

GUIDING ETHICAL PRINCIPLES

As explained in the Introduction, the goal of this Report is to determine who is and should be responsible for protecting and promoting the health of NFL players, and why. In some cases, the law will at least partially answer these questions, at least from a descriptive standpoint. But in all cases it is necessary to undertake ethical analysis in order to evaluate the sufficiency of existing legal obligations, make recommendations for change, and determine the proper scope of extralegal responsibilities. It is ethics that will help us explain the conclusions and recommendations that follow.

In this chapter we outline seven foundational ethical principles that we believe ought to govern the complex web of stakeholders related to player health as described in the Introduction. These principles, generated for the unique context of professional football, served to guide the proper scope and direction of the recommendations set forth for each stakeholder in the chapters that follow, and also as a litmus test for inclusion of various recommendations in the Report. We describe these principles and their development below. Then, in each of the subsequent chapters, we consider more specific ethical obligations of each individual stakeholder as to player health, acknowledging, among other things, existing ethical codes and legal obligations.

(A) Existing General Principles

The principles that guide this Report are neither matters of natural law nor derived from pure reason, nor were they entirely driven by case study of the NFL. Instead, we recognized that “[n]either general principles nor paradigm cases adequately guide the formation of justified moral beliefs”¹ Instead, principles must be designed for specific cases and case analysis must be guided by general principles. Thus, we took both top-down and bottom-up approaches, cognizant of the sometimes fraught relationships of the relevant stakeholders, in order to develop a set of tailored principles applicable to our driving questions about the who, how, and why of protecting and promoting player health.

Stated another way, we began with widely recognized, if not necessarily universally revered, general principles from bioethics, as well as from professional and business ethics and human rights, where applicable—a top-down approach. Here, our question was “which ethical principles

have already been established or suggested that may have relevance to this context?” However, it was particularly important not to simply apply “off the shelf” general ethical principles to the setting of professional football because these principles often are meant to govern a particular kind of relationship—*e.g.*, physician-patient, researcher-subject, business-consumer—and not all the stakeholders we examine fit those molds. Thus, we simultaneously considered unique features of the NFL context to generate more specific and novel principles for this setting—reasoning from the bottom up.

In the end, our approach was to build on ethical analyses that have come before, while recognizing that “[a]ppropriate moral judgments occur . . . through an intimate acquaintance with particular situations and the historical record of similar cases.”²

1) GENERAL PRINCIPLES OF BIOETHICS

The literature on principles that guide bioethics is vast.³ Not only are there numerous proposals for principles that ought to be considered, but there are also strong voices against the use of principles altogether.⁴ Without providing a comprehensive review of this debate, we began our analysis with the most prominent set of principles in modern bioethics: Respect for Autonomy; Non-Maleficence; Beneficence; and, Justice. These four principles have become the foundation of an approach called “Principlism,” which calls for application of these principles and balancing them against one another in order to reach moral conclusions about particular situations.⁵

What do these principles mean? In brief:

- **Respect for Autonomy** means at a minimum respecting “self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding.”⁶
- **Non-Maleficence** refers to the duty to avoid harm. It is “distinct from obligations to help others” and “requires only intentional avoidance of actions that cause harm.”⁷
- **Beneficence** is the duty to positively do good, an obligation “to prevent . . . [and] remove evil or harm” and promote the welfare of the relevant party.⁸

- Finally, the principle of **Justice** refers primarily to distributive justice, the “fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation.”⁹ This principle may be framed for our context as fairness in distribution of burdens and benefits of a given enterprise.

Other principles have also been suggested as alternatives or additions. Scholars coming from the ethics of care tradition have suggested that a principle of Compassion be added to the mix, as a supplement to Beneficence, and feminist and non-Western scholars have pressed for an approach less focused on individual autonomy, with greater recognition that individuals are situated in a much richer community and context.¹⁰

These values sometimes conflict, and on the Principlist view, much of the moral decisionmaker’s work is to come to some appropriate balance among them. A primary criticism of Principlism, however, is that it offers no substantive guidance on how to reach such balance, leading to a great deal of subjectivity. Framed in such general terms, these principles are helpful starting points, but they cannot suffice to resolve the question driving this Report: what role should various stakeholders hold in protecting and promoting the health of NFL players? Further specification is needed.

