Module 4. Communication, leadership and group management

Unit 4.1 Managing medical information

Sports medicine, as with anything relating to people's health, requires considerable sensitivity and professionalism when conveying or communicating certain medical details.

In the case of athletes, when health details such as sports injuries are communicated within the environment of major events or professional teams, more attention and care is required.

The purpose of this unit is to give clear points about what we believe this communication should be like.

Firstly, we should ask who is communicating the information. At important clubs or events there is typically someone in charge of communication. Let's take a look at this communicator's profile, typically known as a press officer or communications director.

4.1.1 Profile of the communications specialist

A professional team's communications specialist should meet several basic requirements. The first, and undoubtedly one of the most important, is discretion, but there are others.

- Discretion is fundamental in any job, but even more so when working alongside a professional club's medical services.

  Why? The answer is very simple: because they deal with information, and information is power.

  Misuse information shared at the wrong time can weaken one's own team (if it is in the hands of others), or can be directly damaging if not used in due course.

  In short, one the most important characteristics that a professional team's communications specialist should know how to handle is discretion.

- Professionalism. They must always know where they are, who they are working for and what organization they are a part of. The impact of being, say, with FC Barcelona is not the same as being with Melilla.

- Respect and cordiality. Respect towards the institution and its superiors as well as cordiality in daily dealings with players and the rest of the staff is essential for the smooth functioning of the team.

- Trust. This needs to be earned on a daily basis. Without mutual trust there is no success. The players and staff need to trust the communications specialist: they are the best in their field and the players and staff should think so as well. There is a reason they are with Barça. In order for everything to work perfectly, there must be mutual trust.

- Anticipating situations. Let's say, for example, that one of the team's very important players is celebrating the anniversary of his debut as a first team player on the date specified for the start of the season. Using this knowledge, the Communication, Marketing and Protocol departments could plan a heartfelt tribute. These types of actions need to be undertaken with appropriate timing and insight, or they tend not to turn out well.

Other characteristics:

- Speaking other languages.

- Mastering social networks.

- Interacting smoothly with the media and competitions (ACB, Euroleague, Catalan Federation ('Federación Catalana'), Spanish Federation ('Federación Española')).

- Managing the team on a daily basis (interviews, reports, statistics, various requests).

4.1.2 Relación del jefe de prensa con el staff y equipo

The relationship between the communications specialist and the staff and/or players should always be based on respect and professionalism. This does not mean that there should not be cordiality (it is better if there is), but professionalism and respect for everyone's work are essential.

The Relationship Between the Physician and the Staff

The relationship between the team sports physician and the team communications specialist is especially important. They should coordinate principles regarding communication or non-communication about an injury, for example. Sometimes knowing when to communicate is just as important as knowing when not to communicate.

The communications specialist should be informed about the physical state of the players at all times. It is important that the communication be smooth and unbiased. The player, the coach and the physician each play an important role in this regard; all three should be informed about what is planned to be communicated when the need arises.

It is important to maintain a close relationship with the staff; help should be offered whenever necessary. It is very easy to be there through the good times, but one must also be there during rough patches. All these things count, and this is one of the prerequisites of a good staff member.

The Relationship With the Team

When it comes to the relationship with players, it is important that this be cordial and respectful, although it is best not to mix the professional and personal sides.

There are some players that one might have a greater affinity with, or would go out to eat with (if the opportunity were to arise); but, by way of a straightforward example, and as a matter of professional ethics, one should never mix with those going out to party.

4.1.3 The relationship of the communications specialist with the Club

The Structure

In the professional structure of a large club the communications specialist is not an independent figure, but rather depends on the Communication Department.

Example: In our example, although the basketball division does function independently, the team communications specialist reports to two senior managers: the head of Professional Sports Communications and the division's general manager.

What does this mean in practice? This means that despite enjoying certain freedom of movement, if there are important decisions that need to be made during daily management (interviews, reports, announcements on the website or social media networks) these will always need to be agreed upon.

Weekly Meeting

If we are talking about a club with various divisions, the interaction with the other communication specialists should be smooth and constant. In order to achieve this, a weekly meeting is advisable in which everyone is present under the supervision of the club's Communications Department head.

Relationship With Other Departments

A professional team's communications specialist should have almost daily interaction with the head of marketing. Promotions for all games, radio and television announcements, general campaigns or photo shoots, etc., should all be agreed upon by both sides.

There is also interaction with other departments such as accreditation or protocol, which create strategies together when it comes time to call former players or former coaches to the team's box to attend games.

4.1.4 Relationship with the Media

Interaction with the various media organizations should always be smooth and take place daily.

Here is a good example of a work tool that improves communication with the media: A few seasons ago, it was decided to initiate a WhatsApp mailing list that facilitated the reinforcement of information that had previously been given in a press release. It has also been helpful for sharing announcements prior to protagonist meetings (coaches or players) that the communications specialist selects for that purpose.

The media, both national and international, often contact communication departments via calls, emails or WhatsApp.

Most daily communication relates to:

- queries: for example, why is a player absent?
- specific questions: for example, when is the deadline for appealing the sentence in the case of a player's accusation against the club?
- clarifications: the answers can be immediate if there are no complications, otherwise always agree with superiors.

Right holders

There is an important distinction between the treatment that must be given, as an obligation, to media rights holders, and media without rights.

What does this mean? Simply, that rights holders receive preferential treatment and have pre-agreed interviews with protagonists before games and post-game. In addition to this, if they request specific interviews they must be accommodated wherever possible.

The Rest of the Media

The rest of the media always receives cordial and personable treatment. This plays a part, or should play a part, in the way communication specialists work. They try to make the media's job easier because they are sustained by what the team produces, and the team needs them in order to further promote their brand.

One thing to keep in mind is social networking. The emergence of social networks caused a lot of damage to traditional journalism, since any person with a cell phone in their hand can capture a moment and turn something that does not seem to be newsworthy into news.

4.1.5 Internal communication with the head of medical services

As we mentioned in section 2, there should be a very close relationship between the communications specialist and the head of a team's medical services.

The utmost trust is required, because sometimes knowing when to communicate is just as important as knowing when not to communicate.

Various factors should be considered in terms of communicating or not communicating news of an injury:

- The influence the player has on the team.
- The interest the next opponent may have in knowing that a player is injured.
- Whether or not it is necessary to share the recovery time. If it is not necessary to communicate it, the phrase "their progress will determine their readiness" is often used. If communication is desired because they will undergo surgery, for example, an approximate recovery time should be given.
- The interests of the player or their representative. For example: Communicating news about a player that has a future with the NBA is not the same as communicating news about one who is in the final stages of his or her career and who is less important to the coach. It should be pointed out that medical press releases always take place with the player's consent.

4.1.6 Communicating with other teams and institutions

Communication with other teams

It is important to know the communications policies of other teams. Frequent meetings should be held with the communication specialists of other clubs in order to understand how they work. The biggest leagues in the world of soccer or basketball, for example, usually do this.

Communication with Major Leagues

The Example of Professional European Basketball

As also happens in other sports (soccer, handball, among others), at the end of every season there is a meeting between all of the Euroleague communication specialists to establish criteria and debate new league regulations. In the case of Liga Endesa, this meeting happens at the beginning of the year and is called a communication seminar.

In both cases the meetings are very beneficial because they essentially serve to debate the bylaws, or standards, of each league. These bylaws, in the case of both leagues, directly affect the television companies with whom there are always details to be addressed and worked on every season.

Examples:

En Euroliga

In the Euroleague the game day guidelines are set in which typically, based on the bylaws, a camera enters the locker room while the coach is having the pre-game pep talk with the players.

