only because of the social processes that normalise pain and injury in sport, but also because of the damaging, potentially devastating, consequences to the health and well-being of many people. Pain and injury occur in an environment that is often cloaked in uncritical and unquestioned acceptance and idealisation. Dominant sport structures retain deep significance as an arena of gender

The author is with the Department of Exercise Sciences, University of Toronto, Toronto, ON. This article is the recipient of the 2002 Barbara Brown Student Paper Award of the North American Society for the Sociology of Sport.
verification, but the gendering of sport is never static, and continues to change as women colonise and adopt forms of sport, and their ideologies, that were traditionally the preserve of men (Theberge, 1997; Young & White, 1995; Young, White, & McTeer, 1994). A dilemma for both male and female athletes is what has been termed the “culture of risk” (Nixon, 1992), which encourages athletes to accept risk-taking in sport and to make light of the consequences of injuries. However, while teaching women and men to ignore pain, the “culture of risk” does not protect them from the physically, socially, economically, or emotionally debilitating consequences of chronic pain and serious injuries.

As researchers, we must continually raise questions about the lived contradictions, for athletes, between the supposed healthfulness of competitive sport and the real experiences of pain and injury in sport. But, we must also acknowledge and question the effect and influence of other key characters in the competitive sport system—particularly those individuals who are at the front lines of the sport injury/pain complex—sport medicine clinicians (e.g., physicians, therapists, trainers). A critical examination of the role of sport medicine clinicians in competitive sport settings is necessary to our investigation of pain and injury in sport, especially the ways in which they negotiate with patient-athletes regarding the treatment of injury and return to competition. This case study examines the relationship between the “culture of risk” and the negotiation of treatment in sport medicine at a large Canadian university (LCU). The project involved a qualitative analysis of the roles of sport medicine clinicians as they interacted with patient-athletes from various sports in the context of a competitive varsity season. Previous research, primarily from professional sport and National Collegiate Athletic Association (NCAA) sources, and anecdotal evidence suggests that a “culture of risk” is promoted in clinician-athlete negotiations. However, few studies have focused on those negotiations. This case study investigates how clinicians interact with patient-athletes beyond the basic level of clinical diagnoses, in order to determine if clinicians at this LCU implicitly contribute to and reinforce over-conformity to the sport ethic which promotes risk-taking behaviour (Hughes & Coakley, 1991).²

Although often equated with hazards and danger (see Lupton, 1999), risk and risk-taking are not completely negative phenomena. In terms of the human condition, certain types of risk-taking may be seen as altruistic, while others are admired and appropriate (e.g., firefighting is a prime example of altruistic and admired risk-taking). However, the focus here is on the negative consequences of risk and risk-taking in sport. In the pioneering study in this area, Nixon (1992) suggests that playing with pain and injury is so common, so normalized in competitive sport among athletes who are aware of the potential negative (risky) consequences of their actions, that he characterises such sport as a “culture of risk.” Ethnographic studies (e.g., Roderick & Waddington, 2000; Walk, 1997; Young & White, 1995; Young, White, & McTeer, 1994) show that this culture is far more complex than Nixon implies. While these studies acknowledge that there is widespread acceptance and tolerance of pain and injury in competitive sport, they also recognise the complex ways in which athletes and others produce and respond to this culture. For convenience, and because this project is primarily concerned with the negative consequences of risk and risk-taking, the term “culture of risk” is used as shorthand throughout the text to refer to the unquestioned tolerance of pain and injury in sport.
**Socio-Cultural Nature of Pain and Injury**

With the exception of a few occupations, there are no other activities in social life where people assume risk in the same ways as they do in competitive sport (see Young, 1993). Researchers in the sociology of sport have recently started to examine the "culture of risk" in greater depth, including research on the role of sport medicine clinicians in different sport settings (see Young, in press). The negotiation of treatment is more extensively examined in the sociology of health and medicine, including research on the history and legacy of medical dominance (see Freidson, 1970; Johnson, 1972; Turner, 1995). However, only rarely does this literature discuss the clinician-patient relationship in a competitive sport setting. Research on medico-legal and policy issues (see Grayson, 1999; Payne, 1990; Pipe, 1998) has paid greater attention to the sport medicine clinician-patient relationship (see Safai, in press, for a discussion of this). The present article briefly explores the literature examining the paradoxes of sport and the practice of sport medicine.

Given their generally excellent health and "posture of physical invulnerability" (Young, White, & McTeer, 1994, p. 185), injury and pain tolerance become physical and symbolic markers of character for many athletes. With the routinisation of pain and injury in sport, as Hughes and Coakley (1991, p. 309) note, "the idea is that athletes never back down from challenges in the form of either physical risk or pressure, and that standing up to the challenges involves moral courage." The strength of this ideology lies in its pervasiveness, particularly as it extends into the identity construction and exhibition of both male and female athletes. If tolerance of injury is evidence of a strong character, to not tolerate injury implies weakness in character. This is problematic since there is a political contradiction here in that praise is reserved for conformity and overconformity to an ethic, but an individual often shows great strength of character by resisting that ethic (see Donnelly, in press).

