

Bodily Modesty, Coach Dependence and Burnout in a Maldivian Olympic Career: A Meta- Autoethnographic Test of Athlete Welfare Surveillance

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Abstract

Athlete welfare surveillance assumes that athletes can report what is happening to their bodies and that the report reaches someone able to act. This article tests both assumptions against one documented Olympic career from a small island state. A retrospective meta-autoethnographic design was used to re-analyse two texts by the same author, a 2006 doctoral thesis and a 2026 autobiographical book. Eight episodes spanning adolescence to retirement were mapped to mechanisms from the sport ethic, men's help-seeking, organisational stress and safeguarding literatures, and were then used to test a proposed Athlete Welfare Ledger. The events occurred between the mid-1980s and 1993 and cannot indicate current prevalence. At sixteen, the athlete concealed severe groin pain and blood in his urine. He first knew no one with whom intimate symptoms could be discussed, and later expected his coach to disbelieve him. Disclosure to a half-sister who was a nurse led to treatment abroad within two weeks. Years later, the same coach arranged painkilling injections for a knee injury without explanation to the athlete, and training continued. The route that worked sat outside the coaching line; the route that harmed sat inside it. Seven of the eight documented harms would have been at least partly detectable by conventional monitoring. The exception was the first barrier, which no questionnaire requiring the athlete to name the symptom would have captured. A minimum protection standard for small sport systems is proposed, with each element linked to a documented episode.

Keywords: Injury Surveillance, Help-Seeking, Premature Retirement, Culture of Risk, Safeguarding, Small Island States, Muslim Athletes, Coach-Athlete Relationship

Introduction

Athlete health surveillance in elite sport depends heavily on self-report. Injury registers, weekly health questionnaires and wellbeing checks all require the athlete to notice a symptom and to communicate it to someone able to act (Bahr, 2009; Clarsen et al., 2014).

When that communication fails, the problem remains private bodily knowledge and never enters the record. Sociological research on pain and injury has shown for three decades that athletes conceal symptoms to protect selection, identity and standing (Nixon, 1992; Roderick, 2006). Safeguarding frameworks add that disclosure depends on power, relationships and the expected response of the person receiving it (Tuakli-Wosornu et al., 2024). The practical question for a sport system is therefore not only whether reporting routes exist, but whether athletes can use them and who receives what they report.

Current explanations of non-disclosure rest on two mechanisms. The first is the sport ethic, in which athletes over-conform to norms of sacrifice, risk acceptance and playing through pain (Hughes & Coakley, 1991). A recent scoping review of youth sport found that normalised pain, peer pressure and coach leadership style continue to produce silence about injury (Venzel et al., 2026). The second mechanism is relational, in that athletes withhold information when they expect disbelief, lost selection or damaged standing with those who control their opportunities (Roderick, 2006; Pennock et al., 2024). Both mechanisms assume that the athlete could name the problem if the social conditions allowed it. Research on men's help-seeking shows that this assumption does not always hold, since embarrassment about genital and urinary symptoms is a recurrent cause of delayed presentation among adolescent boys and young men (Galdas et al., 2005; Fish et al., 2015).

These literatures have rarely been connected. Sport disclosure research treats the symptom as speakable and asks whether the environment permits speech. Men's health research treats embarrassment as a barrier to consultation but does not examine surveillance systems in which coaches and selectors hold the information. Research on religious modesty in health care and physical education has concentrated on Muslim women and girls, and male athletes remain largely unexamined (Benn & Pfister, 2013; Padela et al., 2016). Small states add a structural condition. Where there are few coaches, few clinicians and close social ties, an athlete has fewer alternative routes when the primary relationship fails (Houlihan & Zheng, 2015; Sam & Jackson, 2015). Current welfare frameworks therefore omit two variables: whether a symptom can become speakable at all, and whether the first person to hear it sits inside or outside the coaching line. To the author's knowledge, no welfare surveillance framework has been tested against a documented career in which both variables operated.

This article addresses that gap through a retrospective meta-autoethnographic analysis of one Maldivian Olympic career, using only two texts by the author. The aim was to identify the mechanisms through which documented harms arose, and to test whether a proposed Athlete Welfare Ledger would have detected each of them. Two questions guided the analysis. First, which mechanisms are visible in the published record, and how did small-state and cultural conditions modify them? Second, at what point, if any, would the Ledger have detected each documented harm, and who would have needed to hold the information? The contribution sought is a revision of surveillance design rather than an estimate of prevalence.

Conceptual Framework: Mechanisms that Reach the Athlete

Five bodies of work are used in the analysis, and each is retained because it explains at least one documented episode.

The sport ethic, identity and burnout

The sport ethic describes a set of norms that define a real athlete: dedication, the pursuit of distinction, acceptance of risk and refusal to accept limits (Hughes & Coakley, 1991). Over-conformity to these norms produces positive deviance, which includes training and competing through pain. Social networks of coaches, teammates and medical staff can reinforce this pattern by rationalising the costs of injury (Nixon, 1992). Mediated cultural messages can carry the same norms to athletes without direct contact (Nixon, 1993). Male athletes in particular learn to talk about pain in ways that protect a masculine and athletic self (Young et al., 1994). The same process has been documented in a Muslim-majority setting, where playing through pain was explained in part by social learning within sport (Kabiri et al., 2021).

