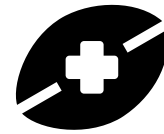


Chapter 2

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Club Doctors



Club doctors are clearly an important stakeholder in player health. They diagnose and treat players for a variety of ailments, while making recommendations to players concerning those ailments. At the same time, the doctor has obligations to the club, particularly to advise it about the health status of players. While players and clubs often share an interest in player health — both want players to be healthy so they can play at peak performance — as we discuss in this chapter there are several areas where their interests are in conflict. In these areas, the intersection of the club doctors' different obligations creates significant legal and ethical quandaries that may threaten player health. Most importantly, even if club doctors are providing the best care they can to the players, the current structure of their relationship with the club creates inherent problems in the treatment relationship. It is this structural problem about which we are most concerned, as discussed below.

Before we begin our analysis, it is important to point out that throughout this chapter we emphasize that the practice of club doctors is likely heterogeneous from club to club at least to some extent. For example, some clubs may be more actively engaged with club doctors, while others may be more hands-off. Nevertheless, we were denied the opportunity to interview club doctors as part of this Report to gain a better understanding of their work. In November 2014, we notified the NFL that we intended to seek interviews with club personnel, including general managers, coaches, doctors, and athletic trainers. The NFL subsequently advised us that it was “unable to consent to the interviews” on the grounds that “the information sought could directly impact several lawsuits currently pending against the league.” Without the consent of the NFL, we did not believe that the interviews would be successful and thus did not pursue the interviews at that time; instead, we have provided these stakeholders the opportunity to review draft chapters of the Report. We again requested to interview club personnel in July 2016 but the NFL did not respond to that request. The NFL was otherwise cooperative. It reviewed the Report and facilitated its review by club doctors and athletic trainers. The NFL also provided information relevant to this Report, including copies of the NFL’s Medical Sponsorship Policy (discussed in Chapter 2: Club Doctors) and other information about the relationships between clubs and doctors.

In April 2016, we engaged the NFL Physicians Society (NFLPS), the professional organization for club doctors, about reviewing relevant portions of a draft of this Report and related work. The NFLPS at that time questioned how many club doctors we had interviewed in developing the Report, apparently unaware of the NFL’s prior response to our planned interviews. We were surprised to find that the NFL had not previously discussed the matter with the NFLPS and immediately invited the NFLPS to have individual club doctors interviewed, an offer the NFLPS ultimately declined. Instead, it chose to proceed with reviewing our work and providing feedback in that manner.

Due to limitations on our access to club doctors we cannot generate club-by-club accounts of current practices. The result may mask a level of variation in current practice, a limitation we acknowledge.

(A) Background

When it comes to ensuring the health of NFL players, much of that responsibility falls on the doctors who provide them medical care. The 2011 collective bargaining agreement (CBA) recognizes this, including provisions that obligate NFL clubs to retain certain kinds of doctors. We summarize those provisions here:

- **Club Physicians:** Clubs must retain^a a board certified orthopedic surgeon and at least one physician board certified in internal medicine, family medicine, or emergency medicine. All physicians hired after execution of the 2011 CBA must also have a Certificate of Added Qualification in Sports Medicine. In addition, clubs are required to retain consultants in the neurological, cardiovascular, nutritional, and neuropsychological fields.¹
- **Physicians at Games:** “All home teams shall retain at least one [Rapid Sequence Intubation] RSI physician who is board certified in emergency medicine, anesthesia, pulmonary medicine, or thoracic surgery, and who has documented competence in RSI intubations in the past twelve months. This physician shall be the neutral physician dedicated to game-day medical intervention for on-field or locker room catastrophic emergencies.”²

As discussed in more detail in Chapter 7: The NFL and NFLPA, Section C: A History of the NFL’s and NFLPA’s Approaches to Player Health, the 2011 CBA added many new provisions concerning player health, including those above. However, also as detailed in that section, the changes to player health provisions in the CBA have largely been incremental, with most changes occurring as part of each CBA negotiation (others occur as part of side letter agreements between CBA negotiations). While these changes have gradually added more protections for player health, they may have also resulted in a fragmented system of care.

Of note, the above provisions added to the 2011 CBA do not require clubs to retain and have available neurological doctors at the games. The absence of this requirement is offset by the Concussion Protocol’s requirement that for every game each club be assigned an Unaffiliated Neurotrauma Consultant” to assist in the diagnosis of concussions (*see* Appendix A).