That said, one final principle that has more recently emerged in the bioethics literature, and indeed offers some method of achieving balance among other potentially competing principles, is the principle of **Community Engagement**. Community Engagement entails collaborative inclusion in the decision-making process of those affected by particular systems and decisions, rather than relying on purely expert or hierarchical decision making.¹¹ This idea is related to Democratic Deliberation, or the process of actively engaging with relevant stakeholders for debate and decision making in a way that “looks for common ground wherever possible” and strives for “mutually accepted reasons to justify” policy proposals.¹²

As described in the introductory sections of this Report and in Appendix N, we endeavored to engage in a robust process for working with all available stakeholders to make sure their perspectives were appropriately accounted for in this Report and its recommendations. In addition to being ethically imperative to give weight to stakeholders’ own perspectives, this approach supported the development of a set of recommendations that are well-informed, practical, and realistic. Thus, we have adopted the principle of Community Engagement, specified as “Collaboration and Engagement,” in our set of guiding principles for the NFL ecosystem, as described in further detail below.

2) PROFESSIONAL ETHICS

Moving beyond broad bioethical principles, many of the stakeholders considered in this Report are members of professional groups—doctors, athletic trainers, attorneys, financial professionals, and the like—with their own systems of education, requirements for licensure or certification, special knowledge and skills, legal and ethical duties, codes of ethics, and systems of self-regulation and discipline.¹³ Consequently, it was also important for us to consider the specific principles already in place to guide their behavior. Professionals have heightened ethical obligations to those they serve in part for tautological reasons: one of the things that has historically defined professions as such is the fact that they seek to help others and have goals beyond mere profit. Professionals are often granted special privileges, special access to information, and special trust, and as a result, have special duties of competence, trust, and beneficence, among others.

Professionals are often granted special privileges, special access to information, and special trust, and as a result, have special duties of competence, trust, and beneficence, among others.

The specific principles of professional ethics applicable to each professional stakeholder are discussed in greater detail in the chapters that follow. However, several principles emerge as themes across the board (and indeed are repeatedly emphasized in sports medicine ethics): managing conflicts of interests (dual loyalty); transparency; maintaining confidentiality; and, balancing autonomy with justified paternalism.¹⁴ In short, this means three things:

- minimizing conflicts of interest to the extent possible, and when they cannot be avoided, making sure that all those potentially affected are aware of the interests at stake;
- using confidential information only for the purpose for which it was disclosed, and being forthcoming about all of the ways in which disclosed information may be shared or protected; and,
- providing individuals with the information they need to make decisions for themselves, but in rare instances, stepping in to avoid complicity with serious and irreversible harm that would result from biased or misinformed decisions.

Each of these concepts is incorporated in our set of guiding principles below.

3) HUMAN RIGHTS NORMS

Another perspective useful as a starting point for generating governing principles comes from international human rights. In particular, the United Nations Educational, Scientific and Cultural Organization (UNESCO) has carved out a distinctive role for human rights in formulating normative principles of bioethics in its Universal Declaration on Bioethics and Human Rights, finally adopted by UNESCO in 2008.¹⁵

This Declaration, in its goals, goes far beyond governing the relations of states and instead aims, among other things:

To guide the actions of individuals, groups, communities, institutions and corporations, public and private . . . to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms, consistent with international human rights law . . . to recognize the importance of freedom of scientific research and the benefits derived from scientific and technological developments, while stressing the need for such research and developments to occur within the framework of ethical principles set out in this Declaration and to respect human dignity, human rights and fundamental freedoms; . . . to foster multidisciplinary and pluralistic dialogue about bioethical issues between all stakeholders and within society as a whole; . . . to promote equitable access to medical, scientific and technological developments as well as the greatest possible flow and the rapid sharing of knowledge concerning those developments and the sharing of benefits, with particular attention to the needs of developing countries.¹⁶