Athletic identity adds a psychological layer, because an exclusive identity can make injury a threat to self-definition as well as to performance (Brewer et al., 1993). When that identity is lost, premature retirement can be experienced as a loss of self (Sparkes, 1998). Burnout is, in this respect, better read as a response to identity and control within a system than as personal failure (Coakley, 1992). Dropout is also multidimensional, and athletes leave for healthy as well as harmful reasons (Crane & Temple, 2015).

Controlling relationships, dependence and organisational stress

Self-Determination Theory predicts that controlling interpersonal environments frustrate autonomy, competence and relatedness, whereas autonomy-supportive relationships sustain motivation and communication (Deci & Ryan, 2000; Bartholomew et al., 2011). Demanding coaching is not controlling by definition. The concern arises when authority over selection, training and opportunity becomes difficult to question, since an athlete may then comply while withholding information the coach needs to make safe decisions. Poor and emotionally abusive coaching has documented psychological effects that extend beyond the immediate interaction (Gearity & Murray, 2011; Stirling & Kerr, 2013). Recent work on safe sport shows how performance dependency legitimises coach authority and narrows the conditions under which it is questioned (Chroni et al., 2026). Organisational-stress research locates further stressors in leadership, logistics, selection, communication and role uncertainty rather than in competition alone (Arnold & Fletcher, 2012; Fletcher et al., 2012).

Embarrassment, modesty and help-seeking

Men's help-seeking research offers a mechanism that sport disclosure models lack. Delayed presentation for testicular symptoms has been linked to embarrassment, fear of appearing weak and the normalisation of symptoms (Chapple et al., 2004; Galdas et al., 2005). A systematic synthesis identified embarrassment and shame as barriers in 13 studies, most of which concerned cancers of the reproductive organs (Fish et al., 2015). Islamic ethics applies modesty to both sexes, and for men the area between the navel and the knee is conventionally treated as private (Sirois et al., 2013). Muslim patients may prefer same-gender clinicians for examinations and conversations involving private body regions, and norms on cross-gender contact apply differently within the family (McLean et al., 2010; Padela & Rodriguez del Pozo, 2011). Empirical work on modesty in health care and physical education has, however, focused on women and girls (Benn & Pfister, 2013; Padela et al., 2016). How religious modesty, adolescent embarrassment and masculine stoicism combine in a male

athlete's decision not to report a genital symptom appears not to have been examined in sport.

What surveillance systems record

Injury surveillance has long relied on time-loss definitions, which record a problem only when it prevents participation, so overuse conditions that allow continued training are under-recorded (Bahr, 2009). Weekly questionnaires such as the Oslo Sports Trauma Research Center questionnaire on health problems (OSTRC-H) were developed to capture problems that reduce performance or participation without time loss (Clarsen et al., 2014). A validated Malay-language version shows that such instruments can be adapted for Southeast Asian athletes (Hadi et al., 2024). Load monitoring is intended to separate normal training discomfort from warning signs, and rapid increases in load are a recognised risk factor for injury (Soligard et al., 2016). For youth athletes, the reference point is the International Olympic Committee (IOC) consensus on healthy, individualised and sustainable development (Bergeron et al., 2015; see also Bergeron et al., 2024). All of these instruments share one feature: they depend on the athlete's report reaching the person who administers them.

Safeguarding and small-state conditions

Safeguarding consensus has moved beyond sexual abuse toward psychological violence, physical violence, neglect and a whole-of-system model of interpersonal violence (Mountjoy et al., 2016; Tuakli-Wosornu et al., 2024). The most recent IOC statement calls for athlete-centred settings in which prevention and response are measured and responsibility is shared across the sport system (Tuakli-Wosornu et al., 2024). Small-state sport research explains why such responsibility is hard to distribute. Small states face distinctive constraints of capacity and vulnerability when they invest in elite sport, and their systems have fewer degrees of separation between athletes, officials and decision-makers (Houlihan & Zheng, 2015; Sam & Jackson, 2015). Small island states can also face acute constraints in sport policy and provision (Darko & Mackintosh, 2015). The analysis below treats these conditions as modifiers of the mechanisms above rather than as independent causes.

Methodology

Design

This study is a retrospective analytic meta-autoethnography. Analytic autoethnography requires the researcher to be a full member of the setting, visible in the text and committed to developing theoretical understanding of wider social processes (Anderson, 2006). Coaching research has used autoethnography to examine power and consent in coach-athlete relationships (Purdy et al., 2008). Meta-autoethnography extends this by returning to the author's own earlier autoethnographic and autobiographical writing and re-examining it from a later standpoint (Ellis, 2009). In sport, a former elite swimmer used the approach to revisit her historical autoethnographic work with a more reflexive voice (McMahon & McGannon, 2017). The present study uses the approach analytically. The earlier texts are treated as a fixed evidence base, and the later standpoint is that of a coach, administrator and researcher testing a welfare framework. The study is reported in line with the Standards for Reporting Qualitative Research (O'Brien et al., 2014).