This discussion leads us to the paradox of competitive sport, and implicates the role of the sport medicine clinician. While competitive sport is considered by many people to build and enhance the body and psyche, it also creates a body and psyche that is damaged (Messner, 1989). Paradoxically, as the body is built up to move through the competitive hierarchies of modern sport, the body is increasingly worn down—in essence, an athletic career also becomes a "pain career" (Bendelow, 1996, p. 171). This interpretation implicates the clinician, in that as athletes work on and wear down their bodies to excel in their sports, there is an ever-present need for the specialised knowledge and abilities of sport medicine clinicians. Thus, overconformity to the sport ethic creates a supply-demand scenario, where the commodity being exchanged is the health and well-being of the human body. Ironically, the supply-demand scenario could be interpreted in two ways—the supply of sport medicine to satisfy individuals who demand specialists for their athletic injuries, or the supply of sport injury to satisfy sport medicine practitioners’ need for clientele. In suggesting this, we cannot overlook the fact that sport medicine, representing a number of different occupational groups (e.g., physicians, therapists, trainers) in and amongst other types of healthcare providers (e.g., general practitioners, chiropractors), is intensely involved in asserting itself as the health authority of the athletic body (see Coburn & Willis, 2000; also see Harvey, 1983 for parallels to other bodily professions). Thus, using physicians as
an example, we have an occupational group that is carving out a niche for itself within the healthcare system as the key source of medical expertise about the sporting body, and who then delegates work to other sport medicine occupational groups (i.e., therapists). Sport medicine physicians are committed to healthy bodies, in both the prevention and rehabilitation of injury, but ironically, can also be seen as sustaining themselves professionally on injured and damaged bodies. This is not to suggest that sport medicine services are unnecessary, but that there are broader social, historical and political factors related to the development and consolidation of sport medicine occupational groups in the healthcare system.

The Organisational Nature of Sport Medicine

What are the implications of this preliminary understanding of the nature of pain and injury in competitive sport for the organisational nature of sport medicine? Although past work in the sociology of health has interrogated the progress and state of modern medicine (see Annandale, 1998; Crawford, 1980; Navarro, 1986; Turner, 1995), medical sociologists have rarely considered the practice of sport medicine and its effects on individuals, or questioned whether clinicians are aiding injured athletes by offering specialised treatment, or are in fact reinforcing the “culture of risk.”

In the sociology of sport, Nixon was one of the first researchers to examine these issues (see also Hoberman, 1992). He investigated what Walk describes as the “conspiratorial alliance of coaches, athletic administrators, sport medicine personnel, and others whose activities perpetuate the acceptance by athletes of risk, pain, and injury in sport” (1997, p. 23). Nixon (1992) refers to these alliances as “sportsnets,” and suggests that interactions in these networks reinforce overconformity to the sport ethic. He argues that what normalises these ideologies is the very fact that there is a medical support system in place for athletes that is immersed in the rhetoric of producing winning teams and athletes. Nixon (1992) suggests that the immersion of these medical systems within a sport establishment ideologically committed to the sport ethic is detrimental to the health and safety of athletes. He proposes the establishment of independent networks of medical personnel who are not so intimately connected to the sport institutions, and urges athletes to look to these independent networks of medical personnel to assess and diagnose persistent injury.

Nixon’s work in this field, although focused primarily on U.S. intercollegiate sport, is pioneering in that he offers the concept of sportsnets as a critical theoretical model of sport medicine systems. Other researchers have used his model as a point of departure, and have since identified the more complex nature of sport medicine systems in both intercollegiate and other sport contexts (e.g., Roderick & Waddington, 2000; Waddington, 1999, 2000; Walk, 1997). Walk’s (1997) study of the experiences of student athletic trainers (SATs) at a large, Midwest U.S., NCAA Division I institution represents one of the first studies to question the notion of “conspiratorial networks” and their influence on sport participants. Walk (1997) contends that the model of a sportsnet is “intuitively suspect and without empirical support,” in that “even a sportsnet may be characterised by flaws in its systems of control, related negotiation and conflict, and some measures of freedom for its members, even those with the least amount of power—[in the case of Walk’s research] student athletes and student athletic trainers” (p. 50). For example,
Walk found that the views held by SATs towards the “culture of risk” were often conflicted and contradictory. They showed both concern for the health and welfare of the student-athlete, and support for the reproduction of injury-legitimating norms. He argues that while sport and sport medicine were insulated from the rest of the institution under study, the sportsnet was not as homogenous and all encompassing as Nixon suggests, particularly in the relationships between SATs and student-athletes that “worked to undermine some of the totalizing and exploitative tendencies the [institutional] sportsnet may have had” (p. 50). While Walk’s study offers a great deal of material relevant to this project, two themes of his article are of note. First is his acknowledgement that while student-athletes often have the least amount of power in the sportsnet, they should not be viewed as “‘dupes’ by minimising the roles and responsibilities they may have in exercising sovereignty over the treatment of their own bodies” (p. 54). This reinforces the importance of agency and its impact on the negotiation process, not just for athletes, but for all the individuals involved in the negotiation process. Secondly, and as a point of departure for this project, Walk reiterates that “future studies of sportsnets should . . . study how the processes of injury-related negotiation and conflict among coaches, athletes, and sports medicine personnel take place” (p. 51).

Post-secondary Intercollegiate Sport in Canada

In relation to professional sport and the NCAA, Canadian intercollegiate sport provides an interesting setting in which to examine the interactions between sport medicine clinicians and athletes. Many Canadian Interuniversity Sport (CIS—the national organising body for intercollegiate sport in Canada) athletes compete in other national and international competitions, and for a number of sports, the CIS represents an elite level of play. CIS athletes are subject to strict guidelines on academic eligibility and progress, and while the issue of athletic scholarships is currently hotly debated amongst the different regional sport federations affiliated with the CIS, most CIS athletes do not receive substantial athletic scholarships and many CIS teams tend to play with less pronounced pressures on success and revenue as compared to some big-time, revenue-producing NCAA Division I-A sports.