The Declaration lists many principles, but particularly relevant to our context is its emphasis on respecting human dignity, empowering individuals to make their own decisions while also requiring that they bear responsibilities for those decisions, the importance of just and equitable treatment of all participants in a social institution, the recognition of conflicts of interest and the need to be transparent about them, public engagement on issues of bioethics, and the importance of using the best available scientific methods and knowledge.¹⁷

To be sure, some of these concepts like the notion of “human dignity” have been simultaneously criticized as too vague and championed as fundamental.¹⁸ Moreover, we are not claiming that any of the problems we discuss in this

Report or which NFL players face by playing football rise to the level of human rights violations, given the simple fact of consent to play and payment for services, the difficulties players face do not compare to the numerous and ongoing tragedies around the world that human rights law is thought to govern. Nonetheless, these UNESCO principles, like the others discussed above, form a useful foundation for generating more specific principles that can govern our analysis of protecting and promoting player health.

4) PRINCIPLES OF CORPORATE SOCIAL RESPONSIBILITY

Finally, because some of the stakeholders we examine are businesses, it is important to understand their ethical obligations through the lenses of business ethics and corporate social responsibility. The most influential articulation of corporate social responsibility principles is the United Nations Guiding Principles on Business and Human Rights, published in 2011 (Guiding Principles).¹⁹

We rely on these Guiding Principles in particular in Chapter 19: NFL Business Partners, but some of their spirit is more generally applicable. In particular, the emphasis on engaging in “meaningful consultation with potentially affected groups and other relevant stakeholders,”²⁰ and the importance of considering the “leverage” available to various stakeholders in calibrating their ethical responsibilities,²¹ are two features that shape our approach in this Report more generally.

(B) Generating Specific Ethical Principles to Promote NFL Player Health

As mentioned above, we view the general principles derived from bioethics, professional ethics, human rights discourse, and corporate social responsibility as helpful starting points, but in general, insufficiently nuanced to account for the unique circumstances of the NFL. Thus, through a series of literature reviews, stakeholder interviews, and expert discussions we sought to formulate a more nuanced set of principles that address the actual issues facing NFL players through bottom-up analysis. In particular, some of the existing general principles demand modification or supplementation to go from their current role—*e.g.*, delineating the ethical roles of healthcare and other professionals—to the larger sphere of this project, analyzing the obligations and making actionable recommendations for *all* stakeholders who can or should play a role in protecting and promoting player health.

In undertaking that analysis we arrived at the following seven principles. We note that these principles are rooted in and support the foundational position described in the Introduction to this Report, in which we set forth our view that competent adults ought to be allowed the opportunity to decide to accept the risks of professional football, so long as they have adequate information and efforts are made to appropriately abate excessive risks.

Respect: The NFL is undeniably a business, but it is a business that relies on individuals who are exposed to substantial risks. These are not passive, inanimate widgets, but persons with inherent dignity and interests, social relationships, and long-term goals of their own. One principle, most prominently espoused by philosopher Immanuel Kant, is that we wrong another when we treat his person “merely as a means” rather than as an “end in himself”²², or in other words, when we use someone only as a tool to achieve some other benefit or goal, rather than as an intrinsically valuable person. This is a paradigmatic way of treating human beings as lacking in the dignity they deserve. Thus, no matter the enjoyment gained by the half of all Americans who count themselves as professional football fans,²³ the revenue generated, or the glory to players themselves, no stakeholder may treat players “merely as a means” or as a commodity for promoting their own goals.

Health Primacy: The fact that football is a violent game and that injuries are relatively common, ranging from the transient to the severe, does not mean that player health is unimportant any more than these facts would suggest that we may permissibly ignore the health risks in other lines of potentially dangerous work. Indeed, part of what the principle of Respect dictates is valuing, protecting, and promoting players’ health capability as a basic good, regardless of how many ready, willing, and able players may be queued up, eager to get their shot at professional success despite the risks.