Sources

The evidence base was fixed before analysis and consists of two texts. The first is *Running in Pain: An Autoethnography of Power, Coercion and Injury in Coach-Athlete Relationship*, a doctoral thesis completed at the University of Otago (Haleem, 2006). It draws on the author's memories, ethnographic notes and training diaries. The second is *(UN)defeated Maldivian Olympian*, an autobiographical book published by Muhibbah Publications (Haleem, 2026). The book covers the author's life to the Seoul Olympic Games of 1988, whereas the thesis continues to his retirement in 1993. No unpublished notes, new interviews or post-publication recollections were treated as data.

Episode selection

Screening both texts identified many more passages about injury, training load, coaching power, disclosure, identity and withdrawal than a single article could analyse. An episode was therefore included when it met two conditions. It documented a harm to health, wellbeing or participation, and it contained a point at which information about that harm could or could not reach someone able to act. Passages describing training practices without such a point, for example the management of gastrointestinal symptoms during training (Haleem, 2006, pp. 185–186), were excluded. Where an event appeared in both texts, the earlier record established the event, and the later account was used only for published reflective interpretation that did not contradict it. Eight episodes met these conditions (Table 1).

Analysis

Analysis proceeded in four stages. First, each episode was coded descriptively for what happened, such as symptom concealment, training through pain, a medical decision, or withdrawal. Second, each episode was compared with the mechanisms in Section 2. Third, the case was examined for contextual modifiers, namely scarcity of expertise, concentrated coaching authority, limited alternative routes, close social networks and bodily-modesty norms. Fourth, each episode was used to test the Athlete Welfare Ledger. For every harm, the analysis recorded whether the Ledger could have detected it, when detection would probably have occurred, and which institution would have needed to hold the information (Table 2).

Quality and rigour

The study did not use inter-rater agreement, whose value in qualitative research is disputed (Smith & McGannon, 2018). Because the study tests a framework against a fixed record, its claims are better judged by realist criteria of empirical adequacy and practical utility (Ronkainen & Wiltshire, 2021). Quality was pursued in three ways. Every episode is cited to page level in its source, so each can be checked. The episode-to-mechanism map is reported in full, which provides an audit trail from passage to claim (Table 1). Rival explanations were sought for each mechanism, particularly for the modesty finding (Section 7.2). Readers are invited to judge the study against published criteria for analytic autoethnography, including substantive contribution and reflexivity (Sparkes, 2020).

Interpretive limits

The analysis is non-diagnostic. Contemporary safeguarding concepts are not used to declare retrospectively that each difficult experience constituted abuse, and a single remembered interaction is not used to characterise a whole relationship. The analysis asks which

mechanism an episode illustrates and which protection might have altered the pathway; it does not judge the motives or character of the people involved. Where the source uses terms such as burnt out or depressed, they are reported as the author's own words and not as diagnoses. The pseudonym "Sato" used in the thesis for the coach is retained.

Historical distance also limits inference. The events occurred between the mid-1980s and 1993, before current safeguarding expectations and routine athlete monitoring became standard. The thesis was itself written more than a decade after the earliest events, although parts of it draw on contemporaneous training diaries. The case therefore cannot audit the present Maldivian system. It can, however, test whether the mechanisms that current frameworks aim to monitor would have been detected in a documented historical career.

Positionality

The author is the athlete whose experiences are analysed and the author of both source texts. He is also a coach, an academic and a former national sport official. He served as Chef de Mission, as Vice President of the Maldives Olympic Committee from 2009 to 2013, and as a member of the national Sports Council (Haleem, 2026, pp. 249–250). These roles give insider knowledge of athlete experience and institutional practice. They also create risks of self-justification, retrospective coherence and role conflict. The analysis therefore gives priority to what is already published, separates evidence from interpretation, and states uncertainty rather than filling gaps.

Relationship to other work

The same two sources inform two other manuscripts by the author. One examines the ethics of representing other people in autoethnographic writing, and the other examines coach authority, consent and Islamic accountability. Both use some of the same passages, including the adolescent medical episode and the 1992 injury episode analysed here. The present article does not analyse representation, consent or accountability. It uses the passages as evidence of disclosure mechanisms and as test cases for surveillance design.

Findings

Mechanisms in the Documented Career

Table 1 maps the eight episodes to the mechanisms used in the analysis. The final column is interpretive and identifies what the Maldivian setting adds to, modifies or challenges in the general literature. The same coach, Sato, trained the athlete in the Maldives from adolescence until 1988 and again abroad in 1991 and 1992 (Haleem, 2006, pp. 184, 186). The episodes therefore describe one relationship across two Olympic cycles rather than several unrelated encounters.