Euroleague bylaws also require a player from each team to respond to a flash-interview question during the rest period of each game; each coach must answer as well, also in question format, when returning to the court after the players' rest period. Once the game has finished, the coach and one player from the winning team will engage with the press in a press conference; this event takes place in English.

Likewise, according to the bylaws, the rights holders (television companies with rights) can request the attention of the coach before the game using an interview format (3-4 questions), as well as after the game, and with the presence of a player. In this case, if the request is made we are obligated to comply. If not, it is not mandatory.

In Liga Endesa

In Liga Endesa the only television company with rights, in this case Movistar Plus, sets the guidelines for request levels during a game. In this case we find ourselves with the classic pre-game interview with both coaches, a flash-interview during the rest period with one player from each team - the same format used by the international Euroleague - as well as an interview with the coach and one player from the winning team.

Other

Other examples of requests are the famous Euroleague and Liga Endesa Media-Days before the start of the regular season: these involve the leagues' own media attention

(video recordings, interviews and marketing actions to supply the leagues themselves with endless content) as well as rights holders from both leagues. In this case, we are talking about Movistar Plus and Televisión de Cataluña.

Throughout the season, there are also constant requests for interviews or reports from the Euroleague itself - in this case, from FMI, the powerful company which manages its audiovisual rights, and from Liga Endesa itself via their audiovisual department. In both cases they generally coincide with the lead-up to important games or in the event of exceptional achievements. One example from this season (2017/18) is the 20-year celebration of Juan Carlos Navarro's debut with the FC Barcelona Lassa first team.

In Summary

Players are always exposed to the media and to their own competitions, which request their image to sell their product. It is the communication specialist's job to advise them so they "sell the product well", make it attractive, convince them of how good it could be for their image and that of the Club and, if needed, to protect them and advise them prior to possible questions that could affect their position within the team.

4.1.7 The 'Return to Play'

The return to play is one of the most important moments in the final stretch of a player's injury recovery.

At the end of any recovery there are two fundamental details to stress while communicating with the team sports physician in charge.

When do they want to communicate?

How do they want to communicate?

The when

It should be when the coaching staff decides, based on the guidelines of the medical staff.

The medical staff are the only ones who really know the progress of the player in question, whether they have met their target recovery times and how the recovery has gone. Afterwards, the coaching staff, with the head trainer, decides the best timing for communication in agreement with the team sports physician and the player and, finally, they inform the press officer so they can prepare the medical release statement.

The "When" times are also important. One option could be after a winning game, after a team's losing streak to encourage them with the news, or after a long recovery period to motivate the player and boost their interest in returning. There are many options for when to communicate this information, although they should all be explored and addressed

alongside the medical services involved (they know the psychological conditions of the affected player and whether the information that they are about to receive could affect them), the coaching staff (mainly the trainer) and the team communication specialist (as the one who will receive input from outside via the press and social networks).

The how

There are many factors that could alter the way a player's return to play is communicated.

Example 1: Imagine a team of 13 players in which one important player is injured. The other 12 players are healthy and playing very well. The decision about how to communicate this return should be very measured, considering every word of the press release so as not to hurt any other teammate or pressure the player who is returning after some time out of competition.

Example 2: Imagine, on the other hand, that the team is stuck in an ongoing results crisis and the player who needs to make their return to the team is a star. In this case, requiring the athlete to return to play after a recovery period to make them look like the team's savior should be avoided.

It is important to remember that any medical press releases should happen under the supervision of the team's head of medical services, as well as the assistance of the Club's medical services manager if necessary, together with the consent of the player in question. The model for the press release is always the same, although when a return to play is expected then there will be a greater impact at the level of the Club's own media.

Unit 4.2 Communication

4.2.1 Introduction

Communication is a multifaceted phenomenon involving the conveyance or exchange of thoughts, ideas, feelings or information through verbal and non-verbal channels. This means talking and listening, and it is most effective when it leads to mutual understanding. It is based on mutual trust and respect.

Athletes communicate with many different people in various ways, both in competition and in training. Coaches base their own performance on effective communication with their athletes and, occasionally, sports failures are caused by problems somewhere in this process: difficulties in conveyance, perception or understanding.

Effective communication contains six elements: The message must be clear, concise, correct, complete, courteous and constructive. Good communication skills enable coaches to get more out of their relationship with athletes.

There are several recommendations for improving these skills:

1. Active listening: paying full attention to what other people say, taking the time to understand, asking relevant questions, and not interrupting at inappropriate times.

2. Continuous evaluation of the effectiveness of the communication process in order to make improvements or take corrective action.

3. Critical thinking: using logic and reasoning to identify strengths, weaknesses, possible solutions, conclusions or alternative approaches to problems.

4. Utilizing methods of written communication based on the needs of the recipient.

There are areas of knowledge and skills that facilitate the development of communication skills. Here are some of them:

- Methodology for solving complex problems:
    - identify the problem,
    - review related information,
    - develop and evaluate options,
    - implement solutions

- Persuasion: this is used to change the way others think or behave.
- Own resource management: capability to motivate and identify the best resources for each objective.
- Language proficiency is required to interact with the recipient. It is particularly important to know the structure and content of the English language.
- Psychology: knowledge of human behavior and performance; individual differences in ability, personality and interests; learning and motivation.
- Administration and management: knowledge of strategic planning principles and resource management.
- Computer skills: administrative systems, word processing, file management, records and form design.
- Sociology and anthropology: knowledge of human behavior and group dynamics.

4.2.2 Physician-patient communication

Communication is the tool that facilitates direct relationships between human beings. A relationship is established between physician and patient, based on communication in which a diverse range of nuances appear.

As a physician, developing communicative skills and strategies is essential for practicing the profession, since the ailments that human beings suffer are based on the understanding and knowledge we have of them. Management of illness requires patient complicity and a commitment to overcome it, and for this the physician must translate scientific knowledge into a language that is understandable to the patient, while being strict and rigorous. The success of this patient participation in managing the process will help ensure the best decisions are made.

Three requirements are asked of the physician for an optimal communication process with the patient:

- To know and be up-to-date with the pathology, the biological processes that surround it and the resources needed to address it. This is acquired through study, experience and teamwork.
- To understand the process-modifying elements involving patients (to know about them and their environment). This is achieved through proximity.
- To empathize with patients in their time of illness and, at the same time, to be able to convey ideas in the best possible way.

Illness is an individual process: not all patients experience illness in the same way or can approach it in the same manner, but trust between the patient and the therapist is of great help during decision-making, especially in the case of very complex decisions. In order to achieve this trust, it is essential to maintain total respect for the medical profession's own code of ethics and for information confidentiality. The physician and the athlete are not equals but share the responsibility for decision-making on the basis of equality and freedom.

Assessment of the environment is essential in high competition sport, although this makes the process more complex. In any sport, and most obviously in team sports, medical decisions can affect the patient, their peers, the competition and the Club for which they compete. Expectations of sporting success or the development of contractual matters may be affected or resolved by decisions made in the face of injury.

Health problems affect the most intimate aspects of the individual, and these situations should only be communicated with the athlete's consent. It is true that athletes' health is relevant for the decision-making process of Club coaches and owners, but data will only be disclosed with the athlete's explicit authorization. In communication, it is said that priority number one is the player, followed by their parents or legal tutors when they are under legal age. Once the player and their parent are updated, if essential, the communication will be extended to the team coaches, administration and property in the terms agreed with the athlete. Only when required by the patient, agents will get informed.

Some physicians have the reputation of being arrogant and not helpful with their patients. Besides, injured athletes receive therapeutic offers and information about their injury through multiple channels, which, sometimes, are in the interest of third parties. The most valued physician is the one who keeps a positive relationship with their patients. When physicians show humbleness, understanding and empathy, they foster mutual respect, credibility, and this will allow a better interaction with the patient, who could be really vulnerable in case of a relevant injury. Athletes are patients who are experts in analysing signals. They can easily tell among the people who surround them who are the ones who make the decisions, and they build their relationship in order to get a personal benefit from those who prioritise the athlete's health above anything else.

