



inside

football medicine

Better decisions. Better performance

INSIDE NOTES · NO. 1

From Field Experience to Better Decisions

Dr Manuel Afonso – October 2026

Introduction – Starting from the field

There are many ways to approach medical organisation in football.

One can start with the available resources, protocols, technologies, individual skills or performance indicators. Each of these has its place. But none of them, on its own, is enough to describe the quality of an organisation.

On the ground, situations are rarely that simple.

An injury is not only a clinical problem. It raises questions of availability, rehabilitation, planning and communication. It involves several professionals whose responsibilities, information and constraints are not necessarily the same.

The quality of the response therefore depends on several dimensions: what each person knows, what each person understands, how information is shared, and how decisions are made and carried out.

These dimensions are not independent.

Relevant information can arrive too late. An accurate assessment can be interpreted differently by two professionals. A medically sound decision can be hard to apply if its implications are not understood by the people concerned.

The problem is not necessarily a lack of competence or goodwill. It may also lie in how the relationships between individuals are organised.

It is from these realities that the thinking of Inside Football Medicine is built.

The aim is not to propose a universal method, nor to claim that every organisation faces the same difficulties. Rather, it is to examine the conditions that allow a medical and performance organisation to function coherently, in an environment where decisions must often be made with incomplete information and competing constraints.

Three questions open this reflection:

- What can data really tell us when uncertainty remains?
- Why does individual competence not guarantee collective effectiveness?
- What happens between professionals when different information and expertise must be turned into a shared decision?

These questions are linked. They lead progressively from a problem of knowledge to a problem of decision, and then to a problem of collective organisation.

This first issue of Inside Notes opens that exploration.

It starts from the experience of professional football, draws on available knowledge where it genuinely sheds light on the subject, and seeks to distinguish field observations, working hypotheses and the conclusions the data can actually support.

The goal is not to remove all uncertainty. It is to better understand how organisations can make sound decisions in spite of it.

///// PART I

From data to decision

More Data. Same Uncertainty.

1. Data does not decide for us

Football medicine today has access to a growing amount of information.

Imaging, functional tests, load monitoring, medical history and performance data all help to document a player's situation more fully. They make it possible to observe, measure, compare and, under certain conditions, anticipate better.

This development is valuable. It broadens the possibilities for assessment and can improve the quality of clinical reasoning.

But having more information does not mean knowing with certainty what will happen next.

An examination describes a state at a given moment. A test measures a capacity under specific conditions. A load indicator describes part of the exposure to effort. None of these, on its own, reproduces the full complexity of a match, with its accelerations, changes of direction, contacts, fatigue and decision-making demands.

The question, then, is not whether data is useful. It is to understand what it really allows us to state, what it leaves undetermined, and how it should be interpreted.

2. From information to interpretation

A piece of data does not acquire meaning independently of its context.

The same result can carry different weight depending on the player's history, the stage of rehabilitation, the demands of their position, fixture constraints or the characteristics of the upcoming competition.

Interpretation therefore requires connecting several elements. It means understanding the limits of the available measurements and accepting that some questions will remain without a definitive answer.

This distinction matters: measuring is not interpreting, and interpreting is not yet deciding.

Between the information gathered and the final decision lie clinical reasoning, an appreciation of context, an assessment of possible consequences and the consideration of residual uncertainty.

Tools can support this process. They do not replace it.

CASE STUDY

When an indicator becomes an explanation

Distance covered in a match is easy to understand, compare and communicate. It may seem to offer an objective reading of a team's physical activity. But what does it really allow us to conclude?

In their 2025 report, *Time to drop running as a KPI in elite football: football fitness and freshness as match-day preconditions* [1], Mandorino and colleagues examine the relationships between match running activity, estimated fitness and freshness indicators, and the results achieved by a professional team. Their analysis covers 25 players from a single Italian club over three seasons.

The authors report an association between certain combinations of fitness, freshness and running volume and the probability of winning. In particular, high fitness and freshness indices combined with a lower running volume were associated with a higher probability of winning in their sample. This result should nevertheless be interpreted with caution: it is an observational study conducted in a single club, and an association does not demonstrate causation. It therefore does not allow us to conclude that running less wins matches.