Table 1

Documented episodes, mechanisms, supporting literature and contextual modifiers in the case

Documented (source)	episode	Mechanism	Supporting literature	What the Maldivian setting adds or modifies
1. Self-imposed refusal to drink during training for weeks to months; severe groin and testicular pain; fainting during a run, after which running continued (Haleem, 2006, pp. 183–184; 2026, pp. 125–127)	Sport ethic; self-generated risk		Hughes & Coakley (1991); Nixon (1993); Brewer et al. (1993)	No mentor or sports science existed to contradict a self-made toughness rule, and the coach rarely had to push.
2. Pain and blood in the urine concealed for about a month; no one known well enough to hear intimate details (Haleem, 2006, p. 184); mentioning private parts felt immoral (Haleem, 2026, p. 127)	Absent recipient; embarrassment and modesty barrier		Galdas et al. (2005); Fish et al. (2015); Padela & Rodriguez del Pozo (2011)	The first barrier was not the coach. The symptom lacked both words and a recipient.
3. When the coach noticed reduced effort, the athlete concealed pain and blood for fear of being thought a liar (Haleem, 2006, p. 184; 2026, p. 128)	Constrained voice under concentrated authority		Bartholomew et al. (2011); Roderick (2006); Pennock et al. (2024)	Training and selection prospects sat with one person, whose expected response shaped what he was told.
4. Disclosure to a half-sister who was a nurse; first doctor's advice to rest ignored; government-funded treatment in India within two weeks; dehydration identified and resolved (Haleem, 2006, pp. 184–185; 2026, pp. 128–129)	Clinical route outside the coaching line; identity-linked non-adherence		Chapple et al. (2004); Brewer et al. (1993)	A family member with clinical training supplied the route that the sport system lacked.
5. Seoul 1988: rising load; repeated reports of tiredness dismissed; self-described as probably burnt out; stopped after 33 km (Haleem, 2006, pp. 189–192)	Load mismanagement; voice without effect		Soligard et al. (2016); Deci & Ryan (2000); Coakley (1992)	The athlete spoke, but the information stopped with the coach.

documented (source)	episode	Mechanism	Supporting literature	What the Maldivian setting adds or modifies
6. 1991 to 1992: weekly running rose from about 70 km to up to 150 km; injuries to both knees; four months of pressure to train; injections given after the doctor consulted the coach, without explanation to the athlete (Haleem, 2006, pp. 186–188)	Clinical route captured by coaching authority		Soligard et al. (2016); Mountjoy et al. (2016); Tuakli-Wosornu et al. (2024)	With no independent clinician, the coach became the channel for medical decisions.
7. February 1992 extract: lost trust in the coach, who would not acknowledge the need for rest; Barcelona marathon run while injured (Haleem, 2006, p. 11)	Relational rupture; continued dependence		Gearity & Murray (2011); Stirling & Kerr (2013); Chroni et al. (2026)	With few alternatives and an Olympic place at stake, rupture and dependence coexisted.
8. End of 1992: self-described as totally burnt out; back pain from training on potholed roads without a track; won the national marathon, then retired at 23 with no plan for life after sport (Haleem, 2006, pp. 225–229)	Burnout; identity loss; premature retirement		Coakley (1992); Sparkes (1998); Crane & Temple (2015)	Results concealed the withdrawal risk, and no exit or transition support existed.

Note. Where an event appears in both texts, the 2006 thesis establishes the event and the 2026 book is cited for reflective interpretation. The final column records the author's interpretation.

A two-stage disclosure failure

At sixteen, the athlete developed severe groin pain during training, which he first attributed to running without underwear. A week or so later he felt a sharp pain in his testicles, lost consciousness during a run, and then got up and continued running (Haleem, 2006, pp. 183–184). He trained through worsening pain for about a month and then began to pass blood in his urine. Throughout this period he told no one.

The first barrier was not the coach. The 2006 account locates it in the absence of anyone to tell. The athlete was more worried about whom to consult than about the pain itself, and knew no one well enough to discuss such intimate details (Haleem, 2006, p. 184). The 2026 account adds a cultural interpretation, describing a culture in which even mentioning private parts felt immoral, and states that he was more afraid of embarrassment than of injury (Haleem, 2026, p. 127). The second barrier was relational. When the coach noticed that he was not training as hard as expected, the athlete concealed the pain and the blood. He feared

that the coach would think he was lying and would tolerate no excuse (Haleem, 2006, p. 184; see also Haleem, 2026, p. 128).

The sequence matters for theory. Sport disclosure models typically begin with a problem the athlete can already name, then ask whether the athlete trusts the recipient, fears consequences or knows the route (Roderick, 2006; Pennock et al., 2024). The case exposes a prior stage in which a bodily sensation has to be converted into communicable information, and in which the athlete must find a recipient to whom the information can be given. If no such recipient exists, the problem never becomes an injury report, a wellness flag or a safeguarding concern. Men's health research has documented this stage in clinical settings (Fish et al., 2015). The case shows it operating inside a sport system, where it preceded the relational barrier rather than replacing it.

The finding does not support a general claim that Muslim athletes conceal intimate symptoms. It supports a case-specific conclusion that the intimacy of the symptom was a documented barrier in this career. The Maldives is a small Islamic island state in which all citizens are Muslim. A protection system there should not assume that every athlete can name intimate symptoms to any staff member, particularly an opposite-sex or non-clinical adult.

A culture of risk produced in an informational vacuum

The medical episode had a self-generated cause. Believing that resisting thirst would make him a stronger athlete, the sixteen-year-old decided not to drink during training runs and kept to this rule for weeks and then months (Haleem, 2006, p. 183). A urologist later attributed the pain and the blood to severe dehydration (Haleem, 2006, pp. 184–185). The 2026 account places this rule in an environment where the coach gave training only on the field, and the athlete had no mentor, no sports science and no older athlete to guide him (Haleem, 2026, p. 125).

