



Where biomedicalisation and magic meet: Therapeutic innovations of elite sports injury in British professional football and cycling



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ABSTRACT

Injury is a conspicuous feature of the practice and public spectacle of contemporary elite sports. The paper argues that the 'biomedicalisation' thesis (medico-industrial nexus, techno-scientific drivers, medical optimisation, biologisation, the rise of evidence and health surveillance) goes some way to capturing the use in elite sports injury of some highly specialised mainstream therapies and some highly maverick biological therapies, which are described. Nevertheless, these main strands of biomedicalisation do not capture the full range of these phenomena in the contexts of sports medicine and athletes' practices in accessing innovative, controversial therapies. Drawing on multi-method qualitative research on top-level professional football and cycling in the UK, 2014–2016, we argue that concepts of 'magic' and faith-based healing, mediated by notions of networking behaviour and referral systems, furnish a fuller explanation. We touch on the concept of 'medical pluralism', concluding that this should be revised in order to take account of belief-based access to innovative bio-therapies amongst elite sportspeople and organisations.

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1. Introduction

Elite sport has become one of the defining spectacles of the modern era. Promulgated via mass media its reach is global, and clubs and teams are packaged through highly visible corporate branding. Annual company spending on advertising in sports in the US has been estimated at \$34.9 billion in 2015 (Plunkett Research, 2016). The global sports industry has recently been growing at a faster rate than overall GDPs (AT Kearney, 2011). The consumer markets are enormous, steadily growing and include the massive sports gambling industry. The global reach and audience for football (soccer), the most capitalised sector by far, epitomises these trends, and the English Premier football League (EPL) is the most lucrative worldwide. Although based in the UK, men's professional football clubs and teams at the highest level have high proportions of performers brought in from overseas in market transactions. The

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top-tier EPL currently has around two-thirds of players who are not UK nationals. The very top players can command salaries of tens of thousands of pounds per week, and though the scale is lower in professional cycling the very top riders winning international events can earn annual salary of £1–3 millions (Hervey, 2015). These sport businesses are associated with a wide variety of professional organisations, agents, service and product providers, media companies, sponsors, event organisers and so on. Acknowledging this, sport has been analysed as a global capitalist phenomenon of a 'sport-industrial nexus' (Manzenreiter, 2005).

This marketisation of elite sport consequently produces extreme performance pressures on clubs, teams, managers, coaches, trainers, sports associations and athletes, especially those at the highest levels in their sports. One of the consequences is a conspicuous high rate of injury. Considered as a workplace, injury rates in football (soccer) are one thousand times greater than that for other industrial workplaces (Ekstrand, 2015). Musculoskeletal bone or soft tissue injury is highly prevalent, and organ and mental health issues also arise. The scope of potential diagnosis and treatments available to athletes is vast, varying from low-tech massage techniques to high-tech interventions such as

shockwave therapy. These therapies are now being joined by novel, innovative biological techniques, some seen as part of the new wave of 'regenerative medicine' on which we focus here.

Elite sports' large resources extend to medical coverage. In the two sports examined as case studies in this paper, professional football and cycling in the UK, similarities and differences can be observed. Professional international-level cycling teams (of which there are about ten based in the UK, comprising 10–15 contracted riders each), like football clubs, typically have a range of commercial sponsors and operate as branded businesses. Most employ one or more doctors/medical directors on full or part-time bases along with others such as nutritionists and sports therapists. In the UK substantial public funds are provided to 'British Cycling', which has both Olympic and popular strands, via national agency UK Sport, which draws on government and public lottery sources. Medical cover is provided to the elite riders through an 'Athlete Medical Scheme' run jointly with BUPA, the largest private medical insurer in the UK. Professional cycling teams employ a variety of medical insurance arrangements and direct payment routes that take into account the extreme mobility of teams in racing and training, including overseas events. Somewhat similarly, medical coverage for top-level footballers and clubs is provided by the 'Medical Care Scheme' (MSC) run by *Health Partners* which is a charitable trust. Nowadays the highest level clubs typically employ full-time specialised medical or physiotherapy staff. Almost all the clubs in the English football league (87/92), including the elite English Premier League (EPL) (19/20), are protected by the MSC scheme, which involves clubs paying for cover for their players for specialist treatment on an annual basis, premiums related to claims history.

