Apunsm Sports Medicine 61 (2026) 100532

Contents lists available at ScienceDirect

Apunts Sports Medicine

journal homepage: www.elsevier.com/locate/apunsm

Editorial

Redefining the role of the team physician in professional football: Between diluted authority and ultimate responsibility

Redefiniendo el rol del médico del equipo en el fútbol profesional: Entre la autoridad diluida y la responsabilidad máxima

In modern professional football, the team physician is expected to bear full responsibility for medical outcomes while progressively losing control over the decisions that shape them. The practice of medicine in elite sport has evolved from a hierarchical, physician-centred model to a complex, multidisciplinary environment. Commercial pressures, performance demands, and the growing number of stakeholders involved in the management of professional footballers have significantly altered traditional decision-making structures.[1,2] In this context, effective functioning increasingly depends on communication, leadership, and alignment among different professional roles.[3]

Historically, the team physician occupied a central role, ensuring consistency in diagnosis and treatment. In many professional settings, however, medical decisions are frequently influenced—sometimes overridden—by coaches, physiotherapists, agents, and external advisors, often due to their closer day-to-day relationship with players. This dynamic introduces pressures to accelerate return to play and may challenge clinical judgment, progressively shifting day-to-day decision-making away from the physician toward other stakeholders with closer proximity to the athlete.[1] Paradoxically, when serious medical issues arise, responsibility rapidly shifts back to the physician, who is expected to assume full accountability despite limited control over preceding decisions.

The emergence of representation agencies with their own medical consultants, alongside the proliferation of digital information sources and non-regulated performance advisors, has further complicated the clinical landscape. Players are increasingly exposed to multiple, and sometimes conflicting, recommendations. This aligns with evidence suggesting that athletes' decisions are often influenced by individuals within their support network, not all of whom possess adequate medical expertise,[4] and reflects the increasingly fragmented structure of player support in elite football, where overlapping professional networks may lead to coordination challenges and inconsistencies in decision-making.[5] In parallel, the outsourcing of medical services by some clubs may weaken the physician–player relationship, reducing trust and continuity of care—key elements of effective medical practice.

Current consensus statements emphasize that the team physician should lead clinical decision-making processes, particularly in return-to-play situations, within a shared decision-making framework that includes the athlete and other stakeholders.[2] However, in practice, these processes are embedded within complex communication networks involving multiple stakeholders, where decisions are continuously shaped by contextual factors, interpersonal relationships, and organizational dynamics.[6] These same frameworks acknowledge the influence of external pressures, conflicts of interest, and contextual factors such as competition demands and timing within the season.

This loss of centrality becomes particularly critical in the context of doping and supplementation. The use of dietary supplements is widespread among athletes, often driven by expectations of performance enhancement and influenced by non-medical sources of advice.[4,7] Importantly, inadvertent ingestion of prohibited substances remains a recognized risk, particularly when supplement use is not guided by qualified professionals.[7] Although athletes are ultimately responsible for substances found in their body under the World Anti-Doping Code,[8] a principle that remains unchanged in the forthcoming 2027 revision of the Code, decision-making around supplement use is frequently shaped by external influences, including coaches, peers, and commercial interests, often without sufficient understanding of the associated risks.[4] This creates a vulnerable scenario in which the physician remains responsible for medical oversight while lacking full control over the footballer's exposure to potential harm.

The current model therefore presents a fundamental paradox: the physician's influence over daily decisions is reduced, yet responsibility in adverse outcomes remains unchanged. This asymmetry reflects well-described ethical tensions in sports medicine, where pressures related to performance, career progression, and external expectations may conflict with the physician's duty to prioritize the athlete's long-term health.[1,9] Within this context, different stakeholders often operate under distinct and sometimes competing interests—ranging from performance outcomes and economic incentives to career advancement—whereas the physician's role remains grounded in the protection of the athlete's health and well-being, both in the short and long term.