It is valuable to briefly contrast the different sport contexts mentioned and their influence on clinicians and athletes (see also Safai, in press). Researchers from the Centre for Research into Sport and Society (CRSS) at the University of Leicester, UK (e.g., Roderick & Waddington, 2000; Waddington, 1999, 2000) are beginning to explore the particular pressures placed on professional soccer players to play with injury, and the pressures placed on clinicians to collude with team management in either playing injured athletes or in hurrying athletes through medical treatment/therapy and back into action. Their research is an extension of some of the issues discussed by Nixon (1992) and Young (1993), and offers interesting insights into clinicians’ rights and responsibilities regarding the practice of medicine in professional sport contexts.

Studies of U.S. intercollegiate sport suggest other types of pressures on clinicians and athletes depending on the level of play (i.e., the division in which the sport program is located). While Nixon’s (1992) work presents a particular view of the NCAA sport system, there are various levels of U.S. intercollegiate sport, each operating with somewhat different competitive pressures. Most research on U.S. intercollegiate sports and athletes focuses on the minority, revenue generating
sports in Division I programs (see Adler & Adler, 2001; Zimbalist, 1999). Coakley (1998, p. 448) points out that, “most people focus attention on big-time, entertainment-oriented intercollegiate sport; these are the ones that get heavy media publicity, and have most of the problems.” Less is known about the experiences of student-athletes in lower division universities or those participating in the National Association of Intercollegiate Athletics (NAIA). Coakley (1998) acknowledges that such programs tend to be more athlete-centred (including a greater balance between sport and academics, and the awarding of fewer athletic scholarships; see also Eitzen, 2001, p. 212), and suggests that these are more comparable to Canadian university programs. By analysing clinician-athlete interactions in a Canadian university setting, this case study contributes to research on the pressures that yield broad differences between Canadian and U.S. intercollegiate sport, as well on the experiences of sport participants in intercollegiate sport programs outside of big-time, NCAA Division I sport programs.

Given that the study focuses on one university, it is important to note some of the features of the administrative unit which manages both intercollegiate sport and the sport medicine clinic for the university. The institutional climate of this administrative unit emphasizes both physical education and health. Its mission statement, values, and guiding principles are directed towards creating an environment that promotes internal analysis and self-evaluation (thus facilitating this study), with the aim of developing best practices to strengthen and improve the role of healthy physical activity, sport and recreation within the university community. Future research on the topic of pain and injury tolerance in Canadian intercollegiate sport would greatly profit from more systematic comparative research on policy between post-secondary institutions, and the ways in which policy translates into and informs the day-to-day actions of institutional members. This case study took at its point of departure the assumption that the established policies were influencing, to some degree, participants’ knowledge of health services available to them and participants’ health decisions with regards to intercollegiate competition. For example, each year, a handbook is produced for intercollegiate athletes as a resource and guide to the administrative unit’s position on health and intercollegiate sport participation (LCU Student-athlete Handbook, 2001-2002). The handbook contains information on a variety of subjects, including personal and academic development, and states that:

[This LCU] is committed to whole person development. Students are at a crucial stage of their intellectual, physical and social development. Athletic skill development should be encouraged alongside:

- intellectual accomplishment, professional preparation and critical reflection; health and well-being, including self-knowledge about health and well-being;
- interpersonal awareness and communication;
- intercultural awareness and communication;
- a commitment to personal excellence;
- a commitment to fair play and ethical behaviour;
- an ethic of care and service; and
- a commitment to a lifetime of involvement in physical activity. (p. 6; emphasis added)
This policy statement does not necessarily lead to the adoption of practices that emphasize health and well-being; policy rarely operates so causally. However, these guiding principles foster an atmosphere that values health and well-being in relation to competitive sport participation and may help to influence athletes and the choices they make about their bodies.

The sport medicine clinic in this study has a multi-disciplinary staff who provide preventive, diagnostic, and therapeutic services for physical activity-related health concerns for all members of the university community (i.e., students who participate in intercollegiate sport, non-intercollegiate students, faculty and staff) at the LCU. Since the CIS has little policy relating directly to the nature and conduct of sport medicine in varsity programs, sport medicine policies tend to be regulated by individual universities. The sport medicine clinic’s staff are often required to attend to numerous athletes from various teams throughout the year, and are not affiliated with a specific team as much as with the entire institution. This has important implications in that the clinic is not only a location on campus to access help for physical activity-related health concerns, but also is the university’s authority on the health and the healthcare of the athletic body. There are no other spaces or locations on this large campus that offer such specialized care. Thus, one could argue that there are no other locations or groupings of individuals who can dispute the actions, the decisions, or the power of this clinic. However, the clinic does not operate independently of the university, and it is accountable and “liable” to it. In turn, the structure of the administrative unit under study, and the relations between the administrators at all levels, fosters an environment that supports the sport medicine clinicians in their recommendations, ideally in protecting the health and well-being of the patient-athlete (a key issue here is liability; see Safai, in press).

Methods

The negotiation of treatment between sport medicine clinicians and student-athletes was examined using a combination of semi-structured interviews with sport medicine clinicians and intercollegiate athletes, and semi-structured focus groups with intercollegiate athletes—the latter designed to supplement and add context to the responses gained in the former. Participants were recruited through a variety of methods, including group e-mails, “snowball” sampling, and with the assistance of institutional “gatekeepers” such as the Athletic Director and Medical Director.