Health is special because it is foundational to all other pursuits, from the ability to meet basic needs to higher order interests, such as pursuing education, leisure, social relationships, and the full enjoyment of life. For this reason, health capability ought to be accorded special moral weight as compared to other possible goods, and we should be particularly wary in cases where goods will accrue to those whose health is not put at risk by the activities in question.²⁴

When players are expected or encouraged to sacrifice their health for the game, or even when they are simply not discouraged from doing so, they are potentially treated as mere means to an end. This is particularly problematic given the background conditions described in the Introduction in which the alternatives available to some players are

dramatically less attractive than playing professional football, potentially leading to substantial pressures to accept risks that they might otherwise prefer to avoid. Players have a moral right to have their health at the very least protected, and often promoted. To be clear, however, this does not mean that all risk must be eliminated. Bumps and bruises and even more serious harms that will be of limited duration do not raise the same kinds of red flags as the serious, long-term, irreversible health consequences that are our focus here.

Thus, as a general rule, avoiding serious threats to player health should be given paramount importance in every dealing with every stakeholder. This principle is supported by the overarching principles of Non-maleficence and Beneficence, because it calls on stakeholders to avoid harm and promote health, as well as Justice, because it prevents players from bearing unfair burdens for the benefit of others. Indeed, the NFL too acknowledges this principle. In the NFL’s 2015 Health and Safety Report, Commissioner Roger Goodell declared that “[t]here must be no confusion: The health of our players will always take precedence over competitive concerns. That principle informs all of the work discussed in [the Health and Safety] report.”²⁵

**Roger Goodell declared that
“[t]here must be no confusion:
The health of our players will
always take precedence over
competitive concerns.”**

However, there may be instances when a player, acting with full information and without bias or other impairment, may rationally determine for himself that other values (such as supporting one’s teammates, winning, and financial rewards) are more important than his health. As discussed in the Introduction, this is the sort of decision that we regularly allow competent adults to make without interference. Again, this determination may be colored by background conditions faced by some players that in an ideal world would not exist (*e.g.*, poverty, poor alternatives for advancement), but such a context is not unique to professional football.^a We are extremely hesitant to suggest that

a With regard to obesity, for example, we know that on the one hand, food consumption is in the realm of an individual’s “choice,” but on the other, it is deeply constrained by poverty, geography (*e.g.*, so-called “food deserts”), and a host of other issues.

opportunities for advancement, including those available to professional football players, be paternalistically withheld from competent adults, recognizing that we are all subject to various pressures, responsibilities, and contexts that might technically impede our unfettered autonomy. Thus, while health matters, and indeed is often at the top of any pyramid of human values, we do not maintain that players must, or even should, always choose health over all other goods. Instead, we recognize that players may be reasonably balancing along many different dimensions as to what makes a life go well, and in some instances this may mean choosing to sacrifice their health, to some extent. In these cases, we can say that Health Primacy must be balanced against the principle of Empowered Autonomy, as described below, and that in some instances Empowered Autonomy will trump.

That said, it is critically important that such tradeoffs between health and other goods ought not be accepted as conditions of entry into the game of football, signals of “toughness,” or otherwise praiseworthy, *per se*. All stakeholders bear an obligation to try to reduce these instances of tradeoff as much as possible, and to reject an institution that demands or expects that players sacrifice their health on a regular basis.

Empowered Autonomy: Serious risks to players’ health in football must be minimized as a structural matter. Beyond that, though, players are ultimately the ones most able to make decisions and take steps to protect and promote their health. In order to effectively do so, however, like all individuals they often need support and empowerment. While they need factual information (including that covered by the principle of Transparency, below), such information alone is not enough. They need information to be presented in a way they (and their families, friends, and other trusted advisors) can understand and utilize, and in a way that accounts for their own deeply held values and goals. They need decision-making tools that help them see not only short-term benefits and costs, but also longer term implications. They need to have unfettered access to competent doctors whose conflicts of interest are minimized, contract advisors, financial advisors, and others they trust to have open and frank conversations without fear of the information being shared in a way that would cause them harm. The goal is not merely to allow players to choose for themselves which capabilities and values to prioritize, but also to promote informed and authentic choice.²⁶

