4.2 Communication

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:

a. Methodology for solving complex problems:
    1. identify the problem,
    2. review related information,
    3. develop and evaluate options,
    4. implement solutions.
b. Persuasion: this is used to change the way others think or behave.

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

4.2.1 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. Within the line of communication, the number one priority is said to be the player, followed by the player's parents. Once the players and their parents are updated, if considered necessary, communication will be extended to team coaches, management and owners, and always within the terms set out by the athlete. On occasion, and when required by the patient, agents will also be included in the communication. It is important to remember that when failed or unsatisfactory practices have been recorded in sports medicine, they are often due to a lack of openness and communication from the professional to the athlete.

In general, physicians have a reputation for being arrogant and unhelpful with their patients. In addition, injured athletes receive therapeutic suggestions and information about their injury via multiple channels, which sometimes conceal hidden agendas. The best-rated doctors are those who maintain a positive relationship with their patients. Showing humility, understanding and empathy on the part of the physician fosters mutual respect and credibility and will allow for better interaction with the patient, who may be particularly vulnerable in the face of major injury. Athletes are expert patients when it comes to analyzing signals, easily distinguishing between those around them who make their decisions and establish their relationship for personal gain, and those who act in the best interests of the athlete and the athlete's health.

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 are often very confident and appreciate the trust of others, including their physicians. It is therefore advisable for the professional to show confidence in their diagnosis, thought processes and recommendations to patients. He must be sympathetic to his patients, particularly athletes, and they will recognize it. 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.

4.2.2 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 changing room will know how difficult it is to implement these behaviors.

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. These athletes are seen as successful projects and these pathologies are associated with failure and are not easily accepted by the general public. Added to this is the mistrust such pathologies arouse, and the athletes concerned are often grateful when these cases are handled quietly. Although drug addictions are less frequent among athletes than in the general population, they may also be present. 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.

When faced with a sports injury, uncertainty among professional athletes is frequent because the stakes are higher and they have to handle a high degree of skepticism. 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.

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:

Based on public interest, is it permissible for the physician to share this information?
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?

Is the breach of confidentiality based on the devaluation of the player something that should be reported?

In this case, a medical announcement is made based on public interest surrounding a significant player's prolonged absence. First of all, a generic approach to the arthroscopic problem is sufficient without the need to go into the details of the diagnosis. Secondly, it also generically refers to the rehabilitation process that the player will follow and, finally, it is reported that the approximate time the player will need to compete again will be five weeks. This period may vary depending on the player's progress, so it is implicit that the player's health is a priority in the decision-making process.

Communication by the surgeon breaches the confidentiality required of all professionals and devalues the player by revealing his meniscus injury to the public. He lies by trying to disregard any potential relationship between a meniscus injury and previous anterior cruciate ligament injuries, a relationship that is accepted and reported 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.

4.2.4 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:

- to improve the health of athletes,
- 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.

Scientific dissemination of results requires creativity to develop new ideas and responses. Something to add to the alternative thinking of the authors should be: reliability regarding the data presented; integrity, because the work requires honesty and ethics; cooperation with teamwork; thoroughness and attention to detail; analytical thinking, using logic to address concerns; self-control of one's emotions; persistence in the face of obstacles; an independent approach to interpreting and presenting results and, finally, innovation and applicability in the study design in order to focus on solving work-related problems.

4.2.5 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.