A physician's best form of marketing is to invest in training and to take the time to tend to athletes' health needs. Medical knowledge improves when experience is shared among professionals, and this process should always be based on respect for the patient and the need for maximum confidentiality.

Sometimes, the physician and other members of the health team, particularly physiotherapists, are familiar with intimate details of the athletes' lives that the athletes themselves share. This sensitive information must be carefully managed, and it is

recommended not to disclose it at any level other than that authorized by the athlete himself. A breach of this confidentiality would result in the loss of player trust.

Here are two situations between a soccer player and the team sports physician. They are extreme fictional stories designed to illustrate two styles of information management in an injury process and the type of dialogue that is established between athletes.

Case study 1

Atlético Deportivo is a football club that relies on players from the youth academy. The coaching staff is made up of professionals with a long career at “Atlético Deportivo".

Physician: Adolfo is a medical expert with 25 years of professional experience, 19 of which are with the team. He knows the sport and the competition well. He has a well-established reputation among athletes and in the sport environment, although his experience raises suspicions among his peers and staff members.

Patient: Jonathan has been the starting goalkeeper for the first team for nine years. Two years ago, at the end of the season, he suffered from shoulder instability and subsequently underwent surgery; since then, he has suffered from a level of discomfort that makes it difficult to complete some training sessions. After the warm-up he has no problems playing matches; he doesn’t really understand what is happening to him or why he still has pain when he already had surgery. A friend has recommended that he consult other professionals about his condition, and even to have an MRI.

Situation: After a training session, before the call-up for the next match. In the final leg of the league, he has no chance of winning the championship, but must avoid relegation.

Adolfo: What's with the training session, kid? You seem to have taken a turn for the worse, I don’t think the gaffer likes this attitude of yours.

Jonathan: Hey, Doc, it’s just that when I move my shoulder, it’s stiff.

Adolfo: Come on, man, it’s nothing. Does the other one hurt too?

Jonathan: Sometimes.

Adolfo: Then it’s nothing, have you done the prevention exercises?

Jonathan: Every day, you told me it's sacrosanct. Maybe we should tell the gaffer about this.

Adolfo (assertively): Just hang in there, there are no risks, it’s just a bit of pain, when you can’t take it anymore I’ll give you something. Anyway, it’s not that bad. No need to bother the gaffer with this, he has enough on his plate. How’s your wife? And the kids?

Jonathan (hesitantly): They're great, but, my shoulder, I dunno...

Adolfo: Family is what counts: if they're okay, you're okay. Now, off to the showers...

Jonathan: (getting braver): You think everything's fine, don't you? But I'm the one who's hurting.

Adolfo: (exasperated): Goddamn it, Jona, it'll hurt where I tell you it will!

Jonathan: Hey man, chill out, don't get upset.

Adolfo: At the most crucial moment of the league you come up with these stories, I'm telling you that you don't have anything serious to worry about! Who do you think was next to you in the operating room and saw just how the inside of your shoulder looks?

Jonathan: All right, all right.

Adolfo: Your shoulder's bothering you, yes, but it can't get any worse. All athletes play with some discomfort. I promise you that if you warm up well you'll be just fine, and you know you're the best. When you're not afraid of the pain, I haven't seen anyone else like you.

Jonathan: Okay, I'll do as you say.

Adolfo: I promise you, things will go just the way I'm telling you.

Jonathan: Okay, I feel a bit better.

Adolfo: Now, off to the shower and on Sunday give it all you've got. If we lose we can all quit!

Jonathan: Thanks, Doc, bye.

Adolfo: See you later, and say hi to your family.

Case study 2

Racing Club is a top-level football team with a chance of winning the championship. The staff is made up of foreign coaches who have won titles with other teams.

Professional: physician, 36 years of age, who's been with the team for two years. He knows the Club but doesn't get much recognition from it. He introduced some changes in the team's nutrition and medical care prior to the training sessions, which aroused slight criticism among the players, but the changes are well regarded by some of the sporting staff.

Patient: Ernesto is a key player and top scorer at Racing Club. This season he suffered three muscle injuries that have cost him his starting position. He doesn't currently have any discomfort but he fears a relapse, so much so that he tries not to talk about it. He also had no discomfort before the previous injuries. This year he aims to attend the Olympic Games, where the National Team is hoping to make history.

Situation: After a training session, before the call-up for the next match. At the end of the league, when the title is about to be decided.

Carlos: How's it going, champion? How did you get on?

Ernesto: Good, good. I didn't notice anything.

Carlos (friendly): You took part in the training session, you practically did it all, right?

Ernesto: I've been telling you for days that it's okay, I feel fine.

Carlos (unsure): If we had more time, before the match I would repeat the strength test with you and do another scan just to make sure.

Ernesto: Do you think I could break it again?

Carlos: Ernesto, there's always some element of risk, the most important thing is that you feel good.

Ernesto: Of course I feel good, but...

Carlos: Your feelings are the best test for understanding how your body is, and we have to listen to them.

Ernesto: Yeah, yeah, but if I could break it again I don't know if I should play tomorrow.

Carlos: If you're not all right, you'd better not risk it; you know how muscle injuries are.

Ernesto: But if I don't play, I won't know how I am.

Carlos: Do you feel all right?

Ernesto: Yes, I do, tell the gaffer that I'll play and let's not talk any more about it.

Carlos: I'd rather wait until the next game.

Ernesto: Yeah, yeah, don't worry, nothing will happen.

Carlos: Okay, okay, whatever you say. But don't break it, because if you do the blame will fall on me; in the end I am the doctor and the one responsible for you.

Ernesto: Come on, Doc, if I get injured the one who suffers is me.

Carlos: I'll tell the gaffer that he can count on you to play but just for a few minutes, I've already warned you how treacherous these injuries can be.

Ernesto (wearily): Okay, thanks.

Comments

In the first case study, with an authoritarian and paternalistic style, the doctor assumes the risks and responsibility for the injury, but ignores the complaints of the goalkeeper and even overrules him. He is an expert professional and close to the athlete, but they maintain an unequal relationship in which the prestige of the professional borders on an abuse of authority, so it is not clear whether the interests of the patient or the team are being prioritized. With this attitude, and when faced with patients who do not accept their role of submission, situations of conflict can easily arise.

It would be advisable for the physician to involve the patient more in the decision-making process, to take into account the patient's complaints and to examine the patient to ensure that the discomfort does not correspond with an aggravation of the injury. On the other hand, the doctor recognizes and values that it is a competitive moment for the team. He also knows the athlete and the athlete's environment well and accompanies him in the operating room, which may explain his manner and his paternalistic, almost contemptuous treatment of the patient and his feelings. In short, he assumes sole responsibility for the decision, with the intention of de-stressing the athlete so that he can focus on the next match.

Athletes could show themselves insecure, and they value other people's confidence, their physicians included. This is why, it is recommended that the professional shows confidence when diagnosing, processing their thoughts, and elaborating a therapeutic plan. They should be understanding with patients. Especially with athletes; they acknowledge that. Along with trust and understanding, they must show a strong moral and ethical character. It is said that if the physician wonders whether or not something is right for the patient, then it is probably not.