Such choice also requires that players have access to good options and alternatives—such as unconflicted and qualified medical advisors, educational opportunities and assistance

with post-play career transitions, and the like—with the freedom to select among them without undue pressure from others. Of course, this does not mean that players must be guaranteed absolute autonomy, as they will always have competing responsibilities and the compensation available in professional sports will remain more lucrative than the vast majority of alternative career paths. Thus, pressures to play are likely to remain, for some players even more than others, but their autonomous decisions about which risks to take and which to avoid nonetheless can be better supported through information and other structural changes.

In addition, players have to contend with the uncertainty of the risks they are considering. Even when the risks of injury and the health consequences of those injuries are known, well-supported statistical inferences about groups still provide no certainty about what will happen to a given individual. If there is a 50 percent risk of some injury, for example, a player will of course still not know which half of the group he will ultimately land in, injured or uninjured. In addition, some risks will be affected by the player’s own circumstances. For example, while the rate of anterior cruciate ligament (ACL) injuries among NFL players may be known, an individual player’s position or size might make him more or less susceptible to such an injury. As a final component of uncertainty, it is important to recognize that the contours of many risks are still unknown—many important questions about the health effects of a career in the NFL remain unclear. While the long-term effects of ACL injuries are fairly well known, the long-term effects of concussive and sub-concussive impacts are still being studied. These additional layers of uncertainty make a player’s choices even more challenging.

Although perhaps not a perfect resolution of the various background pressures players may face, it is essential to take steps to at least ensure that player choice regarding matters related to their health will be free from misinformation, lack of understanding, bias, and avoidable negative influences. Other stakeholders have a responsibility to help achieve these criteria whenever possible. Where they are lacking, however, as in situations of cognitive impairment or unresolved biases, the principle of Health Primacy reigns supreme. Certain stakeholders must also be attuned to situations in which apparent restriction of autonomy might actually be autonomy enhancing, in the sense of effectuating a player’s true desires. For example, given the culture of the game today, a player may prefer to be pulled “involuntarily” from play rather than being seen as not tough enough to play through injury.

Transparency: Again, to avoid treating players as mere means, and to promote Empowered Autonomy, all parties

should be transparent about their interests, goals, and potential conflicts *as they relate to player health*. Failure to do so disrespects players and may also result in player health being inappropriately subrogated to other interests. Thus, information relevant to player health must be shared with players immediately and never hidden, altered, or reported in a biased or incomplete fashion. This means revealing medical information about themselves and about risks to players in general, including new information that would be sufficiently credible to be taken seriously by experts, even if not fully validated or “proven.” This also means information about relationships that could influence judgment and recommendations related to player health. Promoting transparency will allow players to make better decisions for themselves, and also promote trust in all those who play a role in their health.

Managing Conflicts of Interest: Transparency alone will often be insufficient to protect and promote player health. While it is helpful to explain to players where conflicts of interest exist, as it may allow them to be on guard to better protect their own interests, mere disclosure will not help players when sufficient alternatives are lacking. Instead, all stakeholders should take steps to minimize conflicts of interest, and when they cannot be eliminated, appropriately manage them. Often conflicts of interest are painted as nefarious or the result of bad intentions by bad actors, but they need not be. Many conflicts of interest are structural; the way in which a system is set up may create challenges for even well-intentioned and ethical individuals to do the right thing. When structure is the problem, it is structure that must be changed.^b Among other things, this will often involve removing problematic incentives, altering conflicted relationships, creating separate and independent sources of advice, and auditing the behavior of those with incentives that diverge from the primacy of player health.

Collaboration and Engagement: As will become evident in the chapters that follow, protecting and promoting the health of professional football players cannot fall to any single party given the interconnected nature of the various stakeholders. Instead, it depends on many parties who should strive to act together whenever possible to advance that primary goal. Further, part of treating players as ends in themselves and not as mere means is to refrain from

making decisions *about* them and instead to make decisions *with* them. Players should be engaged by stakeholders in all matters that influence their health.