Of particular interest in the study analysed here, is the range of biological and regenerative cellular therapies such as stem cells and 'platelet-rich plasma' (PRP, described below) whose use for treatment for 'return to play' is intensively debated by the sports medicine community. Some international producers of regenerative products address orthopaedics practitioners, defining the field as 'orthobiologics', and targeting sports medicine markets. Given the degree of scientisation and commercialisation of medical products in the field, it is thus reasonable to conceptualise it, building on Manzenreiter's concept above, as a 'Sports Biomedical Industrial Complex'.

2. Conceptualising the therapeutic context

A wide range of structural forces, knowledge practices, medical technologies, inter-related practitioners and institutions can be thought of as constituting the 'therapeutic context' of elite sports. Sports medicine and 'sports science' (biomechanics, physical optimisation, etc.) have mushroomed over the last 30 years, becoming key strands of that therapeutic context. At the same time there has been an increasing biologisation of medicine itself, which has changed the nature of medicalisation (Conrad, 2005). The concept of 'biomedicalisation' thus offers itself as one possible lens through which to help understand current developments in elite sports medicine. According to Clarke et al. (2003, 2010a) there are five key and novel dimensions that are apparent in a broad shift from medicalisation to biomedicalisation. Clarke et al. point, first, to an integration of business and medicine (in the U.S. context), that they term the 'Biomedical TechnoService Complex' (aligning closely with Manzenreiter's concept noted above); second, a 'technoscientization' of medical practices; third, transformations of biomedical knowledge production including especially informatics and medicine's 'evidence-base'; fourth, a focus emphasising health status, risk and surveillance for example through lifestyle research and policy; fifth, biomedical intervention becoming involved in transformations of bodies and individual and collective identities,

including an increasing focus on optimisation and enhancement (Clarke et al., 2003, 2010a). Clarke et al. note the extension of biomedicalisation to many domains of (American) society.

We can observe these dimensions of biomedicalisation in elite sport beyond the U.S. in the academic disciplines of sports science and sports medicine, in the increasing corporatisation and globalisation of sport, in the availability of elite 'evidence-based' medical practitioners in sport, in the high levels of monitoring of sports performance through informatics, in the continual search for science-based higher levels of performance and the implications of this for the professional and personal identities of sports performers and their organisations. Hence, the conceptual lens of biomedicalisation clearly has some purchase on recent scientific and biomedical expansion into sports.

Nevertheless, as we demonstrate below, although biomedicalisation coexists with traditional or 'complementary' medicine (Clarke et al., 2010b), this formulation does not capture the full range of the therapeutic context that we report below in elite sport medical behaviours. Before considering what concepts might help us to understand these behaviours, it is necessary to describe the methodology of the research on which we draw, to describe the biological therapies of primary interest, and to present some of our data. The paper then argues that a concept of 'magical' practices and practitioners, and faith-based healing can help account for the elite sports injury practices, organisation and beliefs that we observe, including reference to the relatively sparse sociological literature on the role of 'magic' in sports medicine (Carter, 2010; Malcolm, 2011). We use the term 'faith-based' to refer to a general act of evidence-free belief or emotional commitment, not to refer to fundamentalist faith communities, a usage common in the United States.

3. Methodology

The overarching aim of the study on which we draw was to investigate, first: commercial, scientific, club, insurers' or other stakeholders' perspectives on appraisal and use of biological and cell-based bio-therapies, including those now known as regenerative medicine; second, to illustrate some of the typical decision-making emerging amongst elite sports medical practitioners, and the dilemmas and ethical issues raised in the context of institutional pressures and long term welfare. As noted above, we focused on case studies of UK professional football and cycling. Musculoskeletal injury was the main clinical focus. The two sports were chosen because of their very different funding profiles, with cycling in the UK being part funded through public sources (UK Sport – British Cycling), the very different forms of club/team organisation and competitions, and the differences in typical injury profiles.

Ethical approval was obtained from the University of Sussex, UK. Between 2014 and 2016 we conducted semi-structured interviews with a highly specialised group of 42 practitioners and stakeholders in the UK, including the heads, deputy heads, academy heads or head physiotherapists of English Premier League (EPL) football clubs (12), medical or physiotherapy practitioners involved in professional cycling (2), companies providing biological therapeutic products (7), medical members of national and Olympic sports organisations and authorities (8), sport and exercise physicians and orthopaedic surgeons in the NHS and private practice (10), medical insurers/advisers (2), retired performers (5), and sports scientists and researchers (5) (not mutually exclusive categories). Interviewees were recruited through personal contacts, conferences and the project sport-specialist advisors; they were given written information and gave explicit consent to take part. We also observed sports and exercise medicine conferences, and specific 'football medicine' and 'cycling medicine' conferences (in the UK,

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