In the second case study, the physician maintains an indecisive and hesitant style under the pretense of being democratic. At an important time in the decision-making process, such as the return to competition after a muscular injury, the physician has revealed all his doubts, as well as, most probably, those of the environment, placing yet more pressure on the athlete. He is not able to make the decision, nor even to share responsibility for it, and not only does he pass all the pressure on to the athlete but he also adds his own concerns about the fear of a recurrence. In this case, the professional should be advised to form an argument on a more fundamental basis, whether based on his own experience,

on functional or imaging tests or, if necessary, on consultations with other professionals with more experience. Making the player decide, putting pressure on him if the decision goes wrong and protecting his own back with the well-known “I told you so” means the physician is not assuming his proper role and his presence is completely unnecessary. His attitude shows that he is concerned about how the situation will ultimately affect him. He is not interested in the team's situation and he does not show any empathy with the player.

4.2.3 Communication of medical matters to the team and to the coaching and management staff

Case study 3

Fede Álvarez is a 28-year-old top-level player. At the beginning of the season, it is detected that he is an asymptomatic carrier of a serious infection, with no organic functional repercussions nor a chance of it being aggravated by playing competitive sports at high intensity. The disease has no specific treatment, but requires analytical monitoring every two months, especially of kidney, liver and lipid metabolism functions. 5% of infected patients will progress to severe organ failure within 15 years, with a fatal outcome. Furthermore, the disease is highly contagious and is transmitted through blood and other fluids (sexual contact).

The athlete's current condition does not contraindicate his participation in the team, but it becomes imperative to take measures to prevent contagion. Sharing kit items, towels or drink containers should be avoided, while physiotherapy and nursing care should always be carried out with gloves. Some of these measures are not common in the dressing room of a football team and incorporating them without proper justification will create reasonable doubts among players in the team environment.

Once the patient has been assessed and informed of the need for monitoring and possible developments, some important decisions must be made:

1. How should the situation be reported, and how should the need to take measures to reduce the risk of contagion to other players be dealt with?

2. How do you inform your coaching and management staff of a situation that is currently asymptomatic, but which may worsen considerably in the future? It should be noted that the athlete’s participation may be compromised and the possibility of renewing a contract with the athlete may be affected.

3. How should the situation be communicated to the physiotherapists who treat the player on a daily basis? Is it permissible to inform them to increase protection measures even at the risk of stigmatizing the player without their consent?

It is a complex case, with the possibility of bad progression and a very high risk of contagion making it all the more dramatic. At the moment, the player's participation is not compromised, which makes the situation incomprehensible in some environments.

It is particularly important to share all information with the patient to improve the decision-making process, involving the patient and obtaining their complicity. What is more, this process should be well-planned and well-founded so as to avoid giving false expectations to the patient or adding more drama than necessary.

Seeking expert advice may be useful, but infectious disease specialists will say that the steps to be taken are the usual steps to reduce the risk of infection (continuous use of gloves, which should be changed at every action, avoid swapping clothes, towels and other kit items). Anyone who knows the reality of a locker room knows that it is difficult to strictly implement these behaviours.

It is advisable to share the decision-making process and information management plan with the patient. Ideally, athletes themselves would communicate their situation to their teammates and other staff; this communication should be planned and accompanied by the necessary medical information that the teammates have the right to know. Athletes cannot be required to inform relevant others of their situation by themselves, but if the physician does so, the physician must do so on behalf of the patient and agree with the patient what information is to be shared.

There are other cases in which the management of information in relation to certain aspects of an athlete's health is particularly complex. All pathologies in the psychosocial sphere are difficult to manage for public figures. Athletes are seen as success projects, and these pathologies are related to failure, and they are not easily accepted by the masses. To this, we have to add the distrust these episodes create. That is why affected athletes are thankful when these cases are handled discreetly. Drug abuse is less frequent in athletes than in the general population, but it could appear.Correct handling of these cases requires extreme confidentiality, but they should be shared with the coach as sports performance can be highly affected and may even compromise the outcome of doping tests.

In a sports injury the uncertainty among professional athletes is frequent since their projects are at stake. In many cases they face high levels of scepticism. If the patient requests it, a consultation with another professional should be facilitated in order to obtain a second opinion. Furthermore, the athletes and managers need all the details of the treatment plan, the processes that will be followed and the timescales. Time management is crucial and necessary for sports teams, so these details must be shared with the coaching staff.

4.2.4 Media and communications

Case study 4

Ricardo Martínez is a top-level player, 25 years old, and suffering from a sharp pain in his right knee when he shoots at goal with his right leg. The patient underwent surgery at the age of 20 to repair an injury to his anterior cruciate ligament in the right knee. At the age of 21, he had to go back for more surgery following a recurrence in the form of a rupture of the plasty.

Although the knee shows no serious symptoms and the imaging tests are negative, the persistence of symptoms for two weeks makes it advisable to request an assessment with the surgeon who operated on the patient four years ago. Together, the team sports physician, the surgeon and the player decide to perform an arthroscopy to complete the assessment of the player, in which a minimal lesion of the internal meniscus is detected and a partial meniscectomy is required to get it back to normal.

A press release is issued by consensus with the player in the following terms: "The player, Ricardo Martínez, underwent an arthroscopy to solve the discomfort in his knee. He will soon begin the rehabilitation process. It is expected that the patient will be discharged within approximately five weeks, although clinical developments will conclusively determine availability".

Three days later, the surgeon gives a media interview in which he explains:

- the good condition of the cruciate ligament plasty that he himself performed years ago;
- the absence of a relationship between the current and previous injuries;
- the presence of a meniscus lesion that was repaired.

Assessing the situation, some doubts arise regarding whether the physician was in breach of confidentiality:

1. Based on public interest, is it permissible for the physician to share this information?
2. Is it permissible to inform the Club's managers and owners of the situation, bearing in mind that this may affect the renewal terms of the player's contract?
3. Is the breach of confidentiality based on the devaluation of the player something that should be reported?

In this case a medical communication is performed according to the public interest in a relevant player who will face a long withdrawal. In the first place, it is enough with a general approach to the arthroscopy problem, without giving details. In the second place,

it also refers, in a general way, to the rehabilitation process the player will follow, and finally, it is informed that player will need an estimated time of 5 weeks to return to competition. This term could change according to the evolution of the player. In it, it is implicit that the player's health is the priority when making decisions.

Unilateral communication on part of the surgeon breaks the confidentiality demanded to any professional, and the player loses value since he is attributed a meniscus injury before the public opinion. The surgeon lies when negating the relationship between the meniscus injury and previous injuries of the anterior cruciate ligament. Such relationship is accepted and documented in medical literature.He only pursues self-interest and self-marketing, even at the expense of revealing confidential information. At present, clubs and athletes who require the intervention of outside professionals are advised to sign confidentiality clauses so as to avoid situations such as those described in this case study.

Finally, this case study raises the question of how this information should be treated behind closed doors, with the Club's owners and management. As always, the ideal situation is to reach a consensus between the athlete and the physician on how to manage the information and provide only the data which has been authorized by the player. In the event that the physician is aware of relevant information that has not been authorized to be disclosed, a conflict of interest may arise. To avoid this dilemma and to avoid players losing trust in the team sports physician, it is recommended that athletes who have suffered significant injuries while working for the Club undergo an independent medical-orthopedic assessment prior to contract renewal.

Of course, the attitude of the doctor who reveals details of anyone's health without the patient's consent is, from a criminal and professional point of view, reportable, even if an attempt is made to justify this action on the basis of alleged public interest.

4.2.5 Scientific communication

The improvement of knowledge is based on the scientific method, which requires the development of a hypothesis that must be discarded after observation. The method, results and conclusions should be shared so that they can be endorsed in other environments and circumstances.

This scientific communication is always based on two precepts:

1. to improve the health of athletes,
2. to improve the quality of the game itself.