Justice: Finally, as a simple matter of fairness, all stakeholders have an obligation to ensure that players are not bearing an inappropriate share of risks and burdens compared to benefits reaped by other stakeholders. Stakeholders should also be aware of the ways in which changing rules, laws, or programs—for example, trading benefits to former players for benefits to current players—may have differential effects on certain subcategories of players, and be attuned to ways in which those disadvantages can be blunted or recompensed. The principle of Justice also demands awareness of implications of actions beyond the NFL itself. The way in which player health is protected and promoted at the top echelons of the sport will influence policies, practices, and culture all the way down the line, influencing the health not only of future NFL players, but also the vastly larger pool of Americans who will play football and never make it to the NFL. Stakeholders should always consider the way their choices will affect this larger population and consider their policies and behaviors in this light.

* * *

In sum, the ethical principles that we advance in this Report reflect well-established principles applied to the unique context of the NFL. They may not prove exhaustive, and we anticipate several others will be generated through critical public reflection on the work herein, but they are the right starting point for further discussion. Ultimately, we can offer one simple meta-principle to guide all the relevant stakeholders, which is a combination of two prominent ethical tools: Kant’s categorical imperative (which demands that we treat others the way we wish to be treated) and philosopher John Rawls’ veil of ignorance (which helps identify as ethical standards those rules of behavior we would select if we did not know which role we would inhabit in a given relationship). That simple principle is this: *in every scenario, ask what system and rules you would wish to be in place to protect and promote health if you or your son were an NFL player.*

In every scenario, ask what system and rules you would wish to be in place to protect and promote health if you or your son were an NFL player.

^b Harvard Law School professor Lawrence Lessig among others has termed this kind of structural conflict to be a problem of “institutional corruption,” which he writes “is manifest when there is a systemic and strategic influence which is legal, or even currently ethical, that undermines the institution’s effectiveness by diverting it from its purpose or weakening its ability to achieve its purpose, including, to the extent relevant to its purpose, weakening either the public’s trust in that institution or the institution’s inherent trustworthiness.” Lawrence Lessig, “*Institutional Corruption Defined*,” 41 J. L. Med. & Ethics 553, 553 (2013).

Summary of Ethical Principles to Promote Player Health

1	Respect	The NFL is a business that relies on individuals who are exposed to health risks, but no stakeholder can treat players “merely as a means” or as a commodity solely for promotion of its own goals.
2	Health Primacy	Avoiding serious threats to player health should be given paramount importance in every dealing with every stakeholder, subject only to the player’s Empowered Autonomy.
3	Empowered Autonomy	Players are competent adults who should be empowered to assess which health risks they are willing to undertake, provided they have been given trustworthy, understandable information and decision-making tools, and the opportunity to pursue realistic alternatives.
4	Transparency	All parties should be transparent about their interests, goals, and potential conflicts as they relate to player health, and information relevant to player health must be shared with players immediately.
5	Managing Conflicts of Interest	All stakeholders should take steps to minimize conflicts of interest, and when they cannot be eliminated, to appropriately manage them.
6	Collaboration & Engagement	Protecting and promoting the health of professional football players depends on many parties who should strive to act together—and not as adversaries—whenever possible to advance that primary goal.
7	Justice	All stakeholders have an obligation to ensure that players are not bearing an inappropriate share of risks and burdens compared to benefits reaped by other stakeholders.