Controlling coaching does not describe this mechanism, because the coach did not prescribe the rule. The thesis records that the athlete's desire to succeed was so intense that the coach rarely had to push him, and that he had come to see pain as the norm for athletes (Haleem, 2006, pp. 183–184). Early work located the pressure to play hurt in messages exchanged within dense sport networks (Nixon, 1992). Later work added mediated cultural messages that reach athletes without direct contact (Nixon, 1993). The case fits the second route, since the 2026 account traces the water rule to stories the athlete had heard about the training of African runners (Haleem, 2026, p. 125). What the scarce setting added was the absence of any expert voice to contradict the rule.

A small-state implication follows. A large system may offer several informal correction points, such as experienced teammates, physiotherapists, school staff or club doctors. A small system can be relationally close yet informationally thin (Sam & Jackson, 2015). Scarcity therefore increases the cost of misreading ordinary bodily signals, and it leaves a young athlete dependent on very few adults.

Two clinical routes

The case contains two routes into medical care, and their outcomes differ. In the adolescent episode, the athlete eventually told his half-sister, a nurse, who arranged for him to see a doctor (Haleem, 2006, p. 184). The doctor advised rest. The athlete, knowing he would not follow that advice, resumed training the next day, and the pain increased. A few days later he returned to his sister. Within two weeks, government funding allowed him to travel to India, where a urologist identified severe dehydration as the cause (Haleem, 2026, p. 129; see also Haleem, 2006, pp. 184–185). Once he drank during and after training, the pain and the blood resolved.

In 1991 and 1992 the route ran through the coach. Training abroad under Sato, the athlete developed injuries to both knees soon after his weekly running rose from about 70 kilometres to as much as 150 kilometres (Haleem, 2006, pp. 186, 188). The coach pressed him to keep training for four months and then took him to a doctor who, after consulting the coach, gave a painkilling injection without explanation to the athlete (Haleem, 2006, p. 187). A hard track session followed the same day, and the cycle of injection, hard training and returning pain continued for several weeks (Haleem, 2006, pp. 187–188).

The contrast is the clearest design evidence in the case. The route that worked began with a trusted person who had clinical knowledge and no stake in selection. The route that harmed began with the person who controlled training, and the clinician then made decisions with that person rather than with the athlete. Clinical access alone did not protect the athlete in 1992, because the clinical route sat inside the coaching line. The adolescent episode also shows a limit of clinical access, since the athlete ignored the first doctor's advice to rest. A restriction that depends on the athlete's own compliance will fail when identity demands continued training.

Load, voice and burnout

The Seoul Olympic Games of 1988 show load and voice interacting. During the preparatory camp in Japan the athlete repeatedly tried to tell the coach that he was tired, and each time was told not to worry (Haleem, 2006, p. 189). The coach continued to increase his training load, and the athlete wrote that he was probably already burnt out on arrival in Seoul. When he tried to talk about his condition, the coach did not seem to listen (Haleem, 2006, p. 191). He was set a target twenty minutes faster than his personal best, slowed after 20 kilometres and stopped after 33 kilometres (Haleem, 2006, pp. 191–192).

In this episode the athlete did speak, so the barrier was not concealment. The information reached the coach and went no further. The knee injuries of 1991 followed a comparable pattern, in which a sudden rise in load was imposed and reported symptoms did not change the plan (Haleem, 2006, pp. 186–188). Both episodes fit the evidence that rapid increases in load raise injury risk (Soligard et al., 2016). They also show that a load record held only by the coach cannot act as a safeguard against the coach's own decisions.

Dependence after lost trust

The thesis opens with an extract, reconstructed from a training diary and dated February 1992, in which the coach expresses frustration after an incomplete session. The author records that he has lost trust in the coach, and that his knee will not heal without rest, which

the coach will not acknowledge (Haleem, 2006, p. 11). He nevertheless ran the Barcelona marathon while injured. In a system with alternatives, lost trust might lead to a change of coach. In a small system with scarce expertise and an Olympic opportunity at stake, dependence continued after trust had gone. This pattern matches accounts in which performance dependency legitimises coach authority and discourages challenge (Chroni et al., 2026).

Burnout, identity loss and premature retirement

By the end of 1992 the athlete described himself as totally burnt out, both mentally and physically, unable to run even a few kilometres, and tired and dizzy all the time (Haleem, 2006, p. 225). He also recorded chronic lower back pain from training on potholed roads, because there was no running track. He won his sixth national marathon on 1 January 1993 and then retired at the age of 23 (Haleem, 2006, pp. 225–229). The thesis describes the loss of his athletic identity, the absence of any plan for life after athletics, and a period in which he felt constantly depressed and worthless (Haleem, 2006, p. 229).

Two features matter for surveillance. First, the athlete left while still winning, so a system that monitors only results would have recorded a national champion and not a withdrawal risk. This is the pattern that a structural reading of burnout predicts, in which the costs of an exclusive identity and limited control accumulate until participation ends (Coakley, 1992; Sparkes, 1998). Second, the thesis records no exit process or transition support, and nothing connected his withdrawal to the preceding years of load, injury and lost trust.

No single mechanism produced these harms. Identity, the intimacy of the adolescent symptom and coaching authority each contributed, and their effect depended on limited specialist support. The athlete was neither simply a victim of authority nor fully autonomous. He was an ambitious young athlete making choices within narrow limits of knowledge, opportunity and culturally acceptable speech.