Most (if not all) of the doctors retained by NFL clubs are members of the NFLPS. Founded in 1966, the NFLPS’s stated mission “is to provide excellence in the medical and surgical care of the athletes in the National Football League

a The CBA does not define “retain” or otherwise dictate the requisite scope of involvement by the various doctors.

and to provide direction and support for the athletic trainers in charge of the care for these athletes.”³ Approximately 175 doctors work with the 32 NFL clubs,⁴ an average of 5.5 per club. The NFLPS holds annual meetings at the NFL Combine to discuss medical and scientific issues pertinent to its membership.⁵

According to NFLPS, 22 of the 32 club’s head orthopedists and 14 of the 32 club’s head “medicine” doctors are board certified in sports medicine.⁶ In addition, although the 2011 CBA requires club doctors to have a Certificate of Added Qualification in Sports Medicine, currently only 11 of the 32 head club doctors have such a certificate. The remaining club doctors were with clubs before the 2011 CBA and were grandfathered in under the new policy.

Of the 32 clubs, only two directly employ any of their club doctors while the other 30 teams enter into independent contractor arrangements with the doctors.⁷ The relevance of this distinction will be discussed in further detail below.

In most of the contracts, the club doctor reports to the club’s general manager, who would have the authority to terminate the doctor.⁸ The NFL does not have any policies

that pertain to supervisory control of medical personnel by coaches or club personnel.⁹ According to the NFL, there are no clubs in which the club doctor is supervised by the head coach.¹⁰ Without being able to independently verify the NFL’s claim, we nonetheless point out that there is no explicit prohibition against a coach having supervisory authority over a club doctor.

The quality of medical care provided by club doctors is obviously an important consideration in this work. For approximately the past 25 years, there has been a practice that has occasionally caused some to call into question the quality of healthcare being provided to players: the practice of doctors or healthcare organizations sponsoring NFL clubs or otherwise paying for the right to be the club’s healthcare provider(s). Such arrangements raise concerns that clubs are retaining the doctors who provide the clubs the most money as opposed to the doctors who are most qualified and likely to provide to highest level of care.

The NFL’s League Policy on Club Medical Services Agreements and Sponsorships (Medical Sponsorship Policy), discussed next, governs these types of arrangements and the relationship between NFL clubs and club doctors.

Figure 2-A: The Current Structure of Club Medical Staff



1) THE NFL'S MEDICAL SPONSORSHIP POLICY

The NFL first instituted the Medical Sponsorship Policy in 2004.¹¹ It prohibited clubs from entering into agreements “under which hospitals, medical facilities or physician groups were designated as club sponsors^b and obtained the right to provide various types of medical care to the club’s players and other employees.”¹² Although acknowledging that such arrangements had “economic” benefits to the clubs, NFL Commissioner Paul Tagliabue determined it was best to prohibit them in light of “questions raised by players and the NFLPA,” “criticism in both the lay and medical communities,” and reference to them by “plaintiffs’ attorneys in medical malpractice cases.”¹³ Additionally, Commissioner Tagliabue noted that such arrangements had resulted in an increase in players obtaining second opinions, “which, because they are paid for by the clubs, erodes the economic benefit to the sponsorship agreements.”¹⁴

Although the Medical Sponsorship Policy was not put into place until 2004, according to former Los Angeles Raiders Club doctor Rob Huizenga, doctors began paying \$1 million or more for the right to be a club’s doctor in the late 1980s.¹⁵ Huizenga noted that the doctors “could use their esteemed position as team doctor to get almost unlimited referrals[.]”¹⁶ Furthermore, according to former Seattle Seahawks Club doctor Pierce Scranton, when the Houston Oilers moved to Tennessee and were renamed the Titans in 1997, the Titans and Baptist Memorial Hospital entered into an agreement of unknown duration whereby the hospital paid the Titans a total of \$45 million for the right to be the official healthcare provider of the Titans.¹⁷ Scranton also suggested that the agreement caused the Titans to encourage players to have all of their surgeries performed at Baptist Memorial Hospital.^c Finally, a 2004 *New York Times* article claimed that approximately half of the teams in the Big Four sports leagues (NFL, MLB, NBA and NHL) had entered into medical sponsorship agreements, with some healthcare providers paying as much as \$1.5 million annually.¹⁸