The tape-recorded interviews and the focus groups lasted 60–90 minutes each. Four sport medicine clinicians (two physicians, two physiotherapists) were interviewed once, while the Medical Director (a physician) was interviewed twice. Two focus groups were conducted with intercollegiate student-athletes. One involved five female varsity athletes from a range of sports—rowing, fencing, track and field (all three of which are non-contact sports), wrestling (contact sport), and rugby (collision sport), while the other focus group involved four male varsity athletes from fencing, track and field (non-contact sports), waterpolo (contact sport), and one athlete who participated in both rugby and football (both collision sports). In the hope of facilitating either the emergence or reinforcement of other risk-related themes, the focus groups were not limited to injured athletes. Furthermore,
five student-athletes (not involved in the focus groups) were individually inter-
viewed, three women and two men from various sports (one non-contact [volley-
ball], two contact [field hockey and basketball], and two collision [rugby]). De-
spite being an opportunity sample, the athlete sample presented a range of pain/
injury philosophies, a range of injury experiences from acute trauma to chronic
overuse injuries, and a range of different sport medicine experiences.

Due to the sensitive nature of this topic, strict measures were taken to main-
tain patient-clinician confidentiality. As a result, the researcher was not able to
observe actual negotiations of treatment between clinicians and athletes, and thus,
this study is limited to retrospective recall of these negotiations by the partici-
pants. Another limitation of this study is its small sample size—in total, the par-
ticipants included five clinicians, five athletes who were interviewed individually,
and five female and four male varsity athletes who participated in two focus groups.
Within sport medicine, there is a typology of sports that includes collision, contact
and non-contact, and the study’s sample includes male and female athletes in each
category. While the case study was not able to integrate a systematic comparison
by category because of the small numbers, very few differences were evident in
the course of analysis between types of sport. Furthermore, the small sample size
precluded systematic investigation of the pain/injury experiences of male and fe-
male athletes in these different types of sport. Finally, while the study offers a
snapshot of the practices and experiences of some clinicians and athletes at one
institution, its findings cannot easily be considered as representative of Canadian
intercollegiate programs at large. Further research needs to be conducted to inves-
tigate the pain/injury experiences of male and female athletes across the typology
of sports and to determine the generalizability of the findings reported here.

Interpreting Sport Medicine:
Athlete Experiences of a “Culture of Risk”

The participants’ responses support previous research on this topic, indicat-
ing that a “culture of risk” does exist even in a risk-taking environment (where
such risks are recognised). As Young and White (1995), and Young, White and
McTeer (1994, p. 182-183) note, there are particular ways of speaking and com-
municating that reflect uncritical and unquestioned acceptance and tolerance of
pain and injury—risk rhetoric and “injury talk.” Such discourses were evident
here. For example, as part of a discussion on downplaying injuries, an athlete
expressed her injury experiences in terms of hiding and concealing, from herself
as well as from her teammates and coaches:

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

Interviewer: Who did you downplay it to?

Athlete: Besides myself? My coaches . . . everyone. Like with [sport the
athlete participates in], it was my first year starting last year, and I want to
stay where I am, I don’t want to give up the opportunity I’ve been given.
With [sport], there’s only [a few players] on our team, so we feel obligated
[to play with injuries].
When discussing injuries with athletes in team contact and/or collision sports, it is evident that athletes in these sports engage heavily in rhetoric that minimises risk. However, in this study, the nature of the sport—whether an individual or team sport, or a non-contact, contact or collision sport—made little difference in how the athletes interpreted a “culture of risk.” Where collision and contact athletes would acknowledge that injury was more prevalent in their sports, non-contact athletes also showed injury-legitimating attitudes and tolerance of pain and risk-taking.

The degree of acceptance of the “culture of risk” incorporated a number of factors including, for example, the amount of off-season time available for recuperation, the stage of the varsity career (e.g., rookie year or final year of eligibility), and/or the importance of the competition (e.g., play-offs or finals). In one example, an athlete recognised that she could “push her limits,” because her season was shorter and she had more time to recuperate. In other examples, participants were more willing to risk the well-being of their bodies when they were closer to the end of their seasons and even more willing when it was the end of their varsity careers or during playoffs or finals. For example, an athlete acknowledged:

Maybe I’m in a biased position . . . but you understand different reasons for participating in sport, and it’s not all about winning and getting points in a game, or suiting up or dressing. I think for a lot of players, if it’s the last straw, the last chance, it’s a whole new motivation. There’s a whole new reason to suck it up, I guess.

This excerpt reinforces much of the risk rhetoric expressed by all the athletes participating in this study—a rhetoric that clings to ideologies of pushing limits, keeping going, and still winning in the face of challenge in the form of pain and injury. It also points to the amount of intrapersonal negotiation that athletes engage in regarding risk and risk-taking in sport at different stages of their lives and athletic careers. Another athlete recounted her changing sense of risk and injury:

I think before I was very hypersensitive to injury. Like all through high school, I’d come home and think “Oh my gosh, I think something is wrong with my shins.” I think I was almost a . . . hypochondriac. And I think that now, I go through things a bit more and ride things out a bit more. But I’m still aware of the point when I should go and see someone, whereas before, I think I went too early a lot of times.