The value of this study goes beyond the question of kilometres covered. A team does not run independently of its style of play. Its activity depends notably on its organisation, its tactical intentions, the opponent and the course of the match. The observed running volume is also the product of the demands the players faced.

It is also necessary to distinguish what a player does from what they are capable of doing. Distance covered in a match is not, on its own, a sufficient measure of physical fitness. It does not fully reflect the physiological or mechanical cost of the activity, nor the reasons why that activity took the form it did.

This example illustrates a more general limitation of performance analysis: a measurement can be accurate without being enough to explain what we observe. Data describes part of reality; a decision requires understanding that reality.

The problem, then, is not necessarily the data itself. It lies in the move from measurement to interpretation, and from interpretation to decision. Before concluding that a team does not run enough, we need to understand what its game asks it to do. Before concluding that a player is not fit because he ran little, we need to distinguish his observed activity from his capacities and his state of readiness.

The question is not only: how much did he run? It is also: why did he run that much, under what conditions, and what does this information really allow us to conclude?

3. Deciding when certainty is impossible

In professional football, some decisions cannot wait for every uncertainty to be resolved.

A player's availability is one example. Professionals must connect the player's clinical status, functional capacities, the demands of competition and the possible consequences of the different options.

Deciding is not simply a matter of adding up results to obtain an automatic answer. It requires determining which information is relevant, which limitations remain and what consequences each option may have.

Acknowledging uncertainty does not license arbitrariness. It requires making the reasoning more explicit: what information is it based on? What limitations have been identified? What consequences have been considered? What could lead to the decision being revised?

Uncertainty does not necessarily disappear when the reasoning is sound. It can, however, be better characterised and taken into account.

4. Reducing uncertainty without claiming to eliminate it

The ambition of football medicine cannot be to predict perfectly what will happen.

It consists, among other things, in gathering relevant information, interpreting it rigorously and using it to make a decision that is as well justified as possible in the circumstances.

This approach involves two complementary requirements.

The first is scientific: understanding what the available tools and knowledge really allow us to conclude.

The second is decisional: accepting that a decision sometimes has to be made while certain questions remain open.

Data should inform clinical reasoning, not replace it.

This distinction leads to a further question. If the quality of a decision depends on how information is interpreted, we must also examine what happens when that interpretation involves several professionals. The problem is then no longer only having relevant information, but understanding how different analyses contribute to a concrete choice. In football, important decisions rarely rely on a single area of expertise. This is where the reflection gradually moves beyond the question of data to that of the collective.

ON LINKEDIN ["More data. Same uncertainty."](#) →

From individual expertise to collective action

A Team of Experts ≠ An Expert Team

5. Individual competence is not enough

An organisation can bring together highly qualified professionals without functioning as an effective team.

The doctor has clinical expertise. The physiotherapist brings knowledge of the player and their functional progression. The physical trainer assesses load and performance demands. The head coach reasons from sporting needs and competition constraints.

Each can be competent in their own field.

But having these skills around the same table does not guarantee that they will produce a shared understanding of the situation, or a coherent collective decision.

Information can circulate without being interpreted in the same way. Priorities can differ. A decision can be clear to the person who makes it, yet remain ambiguous for the person who has to carry it out.

Two realities must therefore be distinguished: the quality of the individuals and the quality of collective functioning.

The first is essential. The second does not automatically follow from the first.

6. The team as another level of analysis

Assessing a team solely through the skills of its members means looking at only part of the problem.

We also need to examine how those skills complement each other, what information circulates between professionals, which disagreements are voiced and how responsibilities are understood.

These dimensions do not, by themselves, guarantee the quality of a decision. They are, however, important questions when trying to understand why an organisation works well in some situations and struggles in others.

A collective cannot be reduced to the sum of its members. We must also look at what happens when they work together.

This proposition should be examined concretely rather than turned into a slogan. An effective team is not defined simply by a good atmosphere, regular meetings or the absence of disagreement.

It must be able to confront different points of view, circulate relevant information and clarify the decisions that require coordinated action.