Retrospective Test of the Athlete Welfare Ledger

The Ledger and existing surveillance

The Athlete Welfare Ledger is a minimum system for making physical, psychological, educational, relational and safeguarding outcomes visible alongside competitive results. It does not claim that measurement alone protects athletes, and it is not a replacement for validated health surveillance. Instruments such as OSTRC-H already record symptoms that reduce participation without time loss (Clarsen et al., 2014). The Ledger is positioned as a layer around such instruments. It adds relational-safety measures, a record of who holds each type of information and, after the test below, a private entry route for sensitive concerns.

Six domains are retained. Physical health covers injury, overuse symptoms, training load, training modification and return to sport. Psychological health covers confidential wellbeing checks, warning signs relevant to burnout and access to referral. Participation and transition covers entry, retention, exit and confidential reasons for leaving. Education and dual career covers examination conflicts, absence and planning for life after sport. Safeguarding covers complaint routes, response time and access to independent advice. Trust and communication covers clarity of selection, confidence in injury management and willingness to disclose concerns. Participation and competition data are plausibly held already by sport bodies,

whereas injury, wellbeing, disclosure and exit-reason data would generally require new processes (Table 3).

Test results

The test asked whether the Ledger would have detected each documented harm, when detection would probably have occurred, and which institution would have needed to hold the information (Table 2).

Table 2

Retrospective detectability of documented harms by Ledger domain, detection point, data holder and required design change

Harm (source)	Ledger domain	Detectable?	Likely detection point	Data holder	Design change revealed
1. Training through escalating pain under a self-imposed fluid rule (2006, pp. 183–184)	Physical health; load	Partly	Routine symptom or training-modification check, if honestly reported	Designated medical service	Record non-time-loss symptoms and hydration practice; do not rely on time-loss injury.
2. No recipient for intimate symptoms (2006, p. 184; 2026, p. 127)	Safeguarding; disclosure	No	Not detected by ordinary logs or verbal wellness questions	Confidential clinical route	Private-concern flag; non-verbal body map; choice of first contact; route that bypasses the coach.
3. Concealment from the coach through anticipated disbelief (2006, p. 184)	Trust; psychological safety	Partly	Only if confidential disclosure checks existed before the crisis	Welfare function outside the coaching line	Measure perceived safety to disclose health problems.
4. Rest advice ignored and definitive care delayed (2006, pp. 184–185)	Physical health; referral	Partly to yes	At first clinical contact, if follow-up and red-flag escalation existed	Medical service	Scheduled clinical follow-up; mandatory review after collapse or visible or persistent haematuria.

Harm (source)	Ledger domain	Detectable?	Likely detection point	Data holder	Design change revealed
5. Overload and dismissed fatigue before Seoul health (2006, pp. 189–192)	Physical and psychological health	Yes	Weekly load and wellbeing record	Programme health staff, not the coach alone	Load and wellbeing data reviewed by someone other than the coach.
6. Load spike, knee injuries and coach-mediated injections (2006, pp. 186–188)	Physical health; safeguarding	Partly	Injury and treatment record, if the clinician answered to the athlete	Independent clinician	Treatment explained to and decided with the athlete, not through the coach.
7. Lost trust; need for rest unacknowledged (2006, p. 11)	Trust; safeguarding	Partly	Periodic relational check or confidential complaint route	Welfare function outside the coaching line	Confidential relational-safety check and a second-person route.
8. Burnout and retirement without transition support (2006, pp. 225–229)	Participation and transition; dual career	Partly to yes	Wellbeing checks during 1992; exit interview in 1993	National athlete-welfare in service	Confidential exit process; transition planning during the career.

Note. Detectability is a design judgement, not an observed outcome. Harm numbers match the episode numbers in Table 1. Years and pages refer to Haleem (2006) and Haleem (2026).

What the test shows

The test does not vindicate the Ledger. Seven of the eight harms were at least partly detectable, provided monitoring existed, the athlete reported honestly and the information reached someone other than the coach. The first barrier of the adolescent episode is different. An athlete who knows no one to whom an intimate symptom can be named may answer a general wellness question incompletely, may not request treatment and may never enter an injury log. Systems designed to create voice can therefore reproduce silence when they require verbal disclosure of an intimate body region to a coach or other non-clinician.

The design response is not to lower the evidential threshold for medical decisions but to widen the route by which a symptom becomes visible. Useful options include a confidential digital or paper body map, coded symptom categories, direct access to a qualified clinician, and a choice of first contact. The adolescent route suggests what that first contact needs. What made the half-sister usable appears to have been family trust and clinical knowledge together, not gender concordance (Haleem, 2006, p. 184). A same-sex clinician option therefore remains useful, but the stronger principle is a trusted first contact with clinical competence who sits outside the selection line.

The data-holder column shows the second lesson. In four episodes the relevant information did reach the coach, or was controlled by him, and it did not protect the athlete (Table 2, harms 3, 5, 6 and 7). Information about load, injury, medical treatment and relational safety cannot sit solely with the person who controls training and selection. Teams can hold day-to-day data, but clinical decisions and confidential concerns require a function able to act without the coach's permission. The case therefore supports functional independence even where full organisational independence is unrealistic in a small state.