This sense of intrapersonal negotiation is also highly evident when asking athletes to discuss their motives to seek medical help for their injuries or, in other words, to engage in interpersonal negotiation with a clinician. For some athletes, the severity of the injury precludes any decision-making on their part about whether or not to see a clinician—they are so injured that they need treatment. Yet, for other athletes, their injuries are not so acute or traumatic, and while they are experiencing pain, they can still function and perform to a certain degree. In these situations, we again see that a multitude of circumstances determines how athletes weigh their need to seek medical advice or treatment versus not seeking that advice or treatment. One veteran contact sport athlete, who was quite familiar with the LCU’s sport medicine clinic and with sport injury treatment, pointed out that he would only seek medical help for his injuries if he was confident, based on his
previous experiences, that he would receive ultrasound treatment for that injury to promote rapid healing. Therefore, he engages in a type of self-diagnosis and self-prognosis as part of his intrapersonal negotiation. For another male contact sport athlete, the decision to seek medical help also involves self-doctoring and in fact, team-doctoring since he refers to his teammates and coaches.

Interviewer: What makes you decide to go and see a clinician regarding an injury?

Athlete: It’s pretty much, if it’s not something that anybody from the team has experience with, it’s just make an appointment, just go to the clinic. But [the injury will have to] probably happen four or five times before they do it. Like for the most part, [a teammate] had a problem with his shoulder, and I had the same problem. So . . . he’s gone to see the physiotherapist and he knows roughly what can help, so okay [I] can talk to him about it or talk to the coach, ’cause they’ve both played nationals and I’m sure they’ve gone through a lot of various injuries or at least seen it. If they don’t know . . . it’s not a big deal to at least get it looked at [by a clinician].

This is reinforced by another participant, a male non-contact sport athlete, who acknowledged that only injuries “you’ve never seen before” would prompt a visit to a medical clinician. As one of the younger athletes on his team, he felt that he could look to other players and coaches—some of whom competed at national and international levels—for guidance for dealing with more “common” types of injuries particular to that sport. This certainly brings into question the influence of teammates on a number of issues. If athletes defer to their teammates in judgements about whether to seek medical help, we must ask if “team-doctoring” influences expectations about pain tolerance or mediates how players relate to physicians and therapists? This is clearly an area that needs to be more fully explored.

Other respondents also discussed conditions under which they were likely to see clinicians. For some athletes, the intrapersonal negotiation and decision-making was more categorical. One focus group participant suggests, “once [the injury] starts affecting play, then for sure. That’s a clear-cut line, but before that it’s up to you, how much pain you can handle.” Interestingly, in response to this comment, another participant in the focus group remarked that he found that “rather than fighting through the pain, forever and ever, if you just went to the therapist and told them, they’d have you fixed sooner than [later].” For a collision sport player, the decision to see a sport medicine physician rested in the hands of the team therapists:

Well, we have the luxury of having therapists, so I think that up to a point where it’s beyond their scope of ability to treat the injury or potential injury, they’ll probably recommend you go see one of the medical doctors. That’s part of their protocol. They’ll try to assess it and do their best to diagnose what’s going on, and if it’s something that can’t be treated just within the team, then they won’t hesitate to suggest that you see one of the physicians and have it diagnosed by one of the doctors down there, and then treated accordingly.

For this athlete, there was little acknowledgement of intrapersonal negotiation, but greater reliance on interpersonal negotiation between himself and the clinicians.
Negotiation of the “Culture of Risk”: Clinicians’ Experiences

In some ways, clinicians’ understanding of the “culture of risk,” and their ways of negotiating with patients within that culture explicitly and implicitly supports athletes’ acceptance of risk, pain and injury. This is not to suggest a definitive promotion of pain and injury tolerance by the clinicians—there is no evidence from this study to support such a claim. Rather, the responses indicate that sport medicine clinicians are influenced by, and influence, a “culture of risk,” and thus negotiate with athletes within that context.

The idiosyncratic nature of the ways in which the clinicians negotiate with the athletes in this “culture of risk” must be emphasized. While there are medical protocols in place for clinicians to deal with particular injuries and/or to help ascertain relevant information, much of the content of the interaction between clinicians and patient-athletes occurs without the benefit of “situational” guidelines. In other words, clinicians rely upon medical protocols to supply diagnostic and treatment guidelines, but those protocols often do not equip clinicians to treat the circumstances surrounding the injury or to address the, potentially competing, wishes of patient-athletes, coaches and even clinicians. As one clinician acknowledged:

All this stuff is so grey. And so I, as a medical professional, I find myself relying on my belief system and my value system to determine what is a potential catastrophic situation versus what is a nuisance situation.

Put another way, this individual acknowledges that clinicians negotiate the “culture of risk” with their patient-athletes via continuous decision-making and weighing of the perceived risks and benefits of playing or not playing with pain and injury. For some of the clinicians, their understanding (and negotiation) of the “culture of risk” was influenced, in part, by their personal sport backgrounds—backgrounds that often included injury experiences and admissions of their own tolerance of pain/injury. Like the athletes, the clinicians acknowledged that negotiations are sensitive to a number of factors, including such circumstances as important times during the season and/or important competitions, or when dealing with different types of intercollegiate athletes (e.g., the benchwarmer vs. the team all-star).

Timing is one such contextual factor. Just as athletes approach the end of their season or the end of their varsity career with different motivations to play with pain/injury, sport medicine clinicians also acknowledge the different stakes involved during the negotiation of treatment at these times.

Interviewer: Is [the “culture of risk”] amplified when it’s closer to the end of season or end of career?