Reassessing the role of the team physician in professional football is therefore essential. Strengthening medical authority should not remain a purely aspirational statement, but should be translated into practical governance measures. These may include written return-to-play protocols that preserve the physician's clinical authority, formal documentation of shared clinical decisions and disagreements, mandatory medical oversight of supplementation and external treatments, and contractual recognition of the physician's professional independence within the club. Beyond safeguarding clinical independence, the team physician should also contribute to the scientific leadership of the club's health and performance programmes by integrating scientific

https://doi.org/10.1016/j.apunsm.2026.100532
Received 5 May 2026; Accepted 13 July 2026
Available online 31 August 2026
2666-5069/© 2026 Consell Català de l'Esport. Published by Elsevier España, S.L.U. This is an open access article under the CC BY-NC-ND license (http://creativecommons.org/licenses/by-nc-nd/4.0/).

knowledge across disciplines and ensuring that multidisciplinary initiatives remain evidence-informed and centred on the player's long-term health.

The increasing professionalization of football should be accompanied by an equally robust institutional framework in which team physicians can exercise their clinical responsibilities independently. This evolution should not be understood as a return to traditional hierarchies, but as the natural adaptation of medical governance to an increasingly complex, multidisciplinary environment. Only by explicitly defining clinical independence, shared decision-making processes and mechanisms for resolving conflicts can responsibility be matched with the authority required to exercise it. Otherwise, physicians will continue to be held accountable for decisions they do not fully control—a situation that remains both clinically unsafe and ethically unsustainable.

Funding

None.

Use of artificial intelligence

Artificial intelligence tools (ChatGPT, OpenAI) were used to support the drafting, structuring, and linguistic revision of the manuscript. The author critically reviewed and validated all content and assumes full responsibility for the final version.

Declaration of competing interest

The author declares no financial conflicts of interest. The author has previously worked as a team physician in professional football and has been involved in medical assessments in youth football and anti-doping activities.

References

1. Anderson LC, Gerrard DF. Ethical issues concerning New Zealand sports doctors. *J Med Ethics*. 2005;31:88–92.
2. Herring SA, Putukian M, Kibler WB, et al. Team physician consensus statement: return to sport/return to play and the Team physician: 2023 update. *Curr Sports Med Rep*. 2024;23(5):183–191.
3. Salcinovic B, Drew MK, Dijkstra HP, Waddington G, Serpell BG. Factors influencing team performance: what can support teams in high-performance sport learn from other industries? *Sports Med Open*. 2022;8(1):25.
4. Maughan RJ, Shirreffs SM, Vernec A. Making decisions about supplement use. *Int J Sport Nutr Exerc Metab*. 2018;28(2):212–219.
5. Silva JR, Buchheit M, Hader K, Sarmento H, Afonso J. Building bridges instead of putting up walls: connecting the "teams" to improve soccer players' support. *Sports Med*. 2023;53(11):2309–2320.
6. Bolling C, Ekstrand J, Waldén M, Bengtsson H, Davison M, Verhagen E, Hägglund M. 'Good communication and good team building, it's half of the work in managing a player': how team doctors perceive communication in the European professional men's football context. *BMJ Open Sport Exerc Med*. 2025;11, e002392.
7. Maughan RJ, Burke LM, Dvorak J, et al. IOC consensus statement: dietary supplements and the high-performance athlete. *Int J Sport Nutr Exerc Metab*. 2018;28(2):104–125.
8. World Anti-Doping Agency. World Anti-Doping Code 2021. Montreal: WADA; 2021. [cited 2026 Aug 11]. Available from: https://www.wada-ama.org/sites/default/files/resources/files/2021_wada_code.pdf.
9. Tenforde AS, Fredericson M. Athlete return-to-play decisions in sports medicine. *AMA J Ethics*. 2015;17(6):511–514.

Manuel Sarmiento-Cruz
Family Physician and Sports Medicine Specialist. President, ABEME (Balearic Association of Sports Medicine Specialists), Palma, Spain
E-mail address: msarmiento1979@gmail.com.