Endnotes

- 1 Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* 404 (7th ed. 2013).
- 2 *Id.* at 398 (7th ed. 2013).
- 3 The term “bioethics” has been defined in many different ways, but generally refers to a field of inquiry broader than medical ethics, which is specifically concerned with the relationships between patients and their healthcare providers, and focuses on the welfare of patients and medical professionalism. Bioethics, in contrast, refers to the normative analysis of ethical problems raised by advances in medicine and biology, and includes dilemmas ranging from the intimate doctor-patient relationship to those facing entire systems that influence health. For further discussion, see Daniel Callahan, *Bioethics and Policy—A History*, The Hastings Ctr., <http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2412> (last visited Aug. 7, 2015), archived at <http://perma.cc/4ZPL-Q4V5>. More simply, bioethics refers to the application of ethics—the philosophical discipline pertaining to notions of right and wrong—to the fields of medicine and healthcare. *What is Bioethics?*, Ctr. For Practical Bioethics, <http://www.practicalbioethics.org/what-is-bioethics> (last visited last visited Aug. 7, 2015), archived at <http://perma.cc/SQ3M-9UAS>.
- 4 For a good summary, see Renée C. Fox & Judith P. Swazey, *Observing Bioethics* 168–173 (2008).
- 5 For the most current version of this classic text, see Tom L. Beauchamp & James F. Childress, *Principles of Biomedical Ethics* (7th ed. 2013).
- 6 *Id.* at 101.
- 7 *Id.* at 150–153.
- 8 *Id.* at 152.
- 9 *Id.* at 250.
- 10 See, e.g., Jan Crosthwaite, *Gender and Bioethics*, in *A Companion to Bioethics* 36 (Helga Kuhse & Peter Singer eds., 2d ed. 2009).
- 11 Clinical and Translational Sci. Awards Consortium and Cmty. Engagement Key Function Comm. Task Force on the Principles of Cmty. Engagement, *Principles of Community Engagement* at 7–8 (2d ed. 2011), available at <http://www.atsdr.cdc.gov/communityengagement/>, archived at <http://perma.cc/245J-Q5FT>.
- 12 Presidential Comm’n for the Study of Bioethical Issues, *New Directions, The Ethics of Synthetic Biology and Emerging Technologies* 29 (2010).
- 13 See generally Elizabeth H. Gorman & Rebecca L. Sandefur, “*Golden Age, Quiescence, and Revival: How the Sociology of Professions Became the Study of Knowledge-Based Work*,” 38 *Work & Occupations* 275 (2011).
- 14 See, e.g., Daniela Testoni, Christoph P. Hornik, P. Brian Smith, Daniel K. Benjamin Jr. & Ross E. McKinney Jr., *Sports Medicine and Ethics*, 13:10 *Am. J. Bioethics* 4–12 (2013); W.R. Dunn, M. S. George, L. Churchill & K. P. Spindler, *Ethics in Sports Medicine*, 35:5 *Am. J. Sports Med.* 840–844 (2007); Nancy M.P. King & Richard Robeson, *Athletes Are Guinea Pigs*, 13:10 *Am. J. Bioethics* (2013); Brad Patridge, *Dazed and Confused: Sports Medicine, Conflicts of Interest, and Concussion Management*, 11 *J. Bioethical Inquiry*, 65–74 (2014); Ron Courson et al., *Inter-Association Consensus Statement on Best Practices for Sports Medicine Management for Secondary Schools and Colleges*, 49 *J. Athletic Training*, 128–137 (2014).
- 15 Universal Declaration on Bioethics and Human Rights, United Nations Educational, Scientific and Cultural Organization, http://portal.unesco.org/en/ev.php-URL_ID=31058&URL_DO=DO_TOPIC&URL_SECTION=201.html, archived at <http://perma.cc/T4BR-NTRG>.
- 16 See *id.*
- 17 *Id.*
- 18 See, e.g., George P. Smith II, *Human Rights and Bioethics: Formulating A Universal Right to Health, Health Care, or Health Protection?*, 38 *Vand. J. Transnat’l L.* 1295, 1313 (2005); Leslie A. Meltzer, *Book Review*, 359 *New Eng. J. Med.* 660, 660–61 (2008); Roger Brownsword, *Bioethics Today, Bioethics Tomorrow: Stem Cell Research and the “Dignitarian Alliance”*, 17 *Notre Dame J.L. Ethics & Pub. Pol’y* 15 (2003); Steven Pinker, *The Stupidity of Dignity: Conservative Bioethics’ Latest, Most Dangerous Ploy*, *New Republic* (2008).
- 19 United Nations Office of the High Commission, *Guiding Principles on Business and Human Rights*, A/HRC/17/31 (Jun. 16, 2011) available at http://www.ohchr.org/Documents/Publications/GuidingPrinciplesBusinessHR_EN.pdf?v=1392752313000/_jcr:system/jcr:versionstorage/12/52/13/125213a0-e4bc-4a15-bb96-9930bb8fb6a1/1.3/jcr:frozensnode, archived at <https://perma.cc/U36F-S7YR?type=pdf> [hereinafter, “Guiding Principles”].
- 20 *Id.* at 19.
- 21 *Id.* at 22.
- 22 Immanuel Kant, *Grounding for the Metaphysics of Morals* 429 (James W. Ellington trans., Hackett Publ’g Co. 3d ed. 1981) (1785).
- 23 *Poll: 49 Percent Are Pro Football Fans*, ESPN.com, Jan. 25, 2014, http://espn.go.com/nfl/story/_id/10350802/poll-indicates-49-percent-americans-pro-football-fans, archived at <http://perma.cc/AJC9-8FPB>.
- 24 See Norman Daniels, *Just Health: Meeting Health Needs Fairly* 29–78 (2008); Martha C. Nussbaum, *Frontiers of Justice: Disability, Nationality, Species Membership* 75–76 (2006).
- 25 Nat’l Football League, *2015 Player Health & Safety Report* 5 (2015), <http://static.nfl.com/static/content/public/photo/2015/08/05/0ap300000506671.pdf>, archived at <https://perma.cc/Y4BN-TUP7?type=pdf>.
- 26 For bioethics and normative ethics literature on the requirement that choice be both informed and authentic, see, e.g., Tom L. Beauchamp, *Paternalism*, in *Encyclopedia of Bioethics* 1914 (Warren Thomas Reich ed., 1995); Thaddeus Mason Pope, *The Maladaptation of Miranda to Advance Directives: A Critique of the Implementation of the Patient Self-Determination Act*, 9 *Health Matrix* 139, 189 (1999).