Clinician: I think we know that there’s a different level of intensity in the competition and there’s a different tolerance of pain or different desire to or willingness to play hurt. ’Cause now “It’s for keeps,” “This is what it’s all about”—all those clichés that get trotted out during play-offs. We implicitly and explicitly support that. Explicitly in that we, where there is a conflict for services [i.e., who has direct access to the clinicians] . . . the one distinction that we make is teams in [national] play-offs come ahead of teams in [provincial] play-offs come ahead of teams in regular season come ahead of
teams in exhibition come ahead of teams between seasons. So we prioritize. So, that’s sort of an explicit support of the importance of championships. Implicitly, I think anyone in the sports business supports it. It’s important to the athletes, it’s important to the coaches. We are working for them . . . we enjoy working for them or else we wouldn’t be here, we’ve all grown up playing sport or being part of it, so there is a certain understanding of the competitive sport model and how there is implicit and explicit support of that. And I don’t have a huge problem, as long people are still making an intelligent and informed decision.

While the clinician is not suggesting that the health of any athlete would be compromised, he acknowledges that pain/injury limits do shift at times towards a greater tolerance and acceptance of the “culture of risk.”

It should be reiterated that no evidence was found to suggest that sport medicine clinicians working with athletes at this LCU deliberately reinforced and promoted the “culture of risk” and/or value the performance of the athlete above his/her health and well-being. While Nixon’s research in this area argued that an institutional alliance exists in perpetuating the acceptance of a “culture of risk” by athletes, more recent research shows that such structures are not monolithic. Walk (1997, p. 53) points out that “there has clearly been a premature leap from theoretically based critiques of sportsnets, devoid of empirical support, to recommendations for institutional and structural changes to medical services within sportsnets.” I endeavour to not make that premature leap here. What the evidence does point to is a need to more fully understand the ways in which the “culture of risk” “frames the medical practices” of the clinicians (Walk, 1997, p. 33). There is also a need to understand that the clinicians are working in a broader environment or culture—a competitive sport culture—and with patients who, at times, under-value health in relation to performance. Sport medicine clinicians are influenced by this “culture of risk” and influence this “culture of risk.”

Being part of the CIS system does influence the negotiation of treatment between clinicians and athletes. While previous studies have noted the way in which some sport programs within the NCAA Division I-A value athlete-students (see Eitzen, 2001), one could argue that this institution in the CIS system positions sport participants primarily as student-athletes. This positioning and prioritizing of athletes as students affects the decisions athletes make with regard to their health, particularly since many Canadian intercollegiate athletes do not come into the CIS system with professional or national team aspirations. Some athletes do aspire to, and reach, those levels of competition, however for most student-athletes as one clinician notes, intercollegiate sport “is . . . the icing on the cake, it’s not the cake.”

This brings us to the space of interaction between patient-athletes and clinicians. While regulation and policy (at either provincial/national or institutional level) have changed the climate in which the negotiations occur, and have defined limits on what the content of negotiations can be, neither regulation nor policy can control that content (see Navarro, 1986; Williams & Calnan, 1996). What is key here is the recognition that each negotiation between a clinician and a patient-athlete is unique to the character of individuals involved and the conditions and circumstances around the injury, as well as pre-existing and pre-defined limits on the clinician-patient relationship. All negotiations occur along a continuum that is dynamic, fluid and framed by an equally dynamic and fluid understanding of risk.
The Dialectic Between Risk and Precaution
Within Sport Medicine

While a “culture of risk” does exist at this LCU, and frames the negotiation of treatment between clinicians and patient-athletes, a “culture of precaution” seems to temper the acceptance and tolerance of pain and injury. In negotiation, the key dynamic between practitioners and clients is the communication, interpretation and exchange of information between physician and patient-athlete, based on the weighing of perceived risks versus the perceived benefits of playing with an injury.

Figure 1 presents one possible way of mapping the interaction (in this case, with physicians) in what are varied and unique negotiations between clinicians and patient-athletes. Realistically, one image alone cannot encompass all the effects of relevant variables such as class, gender, nature of injury, emotion, influence of others, race, dis/ability, or biography on the process of negotiation between two individuals. Therefore, the model presents only one way of interpreting the negotiation process. Figure 1 shows the two-way relationship, between clinicians and athletes based on the exchange of information, and as influenced by the coach (see note 5). Although not fully addressed in the present article, the coach and the physician often have a two-way relationship, whereas as the exchange between the coach and the athlete is less reciprocal. Similarly, when the injury is “exceptional” (e.g., a concussion), the physician-patient relationship is also one-way.

The “culture of risk” within which negotiations between clinicians, patient-athletes and coaches occur is not absolute. It exists alongside what one of the clinicians interviewed termed a “culture of precaution,” which resists the promotion and tolerance of injury as part of sport. As seen in the model and as exemplified by the proliferation of injury-legitimating norms, the “culture of risk” is dominant (indicated by a solid line), but it is tempered by a concern for the health and safety of student-athletes in sport as expressed by all participants (indicated by the dotted line of the “culture of precaution”). For example, a clinician recounts his negotiation with an elite individual contact sport athlete in which he favoured precaution:

---

**Figure 1 — Site of Negotiation: Physician.**
I had an athlete who was competing at the nationals, and this was more of an impression I got . . . that this was someone who was trying out for the national team and his nationals were coming up, and he had injured himself and he wanted to compete. And my perception was that he wanted to compete because he wanted to get on the national team, but after talking to him, and going through everything, it was clear that he wanted to be able to compete because he wanted to be able to compete, but in fact his ranking was so low that he wasn’t going to be able to make the national team. And he was aware of that, so I told him that it’s better that he not compete, and he was quite accepting of this.