Detection timing also matters. The more useful indicators come early: repeated training modification, severe or escalating pain, collapse, marked deterioration, a sharp rise in weekly load, or an athlete's declaration that a private concern needs review. One trigger needs clinical calibration. Microscopic haematuria after strenuous exercise is common and usually benign, so a trigger based on any haematuria would generate frequent unnecessary referrals (Jones & Newhouse, 1997; Patel et al., 2005). The trigger should instead target visible or persistent haematuria and any haematuria accompanied by pain or collapse, with thresholds set by the reviewing clinicians. The adolescent episode met both conditions.

A Minimum Athlete Protection Standard

Each standard in Table 3 is linked to a documented episode, and the baseline column states whether a Maldivian system could plausibly populate the indicator from existing records. The Maldives now has a 20-year sports development plan with a 2040 horizon (President's Office, 2024). The standard is offered as an athlete-welfare component that such a plan could adopt, not as a critique of it.

Table 3

Minimum athlete protection standards, their link to the case, indicators and current Maldivian baseline

Minimum standard	Case link	Indicator	Current baseline
1. Confidential disclosure route that does not require naming an intimate body part aloud to a coach or non-clinician, with direct clinical access, a non-verbal body-map option and a choice of first contact	Episodes 2 and 4	2 Route used; time from concern to clinical review	New process required
2. Documented training load, sudden load increases, major modifications, collapse and significant symptoms, using a validated instrument such as OSTRC-H	Episodes 1, 5 and 6	5 Load and symptom record; escalation trigger; return-to-sport documentation	New standardised health data required
3. Medical decisions made with the athlete and separated from selection authority; right to a second opinion; clinical follow-up; review mandated after collapse, visible or persistent haematuria, or a sharp load increase	Episodes 4 and 6	4 Referrals, second opinions and follow-up completed; treatment decisions documented with the athlete	New process required

Minimum standard	Case link	Indicator	Current baseline
4. Periodic confidential checks of relational safety and confidence to disclose	Episodes 3, 5 and 7	Athlete confidence to disclose; knowledge of an alternative contact	New survey required
5. Coach education in load management, response to disclosure, youth development and safeguarding	Episodes 5 and 6; literature	Completion and renewal of competencies	Partly feasible from coach-registration data; content upgrade required
6. Independent or functionally independent complaint and welfare route outside the coach-selection line	Episodes 6 and 7	Awareness, response time, outcome and protection from retaliation	New or strengthened process required
7. Education, dual-career and transition planning that begins during the career	Episode 8	Transition plan in place; education or employment pathway recorded	Partly feasible where student-athlete data exist
8. Confidential exit process and re-entry pathway	Episode 8	Reason for exit; injury-related exit; willingness to return	New process required

Note. Baseline judgements are the author's assessment of what current administrative records could support and should be verified with the relevant national bodies. OSTRC-H = Oslo Sports Trauma Research Center questionnaire on health problems.

The first standard is the most specific, because the case uniquely reveals it. At least one route must let an athlete communicate that a private medical problem exists without naming the body part aloud to a coach or a non-clinician. The athlete should also be able to choose the first contact. This is not a religious rule imposed on every athlete. It is a design option that removes an avoidable barrier, and it should be available to everyone because privacy preferences vary independently of religion.

The second and third standards address load and medical authority. Basic load and symptom records are feasible without advanced technology, and a validated instrument already exists in a regional language (Hadi et al., 2024). Sudden load increases and red-flag events should trigger review by someone other than the coach. Medical treatment decisions should be made with the athlete, and a coach should not be the channel through which a clinician explains or authorises treatment. In a resource-limited system, referral can be centralised or shared, provided that scarcity does not leave the athlete negotiating alone between pain and selection.

The fourth and sixth standards concern trust. An athlete should know at least one person or service outside the coach-selection relationship to whom a concern can be taken. Periodic confidential questions should ask whether athletes believe they can disclose injury, exhaustion or interpersonal concerns without penalty. The seventh and eighth standards concern the end of a career. The case shows a champion leaving without an exit process or a plan for life after sport, so transition planning should begin during the career rather than after it. A small state may be better served by one national athlete-welfare service than by many weak federation-level structures.

Discussion

Principal findings

The aim was to identify the mechanisms behind documented harms in one Olympic career and to test whether a welfare framework would have detected them. Two findings stand out. The first is a two-stage disclosure failure, in which the intimacy of a symptom and the absence of a suitable recipient kept a serious condition unspoken before anticipated disbelief narrowed disclosure further. The second is the contrast between two clinical routes. The route that began outside the coaching line led to effective treatment within two weeks, whereas the route that began inside it produced injections without explanation and continued training on injured knees. Most documented harms were detectable in principle, so the more important design question is where information goes first.

Absent recipient, modesty, masculinity or adolescence?