Disagreement can be useful if it leads to a better understanding of a situation. It becomes a problem when it remains implicit, prevents mutual understanding or is never translated into a clear decision.

7. From expertise to collective action

In a medical and performance organisation, a decision may involve several levels of responsibility.

Clinical assessment does not answer every question about a return to play. Functional data alone do not determine the demands of competition. Sporting needs cannot, on their own, establish a player's medical status.

These perspectives differ, but they concern the same situation.

The aim is not to make these differences disappear, nor to ask each professional to step outside their field of competence. It is to understand how different areas of expertise can contribute to a decision whose implications are shared and understood.

This means clarifying responsibilities, distinguishing established facts from points that remain uncertain, and making the operational consequences of the decision explicit.

Communication procedures and formalised responsibilities are only valuable if they are actually used and adapted to the context.

Collective organisation therefore deserves to be examined in how it actually works, not only in its theoretical structure.

8. Looking at what happens between the experts

The previous chapters distinguished each professional's competence from the functioning of the collective. What remains is to examine what concretely connects the two: how information is passed on, understood and used; how differences in interpretation are identified; how a decision is communicated to those who will have to act; and how responsibilities are shared when several areas of expertise meet.

These questions shift the analysis from the composition of the staff to how it actually works. They point to what needs to be observed in order to understand why areas of expertise complement each other in some situations and struggle to produce coherent action in others.

The question is no longer only whether the right people are in the room.

It is to understand how their expertise becomes — or fails to become — a capacity for collective action.

FIELD STUDY

The day before a knockout match

Final tournament of a continental competition.

The day before a knockout match, a starting forward returning from injury has a worrying training session. His movements lack precision, his footing is uncertain and at times he limps.

A meeting is held between the player, the head coach and myself, as the national team doctor.

The head coach stresses how important the player is for the next day's match. My medical assessment indicates that he has not yet recovered his full physical capacities. The player, for his part, believes he can play and considers that the main difficulty is the pain, which he thinks he can tolerate.

Three people, three readings of the same situation.

The head coach reasons from the needs of the team and what is at stake in the match. For my part, I rely on the clinical and functional assessment. The player brings his own feelings and his perception of his ability to play.

At the end of the discussion, it is agreed that the player will start the match. He commits to reporting honestly the moment the pain becomes disabling, so that a substitution can be considered.

The player starts the match and comes off in the second half. The course of the game then allows the head coach to do without a forward. The tactical opportunity also becomes a chance to protect the player.

The substitution is therefore not the direct consequence of a medical alert or a request from the player: it is the context of the match that made this option possible.

This situation shows that the initial decision is only one moment in the process. Its implementation also depends on the ability to reassess the situation and to seize the opportunities that arise during the match.

Protecting the player and meeting the demands of competition are not always opposing objectives. A changing context can sometimes make it easier to reconcile them.

This situation nevertheless leaves an open question: how can the conditions under which a decision may be reviewed be defined before the match? Agreement between people is important; clarity of criteria and responsibilities is just as important.

What the literature on interprofessional collaboration contributes

Collaboration between healthcare professionals has been the subject of systematic reviews. Reeves and colleagues [2] analysed nine randomised trials of various collaboration interventions in a range of care settings. The results suggest possible benefits for some care processes, resource use and certain patient outcomes, but the effects are heterogeneous and the certainty of evidence is low to very low. This review therefore does not allow us to claim that any particular form of collaboration works everywhere, nor to identify a universally superior model.

A more recent systematic review by Bouton and colleagues [3], based on 65 articles describing 61 interventions in primary care, reports results that vary according to the populations and health problems studied. Results are more favourable for some groups, notably patients at cardiovascular risk, but remain heterogeneous in other

settings. The authors highlight the limited comparability of interventions and outcome measures.

This work does not directly demonstrate the superiority of a medical-performance model in professional football: contexts, professions and objectives differ. It supports a more limited but useful conclusion: collaboration is an organisational reality to be built and evaluated, not an outcome automatically produced by the presence of several professions.

The World Health Organization's framework on interprofessional education and collaborative practice [4] complements this perspective by addressing the conditions that foster joint working between professions.