Nonetheless, many sports professionals (especially coaches) are not willing to share the data of their teams, because it can result in a loss of competitive advantage. This precept, when it exists, is inviolable and must be respected to the letter. In the event that any data

is shared, it must have the explicit, informed and signed consent of the athletes involved, the team coaches and the Club's owners.

Even with such authorizations, any communication should be made in such a way that it is not possible to identify any of the athletes covered by the scientific communication. This principle, which must be respected for all patients, is especially relevant when the information concerns public figures.

The scientific dissemination of the results requires creativity to develop new ideas and answers. Reliability of the data presented, integrity (because the job requires to be honest and ethic), respect with team work, thoroughness and attention to detail, analytical thinking in order to use logic when approaching problems, self-control of their own emotions, persistence when facing obstacles, independence to interpret and present results, and finally, innovation and applicability in the design of the study to focus it in solving work-related problems should be added to the authors' thoughts.

4.2.6 Communication between team sports physicians from opponent and national teams

Top-level athletes must attend various sporting events, including events outside the Club. In these circumstances, different medical teams will successively tend to the athlete's health, passing from the Club's control to that of the national team. Something similar can happen when an athlete changes from one Club to be signed up by another. For optimal medical care, it may be ideal to share relevant clinical information between the various medical teams that tend to the player. This process must always be ordered and authorized by the athlete.

In some professional leagues, the athlete's relevant medical information is deposited in the computer systems of the league to be shared between the league (through the medical commission) and the athlete himself. In these environments, the transfer of information between the physicians of the teams in which the athlete plays is implicitly authorized. This transfer of information is regulated by computer security protocols that allow and monitor access to relevant information.

Unit 4.3 Managing people and situations

4.3.1 Introduction

Historically, the relationship between physician and patient has been of critical importance to the success of a treatment. Accordingly, respect, attention, a good bedside manner, concern, and the ability to meet the patient's needs (identify their illness, provide relief, and, above all else, cure them) are fundamental. This is an interaction involving two individuals with different personal, cultural, and societal characteristics, in which one party is in need of help and the other provides it.

In addition, the patient's personality will be a determining factor in how their illness presents from a clinical standpoint. One hundred and thirty years ago, Claude Bernard said that "there are no diseases, only sick people." "Many doctors have substituted the use of technology for the clinical method for diagnostic objectives or treatments, given that using it would require the doctor to spend more time and dedication on the patient."

“The greatest mistake in the treatment of diseases is that there are physicians for the body and physicians for the soul, although the two cannot be separated.”

Platon

Hence the need for sports medicine development to focus on the person and not the patient. There is a fundamental commitment within medicine, and that is to provide all of the care needed to mitigate pain, prevent eventual complications and reduce feelings of suffering, be they physical or psychological. For this reason, medical-scientific knowledge is at the core of any medical intervention, but an understanding of how to consider the individual and empathize with suffering, as well as the obligation to try and offer a better quality of life, are just as important. This approach means that we are acting upon a person: guaranteeing health in an overarching sense and increasing the patient's sense of being cared for.

This vision of medical intervention results in a need for fundamental sentiments such as empathy, an understanding of reality, and unconditional acceptance on the part of the professional:

- Empathy, because it bestows the ability to understand the unique nature of the person being cared for.
- An understanding of reality because we need to ensure our ability to deliver a diagnosis and, at the same time, show solidarity with the patient's concern and suffering and be ready to help.

- Unconditional acceptance requires us to accept the patient and their condition without making value judgments about their lifestyle. This improves and facilitates a patent's adherence to treatment. It builds confidence in the medical intervention and leads to a better prognosis with regard to the remission of symptoms.

We will now highlight a set of psychological skills that medical personnel must be trained in so as to foster a more effective physician-patient relationship.

- Assertive communication: Encourages a natural and comfortable relationship in situations that are far from easy, as is the case when managing an injury.
- Self-regulation skills: Emotional control in both verbal and non-verbal communication.
- Problem-solving skills: Facilitate the decision-making process as a source of support for the athlete/patient.
- Emotional support: Encourages change and provides support for decision making (Prochaska, 1997).

In order to address the necessary skills that medical personnel must acquire to improve interaction with the athlete/patient, this document focuses on four key topics that will provide tools to be used during a medical intervention.

4.3.2 The player's environment

It is important that all of the people in an athlete's environment are aware of the importance of their behavior and their emotions, as well as their consequences in all areas related to an athlete's well-being.

The athlete's environment refers to the entire universe of people that exercise some influence over the athlete, and who are agents for change at any given time during the course of the athlete's career.

The most pertinent groups surrounding the athlete may include:

Family environment

The people who shape their beliefs and behaviors, and who are present in their life from the moment they are born.

Sport environment

The coaching staff, medical professionals, sports facilities staff; all of the individuals with whom they come into contact from the moment they begin playing the sport onwards.

Social environment

The athlete's teammates and peers. The influence that teammates and other peers have is unassailable, especially during childhood and adolescence, which are the most important stages for developing our personal beliefs and values. This stage, when that influence is greatest, coincides with taking up a sport and beginning an athletic career.

To add nuance, we have to consider actors who interact with the athlete on a day-to-day basis (coaches, physical trainers, physiotherapists, physicians, teammates, personnel), but if we are discussing the person, then the number of actors increases to include family, friends, classmates and teachers, the Club and the sport. Each of these is a point of reference, as well as the closest transmitter of values and beliefs, as well as knowledge. The way we perceive, interpret and, ultimately, decide how to react in our day-to-day life configures a belief system. As stated by Ramsey, "beliefs become a map inscribed in our system, guiding us, or better yet, leading us in the world in order to fulfill our needs."

This belief system shapes our life and our way of being and behaving; in other words, the beliefs we have determine the meaning that we assign to our experiences, which need to be taken into account during any medical intervention so as to establish a good rapport with the athlete.

All of the professionals who are part of the athlete's environment - be they coaching staff, parents, health professionals, physiotherapists or physical trainers - and who are looking to facilitate interactions with the athlete, can follow the advice below:

- Review their values and beliefs with the aim of developing a more professional, rigorous approach, without falling prey to trends.
- Be informed about behaviors that serve as precursors to high-risk conduct and which may be indicators that such conduct is forthcoming, as well as symptoms that may lead to unhealthy behavior - or that allow unhealthy behavior to continue - that will make athletic progress challenging.
- Use the information available about each athlete (age, performance level, athletic specialty, expectations - both the athlete's own and those of their immediate circle) in order to establish realistic goals in medical interventions.
- Avoid practices that do not take into account the needs and goals of the athletes.
- Understand the different parts of the athletic season (pre-season, training, competition, vacation) when developing a treatment plan.

- Encourage dialogue with other applied sports science specialists who participate in the development of an athlete's career (coaches, physiotherapists, physical trainers, psychologists and tutors, among others).

- Be aware of the morphological changes that occur in early adolescence. In many sports, these coincide with an increase in workload and a greater number of training sessions which are responsible for physical change. The function of the environment is to run in parallel with these natural and necessary changes, which are not negative changes in terms of their impact on athletic performance, but are changes to which the athlete needs to adapt as quickly and seamlessly as possible.

- Be aware of the athlete's progress in their sport and not just of the results they have achieved. Report regularly and positively on all progress made.

4.3.3 Motivation toward the patient

"When we are no longer able to change a situation, we are challenged to change ourselves."

"If we know what we want to achieve, then we must focus on how to do so."

Víktor Frank

One of the terms that may best explain success (or failure) in sports and in other areas of life is the motivation that one has to reach goals. When talking about motivation, or a 'motivating agent', there seems to be the idea that there is a recipe for which we must name the ingredients and the order of steps to be followed. However, each of us has the ability to motive ourselves as well as to motivate others. It's not a question of making a list of techniques, but rather about identifying our personal strengths, leveraging them and applying them in our professional lives as well as our emotional, family and social lives.