The first-stage finding has rival explanations that must be weighed. The 2006 account locates the barrier in the lack of anyone close enough to hear about intimate symptoms (Haleem, 2006, p. 184). The 2026 account adds a culture in which mentioning private parts felt immoral (Haleem, 2026, p. 127). The literature suggests two further readings. Male athletes learn to present pain in ways that protect a tough self (Young et al., 1994), and young men delay consultation for testicular symptoms in secular settings as well (Chapple et al., 2004; Galdas et al., 2005). The published record does not allow these explanations to be separated, and they probably operated together. This limits the cultural claim, but it does not weaken the design conclusion. Whatever the source of the silence, the barrier sits at the same point in the pathway and is removed by the same private route. The contribution therefore rests on where the barrier sits, not on attributing it to religion.

Relationship to existing research

The case extends sport disclosure research in two ways. It adds a pre-relational stage, documented in men's health research, that sport models have not incorporated (Fish et al., 2015; Pennock et al., 2024). It also shows that disclosure is necessary but not sufficient. At Seoul the athlete did report fatigue, and in 1992 injury was known to everyone involved, yet neither report changed what happened (Haleem, 2006, pp. 187–191). The case is consistent with the view that the culture of risk can reach athletes through wider cultural messages rather than a dense network (Nixon, 1993). It is also consistent with the structural reading of burnout, in which withdrawal follows accumulated costs of identity and control (Coakley, 1992). In a scarce environment, the absence of expertise can do the work that pressure from others does elsewhere.

Small states: concentration without redundancy

Smallness does not automatically produce harm, and close relationships can be protective, as the family route in this case shows. The problem is concentration without redundancy. One coach shaped the athlete's training, competition targets and access to medical decisions across two Olympic cycles, and there was no running track on which to train safely (Haleem, 2006, p. 225). When there is one coach, one selection route and limited access to clinicians, ordinary relational failures carry greater consequences because the athlete has few alternatives (Houlihan & Zheng, 2015; Sam & Jackson, 2015). Functional independence therefore becomes more important as organisational independence becomes harder to

achieve. External clinical second opinions, centralised confidential reporting and shared welfare services can create redundancy without reproducing the bureaucracy of a large state.

Limitations

Several limitations require consideration, each with a likely direction of bias. First, one historical career cannot establish the prevalence of injury, unsafe coaching, burnout or dropout. The events occurred in a system that has since changed, and extrapolation to current Maldivian sport would probably overstate present risk. Second, the same person experienced the events, wrote the source texts and analyses them here. This provides longitudinal access but invites selective attention, self-protection and retrospective coherence. The cultural interpretation of the adolescent silence appears only in the 2026 book, written about four decades after the events. The 2006 thesis frames the barrier as the lack of a suitable person to tell. Later reflection may favour culturally meaningful explanations, which would bias the analysis toward over-attributing silence to modesty. The analysis addresses this by treating the earlier account as primary. Third, the Ledger test is hypothetical. It asks whether an indicator could plausibly have captured a documented harm, not how a historical institution would have responded. Because the test assumes that monitoring existed and was trusted, it probably overestimates detectability, and it should be read as a design stress test rather than outcome validation.

Practical applications

Four groups can act on these findings. National programme medical officers can add a private-concern option to existing health questionnaires, so that an athlete can request clinical review without naming the body region to coaching staff. Olympic committee and Ministry welfare officers can name, for each national squad, a first contact with clinical training who sits outside the coaching line, and can place confidential welfare data with that person. Clinicians treating athletes can explain treatment to the athlete directly and decline to make treatment decisions through the coach. Coaches can treat collapse, marked deterioration, visible or persistent haematuria and sharp increases in weekly load as automatic referral events. None of these actions requires expensive technology, but each requires a decision about who receives information first.

Future research

Four studies would test the claims made here. First, an audit should map which injury, participation, student-athlete and safeguarding data Maldivian bodies currently hold, and who holds them. Second, a survey of national-squad athletes of both sexes should measure preferred first-contact routes for sensitive health concerns. Third, a pilot of OSTRC-H with an added private-concern item in a small number of national programmes should record uptake, time to clinical review and athlete-reported burden. Fourth, interviews with retired Maldivian athletes should examine how career endings were experienced and whether any exit support existed. Research design must take deductive disclosure seriously, because in a small society sport, island, age, event and achievement can identify an individual after names are removed.

Conclusion

In one documented Maldivian Olympic career, an adolescent athlete concealed a serious medical condition. He knew no one to whom intimate symptoms could be named, and he expected his coach to disbelieve him. Disclosure to a half-sister with nursing training led to

effective treatment within two weeks, whereas a later medical route controlled by the coach produced injections without explanation and continued training on injured knees. Seven of eight documented harms would have been at least partly visible to conventional monitoring, but only if the information reached someone other than the coach. Welfare surveillance in small sport systems therefore needs a private entry route for sensitive symptoms and a first contact with clinical training outside the coaching line.

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Conflict of interest

The author declares no conflict of interest. The historical governance roles described in Section 3.7 are not treated as evidence for any claim, and the author no longer holds a role in the Maldives Olympic Committee or the national Sports Council (Haleem, 2026, p. 250).

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Ethics and data availability

No new human participants were recruited, and no new interview, survey or observational dataset was generated. The study re-analyses the author's own previously completed texts. The pseudonym used in the thesis was retained, and no new identifying detail about other people was introduced. The thesis is catalogued in the University of Otago repository, and its full text is available through library interloan. The book is available in print (ISBN 978-967-2015-67-1). Cited pages from both texts can be supplied to the editor and reviewers on request.

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