STAKEHOLDERS






Next, we provide an in-depth analysis of each stakeholder in NFL player health. We have organized the stakeholder discussions into parts that are indicative of their relationship to NFL players as well as other stakeholders, as follows:

- Part 1. Players.
- Part 2. The Medical Team: Club Doctors; Athletic Trainers; Second Opinion Doctors; Neutral Doctors; and, Personal Doctors.
- Part 3. The NFL; NFLPA; and, NFL Clubs.
- Part 4. Club Employees: Coaches; Club Employees; and, Equipment Managers.
- Part 5. Player Advisors: Contract Advisors; Financial Advisors; and, Family Members.
- Part 6. Other Stakeholders: Officials; Equipment Manufacturers; The Media; Fans; and, NFL Business Partners.




In addition, Part 7 examines the role of Other Interested Parties: The NCAA; Youth Leagues; Governments; Workers' Compensation Attorneys; and, Health-Related Companies.




Finally, it is important to recognize that while we have tried to make the chapters accessible for standalone reading, certain background or relevant information may be contained in other parts or chapters, specifically Part 1 discussing Players and Chapter 7 discussing the NFL and NFLPA. Thus, we encourage the reader to review other parts of this Report as needed for important context.

Stakeholders in NFL Player Health

 Club Doctors	 Athletic Trainers	 Second Opinion Doctors	 Neutral Doctors	 Personal Doctors
---	--	---	--	---

 NFL	 NFLPA	 NFL Clubs
--	--	--

 Coaches	 Club Employees	 Equipment Managers
--	---	---

 Contract Advisors (Agents)	 Financial Advisors	 Family
---	---	---

 Officials	 Equipment Mfrs.	 Media	 Fans	 NFL Business Partners
--	--	--	---	--

 NCAA	 Youth Leagues	 Government	 Workers' Comp. Attys	 Health-related Companies
---	---	---	---	---