Throughout this reading, we will examine how physicians can become motivated to motivate their patients, given that, as with coaches, the physician is the best change agent with regard to the patient's behavior.

In the literature, the term motivation is used in a variety of ways:

The direction and intensity of one's effort (Sage, 1977) is a definition that is frequently used as a starting point for motivational theories in sports psychology. In addition to this concept, we can add others related to personality traits, the impact of external influences, or the consequences of a behavior.

Once we know what it is we're discussing, it is important to remember that there are two fundamental components to motivation (figure 1):

1. The first component relates to direction: what is the individual seeking, approaching or attracted to? Ultimately, the subject of our attention determines our path.

2. The second component, which is no less important, is intensity, which refers to the quantity of effort used in a specific situation to continue in a given direction. How much are we willing to pay to achieve a specific goal? What are the obstacles and opportunities we encounter? What personal traits do we have for achieving our goal?

On one hand, we choose a path, or set a goal or a target; and on the other hand, we either know, or must consider, how much it will cost, what we will need, how long it will take us or how much time we have. These two components are critical in order to ensure that our motivation is not undermined and that we can tolerate frustration (which will, of course, decrease our motivation) as we pursue the goal we have set.

That being said, in the case of the relationship between a physician and a patient/athlete, the physician is the one who determines the direction and intensity. This is due to the fact that the goal, or the driver, of a medical intervention is to cure or reduce the symptoms of an illness; it is the physician, therefore, who will define it. During this process, keeping in mind the patient's goal (direction and intensity) will allow the physician to address unrealistic expectations. The chronicity or temporary nature of a pathological picture should not become an obstacle which causes us to lose sight of the most important part of an illness or injury: ensuring that our patients maintain a high level of interest for dealing with it as best they can and focusing on improving their condition.

In an athletic environment, a very similar process occurs when the athlete contracts an illness or suffers an injury that removes them from the field of play. Both situations assume a sudden change in their initial goals. Often this is driven by the different professionals who work with him, from the coach to physicians, physiotherapists, physical trainers and psychologists.

Communication plays a key role in this process, in which our most important task is defining a goal which will determine the athlete's attention, for which we can establish timelines and anticipate situations and reactions. The communication style we use can lead to an optimal motivational climate, in which the patient follows medical guidelines: this is belief in and commitment to treatment.

There are two ways to improve communication between physician and patient:

Assertive Model

Ideas, opinions or perceptions are communicated in a clear and concrete way, based on two factors: the ability to take action based on self-confidence without aiming to hinder the recipient.

Consulting Model

In addition to the aforementioned model, we suggest another style, which is that of help, guidance and advice in order to identify a common goal during a medical intervention.

Either one will improve communication with the patient as long as they feel better heard and cared for.

A physician often has to assess symptoms (which are not always well-defined) and analyze a variety of diagnostic tests, both of which require time spent on tasks other than the immediate physician-patient goal of finding a cure or establishing the absence of a disease. To this we add the patient's own uncertainties, which place the entire responsibility for the diagnosis - as well as that of future decisions and any consequences they may have - on the physician. It is important to have excellent communication skills, meaning that one must have the resources to address a myriad of situations that may occur during a professional career, leading to the type of relationship that will stand the test of time.

In these situations it is impossible not to communicate (Watzlawick, 1991). During a medical consultation, something is always communicated. At the very least, we should aim for this communication to be efficient and focused on the main goals of both the physician and the patient.

When we talk about an assertive communication style, we refer to delivering a message:

- Cleary To the patient.
- In a straightforward manner Without uncertainty (where the diagnosis permits).
- Appropriately Focused on the patient's needs

These three characteristics will allow us to become aware of a physician's personal communication style. In order to deliver a message, there must be a message recipient and, therefore, a listener: listening must be active and empathetic. The message has emotionally-charged content that we need to be able to perceive and, above all else, handle.

With a consulting model (figure 3), we are able to go even further. This method uses resources that have already been internalized by the physician in order to treat the patient, in order to generate even small changes in their behavior, beliefs or attitudes, without the patient feeling pushed into doing so. It simply happens because what is being

sought in counseling is the patient's involvement. Health is not something that should be forced on someone. This model enables the patient to commit to the part of treatment which involves them, meaning that they will feel directly involved in their own progress because they exercise control over themselves (table 1). Within this model, information suggests something more than merely the transmission of content related to illness and treatment. It involves putting the patient in touch with some of the emotional reactions that these episodes usually trigger, as well as foreseeing family, social or professional consequences, resistance to change and the patient's personal resources. It means helping them face their emotions and become personally aware of their condition, but with the support of the physician, who is the expert on the matter.

Last, but not least, the physician must open up channels with the patient's community, which can often serve as a facilitator for positive progress in treating an illness.

Consulting Model

- Reinforce the patient's claims
- Listen, prioritizing the athlete's claims
- Take the patient's goals into account
- Accept ambivalence on the part of the patient
- Guide the patient toward acceptance of their reality
- Assess using milestones, without undue pressure
- Take the patient's lifestyle into account

Up until this point, we have talked about how physicians can integrate motivational resources in order to keep the patient's level of commitment and motivation high. But we cannot wrap up without first drawing your attention to a topic that often generates unhealthy attitudes with regard to the physician-patient relationship: namely, the level of emotional involvement on the part of the health professional, be it too little or too much. After discussing goal-setting, designing an action plan for the patient which indicates (insofar as is possible) timeframes, and outlining everything with a communication style that is well-suited to the patient, and which also respects the physician's personal style, we can't forget that for the patient, being supported, listened to and feeling important (even if the consultation lasts just ten minutes) is the driving force that will help them begin to confront their condition.

As noted previously, an injury brings about moments of crisis, uncertainty and doubt. In order for the patient not to remain stuck in a phase that prevents them from looking forward toward recovery, it is necessary to offer them an opportunity to express their

doubts, questions and fears. Sometimes uncertainties do not arise during the consultation itself, but afterward, when they find themselves alone, ruminating on a variety of scenarios related to their situation. Having an a posteriori space to address their concerns will decrease the patient's degree of anxiety; they will feel emotionally supported and will be able to adhere quickly to the planned treatment.

While a physician cannot become emotionally involved, distance is not the best method by which to establish a smooth relationship with the patient and their relatives. The ability to detect their emotions and show that you have understood them will not reflect negatively on the physician.

4.3.4 Psychological variables in athletes: approaches and tools

Throughout section 3, we will provide tools that the physician and patient can use to work together on adherence to injury rehabilitation. The patient can be taught these techniques in order to be able to reflect on their current situation and where they are headed. These techniques also allow for relationship-building and coordination between the medical professional and the patient, as well as for assessment of any progress made.

Motivation

In section 2, we discussed the motivation which a medical professional needs to project in their role as motivator for a patient/athlete. A health professional is a change agent with regard to a patient's behavior.

Goal-setting allows us to determine the most appropriate goals at any given time, according to the situation in which we find ourselves. This exercise will serve as a roadmap, a guide for the patient: what do they want to do; when do they need to achieve it by; and what concrete actions do they need to carry out in order to achieve it? With this tool, both patient and physician can assess progress and take daily steps forward.

In order to be able to set goals successfully, the goals must have the following characteristics:

- Explicit: well-defined so that they can be understood and analyzed.
- Precise: they specify what they are referring to.
- Meaningful: to the patient's recovery.
- Defined time parameters.
- Achievable: the goals can be reached.
- Observable.

- Measurable.

Table 1: Example of Goal-Setting Techniques

Short-term goals	Date of completion	Steps to be taken

Source: Developed by the authors.