Both Nixon (1992) and Walk (1997) acknowledge the paradoxical nature of comments made by coaches, clinicians, and athletes that support risk-taking and injury, while communicating concern and caution for the health and welfare of student-athletes. In this study, most clinicians were quick to point out that, for the most part, the athletes and coaches at this institution tended to err on the side of caution when it came to pain and injury, and that they did not heavily subscribe to stereotypical behaviours of denying, hiding or downplaying injury.

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

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

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

This supports the existence of a “culture of precaution” that interacts with the dominant “culture of risk.” While the athlete defines “a strained muscle” as an injury that can be “mess[ed] around with,” the effects of head injuries are “permanent” and “huge.”

Discussions of head injuries offered other examples that, for the most part, support the “culture of precaution.” In fact, where the limits of playing or not playing with injury can be shifted and blurred if the injury is musculo-skeletal in nature, there is zero-tolerance for playing with head/brain injuries at this institution. Returning to Figure 1, while much of the dialogue between clinician and patient-athlete is two-way, a one-way arrow also exists going from the clinician to the patient-athlete in an attempt to illustrate the fact that the line of communication significantly changes when the injury is exceptional (e.g., head injuries). When the injury is neurological in nature, the clinicians argue that the patient-athlete is not in a position to negotiate or bargain. However, while the clinicians believe in, and generally practice a zero-tolerance policy regarding head injuries, not all patient-athletes support this policy or accept clinicians’ recommendations. While some
athletes see the potentially devastating consequences of head injuries, as in the quote above, others choose to ignore the risks and negotiate with clinicians accordingly. One clinician recounted her experiences with such an athlete:

There was a varsity hockey player who I talked to for a while about quitting, and he didn’t. But, probably the best thing was for him to never play again 'cause of the amount of concussions and the severity of them that he already had. He had testing done, and everything else . . . he was having a lot of post-concussive symptoms. So, the first time I saw him, I talked to him about it and I don’t think he ever followed up with me, even though I asked him to. And then I talked to the trainer and after an appropriate time, he went back to play again. So, he didn’t give up hockey. And then I saw him for another injury, and I talked to him again—you know, “if you have another concussion again, it could be very serious . . .” —and I didn’t see him again.

Another clinician noted that patient-athletes often engage in negotiating and bargaining with him over the subject of head/brain injuries, which they often do not understand or interpret as significant. He proposed that this is partly a result of the fact that there are different intensities of head injuries that present themselves differently. However, all indicate some degree of brain tissue trauma, and while most lay people would recognise unconsciousness as a clear sign of head injury, fewer would know that a headache or a general feeling of unease after a knock to the head can also be indicative of a brain injury. He also suggested that the disbelief results from the lack of visibility of head injuries. While a broken bone is represented visually by a cast or crutches, a head injury is often invisible. Still, head injuries are not negotiable; they represent one area where the “culture of precaution” is enforced.

A final aspect of the negotiation of treatment, one that has rarely if ever been examined, is the promotion of “sensible risks” by clinicians to injured athletes. This was most evident in interviews with athletic therapists and physiotherapists, due in part to their different relationships with patient-athletes based on greater contact time (depending on the type of injury and rehabilitation required). Therapists characterize the ways in which patient-athletes are encouraged to return to competition as “goal-setting and testing.” One went so far as to participate in the sport with the athlete to check whether she could return to the sport, and also in an attempt to ease her apprehension about doing so. He describes this in the following way:

A rugby player, was recovering from knee surgery. And part of her [return to competition] criteria was sport specific tasks. She had good range and good strength, so we went to a room where mats were set up and went through tackling. She had to tackle me, I had to tackle her, to see if, not only physically but also psychologically, she was ready to be hit, take tackles and absorb force. And we probably spent 20 minutes in the room going through scrummaging, we were twisting each other up in scrummage type positions, tackling stuff, and then I made her run the pit a couple of times to tire her out, and we did everything over again. And she was able to successfully do it without any pain, she felt confident, she felt strong, and then we said “Okay.”
I’ve had patients who are overly protective, and I say to them “Just go and start playing. Don’t worry about it. Don’t come back until you hurt yourself again.” I’ve occasionally had people who are overprotective which is good ’cause you know they’re not gonna be foolish and hurt themselves, but at the same time, my job is to get them back as soon as possible. I had a varsity ____ player who hurt their ankle, was really afraid and wearing an aircast for like 3 or 4 weeks, and I [said], “There’s no way you should be wearing that for that long, get it off, get walking.” He started to feel a lot better, ’cause he was starting to move again, felt a lot better psychologically, he was “Oh yeah, I was hoping to get in this season,” he played half a year. It took him a while to get back into it, but I laid out everything for him, “As long as you do this and this, you’re fine.” And he went through a progression really quickly and I was like “Hey, there you go.” I’ve had situations where you can get off and get back into it as soon as possible, and they’ll [ask] “Well, can I try this?” and I’ll [say] “Sure, try this. If it hurts then you can’t, if it doesn’t then you can keep going.” Progressing the levels again . . . and that again is what functional rehab is for, give the athlete confidence that they can hit each level until they reach their potential, as opposed to, [throwing] someone back into activity ’cause that’s when you hurt yourself. So again, patient education, showing them that they’re not okay or that they are.

For this clinician, goal-setting and testing are fundamental to patient education. However, what the above passage also communicates is the notion of “sensible risk-taking.” This is not the same as promotion of a “culture of risk,” but rather the facilitation of re-entry into competition, physically, emotionally and psychologically. This is integral for patient-athletes who have been (or are perceived to be) marginalised from their regularly healthy bodies (cf. Scarry, 1985), from their usual sport experiences, or from their peers, and who have lost confidence in their abilities. Furthermore, this is a concept that also contradicts the “conspiratorial” sportsnet, and supports other research showing that the “culture of risk” is a far more complex concept than simply simply overconformity to a sport ethic.