In football, the constraints are specific: a competitive calendar, player availability, performance demands and sometimes urgent decisions. The healthcare literature cannot therefore be transposed as it stands. Rather, it provides a framework for asking the right questions: how do areas of expertise complement each other? How are disagreements handled? How does a decision become coordinated action?

ON LINKEDIN ["A team of experts ≠ an expert team."](#) →

Building a medical-performance system

9. From medical staff and performance staff to medical-performance staff

The limits of data and those of individual expertise lead to a question of organisation: how can we create the conditions for incomplete information, different analyses and distinct responsibilities to contribute to a coherent decision? The medical-performance system is a proposal for answering this question. It is not a model whose superiority has already been demonstrated in the literature, but a working framework to be made explicit, adapted to each club and evaluated in how it actually works.

Medical staff and performance staff bring together different skills, all necessary to support the player. Their coexistence, however, is not enough to create a shared way of working.

Moving to a medical-performance staff is not simply a matter of bringing the two groups closer, holding more meetings or sharing more data. It means organising their expertise around a common understanding of the player's situation and coherent decisions.

The professions do not merge. Medical responsibilities remain medical; responsibilities for training and performance remain with the professionals concerned. The aim is to make their contributions complementary, understandable and operational.

The term **medical-performance staff** refers to the human organisation. The term **medical-performance system** describes how it works: the information, interpretations, decisions, responsibilities, actions and feedback that connect the professionals.

Within this system, a medical-performance coordination function can be identified. It organises the flow of information, records decisions and who is responsible for them, checks follow-up and triggers planned reassessments. Depending on the club, it may be entrusted to a dedicated professional or taken on by a member of staff; it does not take the place of the doctor or the head coach in their own decisions.

The aim is not to bring medical staff and performance staff closer together. It is to make them work as a medical-performance system.

10. Building a shared understanding of the player

A player can be described in several ways depending on the professional observing them. The doctor focuses on clinical status and relevant risks. The physiotherapist follows functional progression. The physical trainer assesses the response to load and the ability to meet training demands. The head coach considers the needs of the team and the constraints of competition.

These readings are not interchangeable. They need to be brought together.

A shared understanding does not mean that all professionals must hold the same opinion. It means that each understands the essential elements contributed by the others, the remaining uncertainties, the limits of their own field of expertise and the practical consequences of the collective decision.

The question is therefore not only: “What do we know about this player?” It is also: “What does this information mean for the other professionals and for the next decision to be made?”

11. Clarifying responsibilities and conditions for reassessment

A coordinated decision requires distinguishing several roles: who assesses, who contributes expertise, who must be consulted, who is responsible for the decision within their field, who communicates the instructions and who checks their implementation. “Collective” does not mean that every decision is made by everyone, nor that responsibilities become blurred.

This clarification is particularly important when objectives may come into tension. A return-to-play decision, for example, draws on the medical assessment, functional progression, the ability to tolerate load, the demands of the match and the player's own perception. None of these elements should be mistaken for the decision as a whole.

■ Example – Allocation of roles in a return-to-play decision

Role	What they contribute	Responsibility / limits of the role
Doctor	Clinical assessment, identified risks, remaining uncertainties	Medical fitness-to-play decision within their field; make restrictions, warning signs and conditions for reassessment explicit
Physiotherapist	Functional progression, response to tests, tolerance of rehabilitation exercises	Leads rehabilitation and contributes to functional assessment; does not replace the medical fitness-to-play decision
Physical trainer	Load tolerance, physical capacities, response to reconditioning	Plans and adjusts load within the restrictions and objectives communicated; reports any concerning responses
Head coach	Team needs, tactical demands and match constraints	Selection and playing-time decisions within the medical limits; reassesses sporting options if the context changes
Player	Own feelings, perception of capacities, symptoms and progress	Takes part in discussions and reports symptoms honestly; does not bear sole responsibility for medical assessment or fitness to play
Medical-performance coordination	Overview of information, deadlines, expected decisions and handovers	Organises the flow of information, records decisions and who is responsible, checks follow-up and triggers planned reassessment; does not replace the doctor or the head coach in their own decisions

This table is indicative: titles, delegations and approval processes must be adapted to the club's organisation and the applicable regulatory framework. It does not replace professional obligations or individual responsibilities. Its value lies in making visible each role's contribution and limits, and the decisions that must remain assigned to an identified person.