Achieving short-term goals not only moves the patient closer to their final goal (complete recovery) but it also allows them to work on motivation and self-confidence in the short- and long-term.

Attention: Being Present

Attention is a crucial psychological variable for high-level athletes with regard to achieving athletic success. From the very beginning, in order to learn technique and to master, practice, and strengthen skills, there is a base level of attention and focus needed.

During an athlete's rehabilitation, attention is equally important: concentrating on the 'here and now' and, in many instances, relearning what has already been learned. This not only helps prevent certain injuries, but it also needs to be taken into account when an athlete is recovering.

Another technique that encourages attention is visualization. Alongside relaxation, it can assist with recovery, treatment adherence and patient motivation in terms of treatment.

Using information provided by the medical team, the patient will be able to apply visualization techniques to the injured area (Palmi, 1988), in which they will work on mental imagery, allowing for the ideomotor effect (also known as the Carpenter effect). This effect can be defined as the feeling a person experiences at a neuromuscular level when they imagine themselves performing an action, or when they are carrying out an external visual inspection, leading to electrical activity that activates the cerebral areas which control the movement patterns of the imagined gesture.

Visualization can be performed in two ways:

- External: the patient imagines themselves as a spectator watching themselves perform exercises recommended by the professional.
- Internal: the patient imagines the sensations that they feel when they do those exercises.

The more realistic the visualization is, the more impact it will have on the patient; they can imagine their actual training facility, its smells, sounds, textures, etc. These two forms of visualization are not mutually exclusive. We can even say that they are complementary, in that they both help with the patient's self-esteem and motivation when the images are associated with positive feelings and successful situations.

Activation

Another variable to understand in the world of sports is the optimal activation level needed in each athletic situation and, more importantly, how to manage it according to the player's circumstances. Taking into account the context in which we find ourselves, both physician and patient must understand and manage the existing activation level during the medical process.

Relaxation techniques are one resource for helping the athlete to endure various situations that may arise during illness or convalescence (uncertainty, pain, fear), and which can help maintain control over our activation level, increasing or decreasing the amount of activity needed based on the situation in which the patient finds themselves.

There are different types of relaxation: we recommend using the one that best suits the subject and will help them achieve their objective (optimal activation level) more quickly.

- Jacobson's relaxation technique, which focuses on stretching the entire body zone-by-zone.
- Autogenic relaxation: autogenic training.
- Mindfulness.

- Others (music, relaxing imagery, personal routines, etc.)

The most important thing is to experiment and find the technique which is best suited to the individual and with which they are most comfortable.

Self-Confidence

We can define self-confidence as a person's belief in their ability to perform a desired behavior to a satisfactory level. It is the ability to believe in yourself and in the self-efficacy that will enable you to reach your maximum potential.

When a physician treats an injured athlete, self-confidence is affected. In some cases it will be temporary, especially if the athlete feels they are improving rapidly and the recovery time is short; in others, depending on the seriousness of the injury and the time needed for rehabilitation, it can be longer-lasting.

We suggest undertaking exercises for identifying personal strengths and areas for improvement. This is applicable to recovery from a sports-related injury as a tool that helps us become aware of the resources we have at our disposal and how they can be used.

Below, we suggest another task that encourages the patient to reflect on their emotions in order to work on their self-esteem, which will, in turn, have an impact on their self-confidence.

Table 2: Sample Exercise for Increasing Self-Confidence

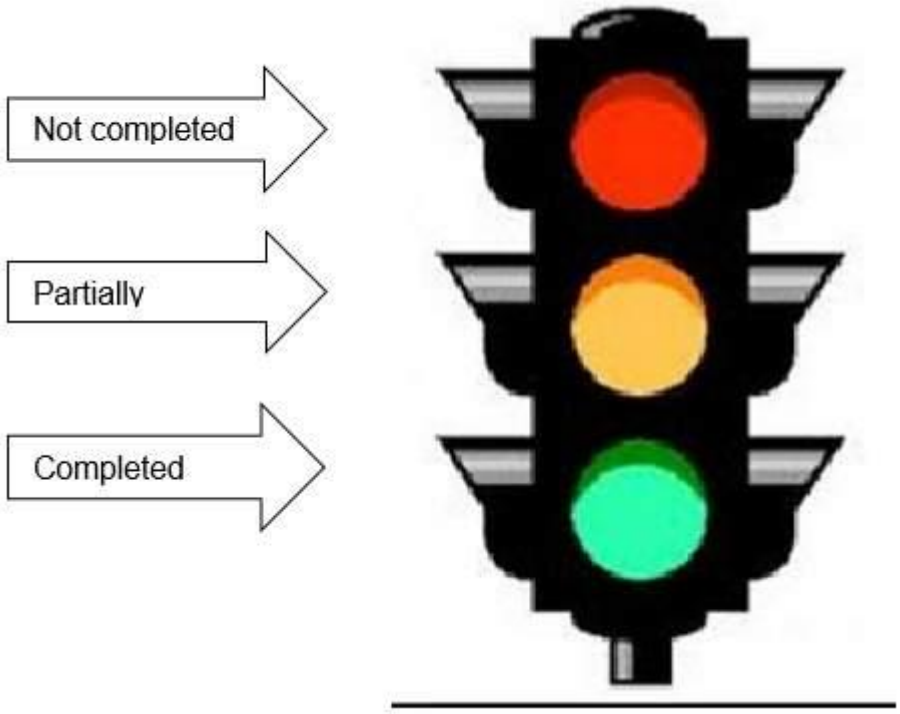
Goal: where and when	**Do 6 sets of an exercise that really challenges me.**
How capable do I feel of accomplishing it?	**1 2 3 4 5 6 7 8 9 10**

Outcome	**I completed it in its entirety.**
What did I learn about myself?	**I didn't finish and stopped doing the sets.** **I'm proud of myself.** **I'm satisfied with my day.** **Doing these things makes me feel capable of anything.**

Source: Developed by the authors.

Another visual, easy-to-use tool is the stoplight technique:

Figure 1: Stoplight Technique



Source: Developed by the authors.

This technique connects the colors of a stoplight with the completion (or incompletion) of recovery milestones identified by the physician while, at the same time, associating the color with the feeling that comes from completing the proposed medical actions.

Table 3: Application of the Stoplight Technique

Monday	Tuesday	Wednesday	Thursday	Friday
X	X	X	X	X
X	X	X	X	X

Source: Prepared by the authors.

After reaching the recommended milestones, the patient takes time to fill the grid in with colors, thinking about their performance and their feelings associated with it. For example:

1. If I completed what I set out to do, how do I feel? Happy, proud, responsible, capable.

2. If I have partially completed it? I feel good, but I could have pushed myself more; today was not my day.

3. If I did not complete what I set out to do? Cheated, sad, reluctant.

This exercise can spur on the patient to work on their awareness of positive emotions associated with recovery and to feel more capable of what is being asked of them. In the case of negative feelings stemming from not meeting established goals, it will help to suggest new goals to work on the following day.

Another suggestion to make to the patient is to establish a reward system to apply they are meeting their minor goals, so as to reinforce the behavior that led them to do so. With regard to situations in which the subject has lost confidence, we must tell them to think

about their achievements, all of the goals they have reached and progress they have made over time. One bad day is not synonymous with failure, but rather represents new challenges for the following day.

4.3.5 Psychological approach to an athlete's injury

Injuries to athletes are often considered a professional risk. However, injuries don't come out of nowhere: they have causes. Some of them are the result of an interaction within the athletic environment (such as a playing field in poor condition, bad weather) or with other people or objects (a collision with a teammate or an opponent). In addition, when reviewing the scientific literature, examples of injuries caused by personal issues frequently appear: a poorly-executed warm-up, a lack of skill, fatigue, lack of attention, poorly managed stress, etc.