**Conclusion**

In this case study, it is evident that as the “culture of risk” frames the ways in which clinicians and patient-athletes negotiate treatment, the “culture of precaution” also frames the ways in which individuals view their health and well-being. Furthermore, in the notion of “sensible risk,” this study points to some of the ways in which clinicians operate to direct athletes back towards sport participation after being injured—in a sense, this is risk-taking that is guided and supported by medical professionals. What is essential to draw from this study is that these concepts—the “culture of risk,” the “culture of precaution,” and the promotion of “sensible risks” influence and are influenced by clinicians, athletes, and even coaches. The relationship between these concepts helps us, as researchers, to better conceptualise the pain/injury-negotiation complex. Furthermore, it begins to add layers to, and complicate, our understanding of the practice of sport medicine in general, if not solely at the Canadian intercollegiate level.

Much of the research in this field (including Nixon’s and Walk’s influential work) has focused primarily on post-secondary intercollegiate sport, with more
recent research contributions on the practice of sport medicine in professional sport in the United Kingdom. This case study does not rectify the situation, since its focus is on intercollegiate sport at an institution where the pressures to tolerate injury are offset by a counter-culture of precaution. This is likely an important structural and cultural difference between such an institution and other sport contexts, such as NCAA Division I-A sports or professional sport organisations. The case study offers a snapshot of what might exist when organisations attempt to explicitly address the health and well-being of athletes.

The clinic and the clinicians examined in this study have an important effect on the way intercollegiate sport is conducted, and this is influenced by the clinic’s location in an educational and health-oriented administrative unit. The sport medicine clinic is not just a service, but rather valued as a space where physical vulnerability can be exposed and where healing does occur. Ultimately, even though the negotiations that occur between clinicians and patient-athletes are fluid, dynamic and show some evidence of the “culture of risk,” the core process remains centred on the desire to heal. This is a result, in part, of an institutional focus that emphasize policies creating an academic and athletic context in which health and well-being are prioritised and valued. One could effectively argue that the very concept of a “culture of precaution” is an extension of the emphasis on healthy and positive life-long sport participation.

Since this project is one of the first attempts to locate and examine the negotiation process between patient-athletes and clinicians, it would be “premature” (Walk, 1997) to recommend policy-related transformations for institutions. Future studies must empirically investigate the ways in which policy works in framing the practice of sport medicine or the sport medicine clinic, and the effect of policy on the structure within which negotiation occurs. We must understand that while policy can structure the context of negotiation, it cannot determine the content of negotiation. It can nonetheless influence the attitudes of individuals towards injury, an example being the increasing awareness of the consequences of concussions, and the subsequent creation of guidelines and policies with regard to the non-negotiation of head injuries—evidence of moves towards safeguarding athletes and their life-long health.

References


**Notes**

1 While researchers are beginning to tease out the different pain experiences of athletes, existing research has not clearly elucidated the nature of pain in sport—specifically the differentiation between pain of effort from bodily exertion (e.g., training) versus pain of injury. Furthermore, while the two are not completely discrete, athletes are rarely taught to distinguish between the two in the “culture of risk.”

2 Hughes and Coakley (1991, p. 310) have characterised the acceptance of pain and injury in sport as “positive deviance,” which they suggest refers to a form of overconformity that goes so far in “following commonly accepted rule or standards that it interferes with the well-being of self or others.” Much of the positive deviance in sport involves an unquestioned acceptance of the “sport ethic,” defined as “the cluster of beliefs that many people in [competitive] sports have come to use as the dominant criteria for defining what it really means, in their social worlds, to be an athlete” (Coakley, 1998, p. 152). This includes such beliefs as making sacrifices for “The Game” and accepting risks and playing through pain. Not all athletes conform to this ethic, but these norms make up the mindset of many athletes in competitive sports. Hughes and Coakley (1991, p. 316) stress “the norms of the sport ethic are positive norms; it is under the condition of uncritical acceptance and extreme overconformity that they are associated with dangerous and destructive behaviour.”

3 Nixon has investigated pain and injury tolerance in a number of ways (see also Nixon, 1993, 1994, 1996a, 1996b).
4CIS policy does specifically address two sport medicine-related items. First, it does specifically address the use of performance-enhancing substances. Second, it specifically mentions the sport medicine requirements for football. Football is the only sport that is required by the CIS to have a full complement of physicians and trainers at each and every game, usually provided by the home team. The full complement includes a sport medicine physician or orthopaedic surgeon, a minimum of one full-time athletic and/or sport physiotherapist, and student therapists.

While beyond the scope of this paper, this case study also considered the role of coaches (who were interviewed in focus group sessions), and the ways in which the coach is both an intermediary between and influence on clinicians and student-athletes within the “culture of risk.”

After the completion of the case study, the researcher was introduced to a similar model presented by Veatch (1981), who proposed a “triple contract theory” to describe tripartite negotiations between clinicians, patients, and society. In the sport world, one could replace the third corner of the triangle with team/coach as opposed to society (D. Richards, personal communication, July 2002).

Acknowledgments

Thank you to Peter Donnelly for his guidance with this study, and to Nancy Theberge and the anonymous reviewers for their constructive feedback on earlier drafts. Thanks as well to Doug Richards for his assistance with this project.