It is also useful to specify, before acting, what could lead to the initial choice being reviewed, who must be alerted and who makes the corresponding decision. A decision may be appropriate given the information available at a given moment, and then need to change if the player's condition, the context or the demands change. Reassessment does not erase responsibilities: it reactivates them in a context that has changed.

The situation described in the field study illustrates this dimension. The prior agreement had provided for the player to report pain that became disabling. During the match, the tactical context gave the head coach the opportunity to substitute him. The decision took place within an evolving situation, not as the mechanical application of a choice made the day before.

The challenge is to make these opportunities for reassessment explicit, without assuming that a protocol can anticipate every situation.

12. Observing how things actually work in order to improve them

An organisation can have a clear organisational chart, written protocols and regular meetings, and still encounter difficulties in the flow of information or the implementation of decisions.

We therefore need to look at work as it actually happens: how information arrives, who interprets it, how disagreements are expressed, how decisions are communicated and what happens next.

The analysis does not focus only on visible errors. It also examines the mechanisms that make the work easier: an early handover, a clearly understood responsibility, a disagreement dealt with early enough, or an opportunity for reassessment identified before it becomes urgent.

This approach involves observing situations, comparing the viewpoints of professionals and comparing planned procedures with actual practice. It does not seek to systematically attribute difficulties to an individual. It seeks to understand how the system contributes to the outcome.

It is at this level that an audit of medical-performance functioning makes sense: not as a simple document review, but as a structured analysis of the interactions between expertise, decisions and actions.

The aim is not to create a uniform model for every club. It is to identify the conditions which, in a given organisation, can make decisions clearer, better coordinated and more consistent with the player's needs.

Conclusion – From expertise to better decisions

Data is essential, but it does not decide for us. Individual expertise is essential, but it does not guarantee collective functioning. Communication is essential, but it is only valuable if it helps professionals better understand the situation and act coherently.

IFM's approach connects these three levels: information, decision and organisation. The medical-performance system is a proposal for organising the conditions in which distinct areas of expertise contribute to a shared understanding, clearly assigned decisions and coordinated action.

The aim is not to remove uncertainty, differences of opinion or the constraints of competition. It is to handle them better. The quality of an organisation depends not only on what each person knows, but also on how it connects that knowledge, clarifies responsibilities and turns decisions into coherent action.

References

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3. Bouton C, Journeaux M, Jourdain M, Angibaud M, Huon JF, Rat C. *Interprofessional collaboration in primary care: what effect on patient health? A systematic literature review*. BMC Primary Care. 2023;24:253. doi:10.1186/s12875-023-02189-0. Review of 65 articles covering 61 interventions in primary care.
4. World Health Organization. *Framework for Action on Interprofessional Education and Collaborative Practice*. Geneva: WHO; 2010. WHO/HRH/HPN/10.3. <https://www.who.int/publications/i/item/framework-for-action-on-interprofessional-education-collaborative-practice>

Further reading

Inside Football Medicine posts related to this issue:

→ “Something built from the field, for the field.” – the launch of Inside Football Medicine

→ “More data. Same uncertainty.” – related to Part I

→ “A team of experts ≠ an expert team.” – related to Part II

About the author



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A sports medicine physician, Dr Manuel Afonso has built his career at the heart of professional football, at both club and national team level.

CS Sedan Ardennes (2004–2014): Ligue 1, Ligue 2 and Coupe de France final.

Senegal national team (2019–2024): AFCON 2019 final, AFCON 2021 winners, 2022 FIFA World Cup.

Olympique Lyonnais (2025–2026): Head of Medical Services, Ligue 1 and UEFA Europa League.

He is currently the team doctor of the Angola national team and is developing Inside Football Medicine (IFM), a consulting and audit practice dedicated to how medical and performance staff work in football.

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