Some aspects of injuries caused by an athlete's own behavior are a window into the athlete's character, mental health and personal circumstances. According to Cratty (1993), athletes who are predisposed to injury tend to feel insecure and very anxious. Those who worry too much tend to attribute their injuries to causes such as a lack of concentration or attention and/or insufficient bodily awareness. Similarly, athletes who overtrain, are exhausted or are highly irritable also tend to be predisposed to injury. This is especially true when they are undergoing significant changes in their life, such as a new training facility, a change of coach, a disagreement with an sporting organization, a death in the family, marital problems, or starting or ending formal education (Bramwell, Masuda & Holmes, 1975). Just as we have this information, we do not have the facilities to measure these factors and their impact on athletes. With this data, it is necessary to emphasize the importance we should place on psychological variables from a medical perspective when treating an injury.

Not all athletes react the same way when dealing with the psychosocial factors that can indirectly lead to injury. However, there is a consensus with regard to recognizing certain emotional reactions or adaptive stages. We can identify 5 stages: denial; anger; adjustment; a sense of loss and depression; and, finally, acceptance. These have much in common with the psychological reactions that make up the "grieving process" (Glover Weisenfeld, 1985; Kavanaugh, 1972; Kübler-Ross, 1969).

Whether these stages are or are not sequential, progressive, or even evident is not as important for health professionals or coaches as is the need to find a way to move from denial to acceptance as quickly as possible. Athletes who cannot accept the fact that they are injured are not capable of focusing on the process of rehabilitation, thereby decreasing or delaying the possibility of a full recovery.

In Buceta's work on prevention of and recovery from injuries, some adverse effects with regard to athletic performance as a result of injury were observed:

1. For the affected athlete, injuries mean bodily dysfunction that causes pain, is the source of irritation, restricts personal autonomy, and increases the risk of greater dysfunction.

2. Depending on their severity, injuries may lead to a drastic reduction in athletic activity, sometimes for a long period of time or, in the worst cases, permanently.

3. Injuries bring with them important changes not only in the injured player's athletic environment (reshuffling, re-signings, terminations, transfers, etc.) but also in their personal, professional and social spheres.

4. Injuries are typically accompanied by symptoms of a depressive nature, anger, contrariness, resentment and/or irritability that may have an enormous impact on the behavior and well-being of the injured party and those around them.

5. Injury rehabilitation requires time, dedication and effort, not to mention a positive attitude which fosters consistency, tenacity and the ability to withstand pain and frustration.

One thing to keep in mind is the difference in behavior between an injured athlete and the athlete who feigns injury or symptoms, which leads to a drop-off in his performance. Firstly, the attitude toward injury is different between the two: athletes who are injured feel consternation and regret when injured because they can't use their talent and effort to help achieve team and personal goals; those who are feigning injury always put team goals on the back burner. Moreover, the implications for treatment, the length of the rehabilitation process and how to assess the intervention also differ between the two. An injured athlete tries to attend all team training sessions and matches, participates assiduously in rehabilitation sessions and makes an effort to follow the instructions given by physicians, physiotherapists and sports psychologists. Their goal is to return to training and competition as soon as possible. On the other hand, the athlete who is feigning injury is using treatment as the perfect excuse to miss out on training and competition, while also ensuring that their simulated misfortune gains them attention and sympathy from those around them (Buceta, 1996).

Buceta (1996) examines the following situational variables that can prompt sports injuries:

1. Stressful events of a general nature (family problems, financial troubles, loss of loved ones, minor daily challenges, etc.).

2. Stressful events related to athletic activities (changes in team or coach, changes in level of play, status changes, etc.).

3. Athletic lifestyle (frequent travel, changes in residence, strict self-discipline, etc.).

4. Training-specific demands (continued demands for improvement, constant over-exertion, perpetual assessment, etc.)

5. Competition-specific demands (uncertainty with regard to the results, a lack of control over one's own performance, social assessment, frustration with poor results, etc.).

6. Other situations related to athletic activity (interactions with the media, negotiations with managers, etc.).

7. Specific factors associated with the occurrence of previous injuries (movements or actions that have a special physical risk) (Buceta, 1996).

Based on this, it makes more sense to suggest an interdisciplinary approach to injury, both with regard to prevention and rehabilitation. Palmi (1995) suggests the following:

a) Improve specific training for sports professionals (risk awareness and risk reduction);

b) Improve the athlete's psychological resources (individualized mental training programs);

c) Plan training and competition, taking into account realistic goals and progressive demands (training, competition, mental load, rest);

d) Improve the technical resources that may be able to decrease injury risk (Palmi, 1995).

The Kübler-Ross Model (1969), adapted for injuries:

In the initial period following an injury, athletes typically do not accept the evidence and show surprise instead. This leads to a range of behaviors relating to denial of the severity of the situation. Not adhering to medical recommendations for rehabilitation is one such behavior. This makes rehabilitation more difficult.

In the second stage, we deal with an emotional response (anger, rage): when the injured athlete accepts their condition and its severity, they may experience high levels of frustration. The athlete may direct this back at himself or herself, or towards those who surround him or her.

Next comes awakening. Once the athlete has accepted the reality of the situation, they usually think of future possibilities with a certain degree of optimism, trying to imagine scenarios that will not put them back in their current position.

In the fourth stage, depression, having accepted the severity of the injury and the very real consequences that it will have, among them absence from competitions taking place during the season, the athlete experiences a high degree of uncertainty, showing responses characteristic of a depressive state.

Acceptance is the final stage of this theoretical model. Once depression has been overcome, the athlete is able to focus on optimizing their rehabilitation process, as well as setting goals to meet upon return to training and competition.

Palmi (2001) affirms that emotional support for an injured player plays a fundamental role within a successful recovery process. This is due in part to the fact that when athletes perceive this support, it helps them overcome obstacles. This support can be divided into three different categories:

- Support from the medical team.
- Support from the athletic team.
- Support from family and close friends.

Below are some recommendations that can help in providing support:

Guidelines for working with the injured athlete

1. Build a rapport, creating a solid therapeutic relationship with the injured athlete: In order to do this, the physician must address the injury while taking into account the affected athlete's perspective. To do so, they must understand the possible repercussions for their performance in the short- and medium-term. In this way, they can develop a relationship based on trust, showing cooperation with and commitment to the athlete, which will lead to better adhesion to treatment.

2. Keep the athlete constantly informed with regard to the injury and their progress: From the very first moment, provide specific information about the severity of the situation and all of the factors which need to be taken into account for a successful recovery. As part of this, it is important to coordinate with the player and the coaching staff to establish short- and medium-term goals. This will only make sense if followed by full backing of the athlete throughout the recovery process, as well as upon their return to play.

3. Ability to confront situations with varying degrees of severity: Develop resources and identify the athlete's own resources when it comes time to successfully move forward in the injury process. Among the psychological techniques which have been found to be useful during the rehabilitation process are: positive self-talk, visualization, stress control, and focusing on the present moment.

4. Assistance from the athlete's inner circle: Emotional highs and lows often occur when an athlete resumes athletic activity following injury. This has to do with a number of factors, such as athletic performance or participation in competitions as well as the sensations and symptoms related to the injury itself. For this reason,

the influence of the people closest to the player, both inside and outside the team or club, is critical. This means that the physician's involvement in this area is a determining factor in the success of resuming athletic activity.

In conclusion, it is important that all of the people in an athlete's environment are aware of the importance of their behavior and their emotions, as well as their consequences in all areas related to an athlete's well-being. Positive gestures during the formative years in sports can serve to develop healthy habits in the adult stages. Families and coaching staff, as described in the paragraphs above, are points of reference and providers, not only of knowledge, but also of values and beliefs.

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