The 2004 Medical Sponsorship Policy explicitly permitted clubs to continue to enter into sponsorship agreements with healthcare providers, provided the agreements did not involve the healthcare provider delivering medical services to the club.¹⁹ For example, a hospital could enter into an agreement with the club to advertise itself as the “Official Hospital of [club]” provided that very same agreement did

not also call for the hospital to provide medical services to the club. The hospital could have, however, entered into a *separate* agreement to provide medical services to the club wholly apart from the sponsorship agreement. Last, under the 2004 Medical Sponsorship Policy, clubs were required to submit a copy of any proposed sponsorship agreement with a healthcare provider to the NFL for approval before execution.²⁰

The Medical Sponsorship Policy was amended in 2012 in two principal ways: (1) clubs were prohibited from entering into medical services agreements whereby a particular healthcare provider became the *exclusive* provider of medical services to the club; and, (2) clubs were required to contract directly with the club’s internist, orthopedist, and head physician, *i.e.*, clubs were prohibited from entering into agreements with entities (*e.g.*, hospitals) for the provision of these medical services.²¹

According to the 2012 Medical Sponsorship Policy, the NFL undertook the amendments after reviewing “relevant policies promulgated by professional associations (*e.g.*, American Orthopaedic Society for Sports Medicine) or that exist in other professional sports, or that have been recommended by experts in medical ethics and conflict of interest.”²²

The Medical Sponsorship Policy was amended again in 2014.²³ The 2014 amendments included: (1) a prohibition on agreements whereby the club doctor reports to a medical services provider (MSP) (defined below) rather than the club; (2) a prohibition on agreements whereby an MSP reserves the right to select the doctors mandated by the CBA; and, (3) a requirement that each club have a senior executive annually execute a Certification of Compliance with the Medical Sponsorship Policy.²⁴

The 2014 Medical Sponsorship Policy also defined “Sponsorship Agreements” as “agreements with MSPs involving the sale or license by the club of commercial assets such as naming rights, stadium signage, advertising inventory within club-controlled media, promotional inventory (*e.g.*, day-of-game promotions), hospitality, and rights to use club trademarks for marketing and promotional purposes.” According to the Policy, MSPs include “hospitals, universities, medical practice groups, rehabilitation facilities, laboratories, imaging centers and other entities that provide medical care and related services.” Although doctors are not specifically included in the definition of MSPs, the NFL includes doctors as MSPs for purposes of the Policy.²⁵

^b The 2004 Medical Sponsorship Policy did not define “sponsors.”

^c Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL* 154 (2001) (“Does any Titans player wonder why he is so strongly encouraged to get his operation at Baptist?”).

At its core, the Medical Sponsorship Policy permits clubs to enter into a Sponsorship Agreement with an MSP, but prohibits such agreements that also include the provision of medical services. Stated another way, “[n]o Club may enter into a contract for the provision of medical services to its players that is interdependent with, or in any way tied to a Sponsorship Agreement with a [MSP].” The Medical Sponsorship Policy does not define “interdependent” and instead the NFL reviews the arrangements to ensure there is no interdependence.²⁶

The Policy also explicitly declares that clubs are permitted to enter into agreements with MSPs whereby the MSP obtains the right to advertise itself as an “official” or “proud” “sponsor,” “partner,” or “provider.”²⁷ A review of club websites and media guides shows that at least 25 clubs currently have some type of “official” healthcare sponsor or partner.

Additionally, based on our plain text reading of the Medical Sponsorship Policy, it does not prohibit MSPs from paying for the right to provide medical services to players and also does not limit an MSP’s ability to bargain for the right to provide healthcare to a club by offering discounted or free services. In reviewing a draft of this chapter, the NFLPS stated that no MSP currently pays for the right to provide medical services to players. Additionally, the NFL stated that the Medical Sponsorship Policy does prohibit MSPs from paying for the right to provide medical services and from offering discounted or free services. We disagree with the NFL’s reading. While the NFL may enforce the Medical Sponsorship Policy in such a way, we disagree that the plain text of the Policy prohibits such arrangements. In any event, it appears that the NFL agrees with us that the Policy *should* prohibit any club doctor from paying for the right to pay for the right to provide healthcare to players. If the Policy is intended to prohibit club doctors from paying for the right to provide medical services to players, the text of the Policy should be clarified.

Importantly, even in situations where an MSP enters into an agreement to provide medical services to a club but has not entered into a sponsorship agreement of any kind, the MSP can benefit from the association. The MSP could still identify itself as a healthcare provider for the club on its website and in advertisements, within the bounds of relevant intellectual property, professional advertising, and consumer protection laws and regulations. In other words, the MSP likely could not use the club’s logo without permission or try to make it appear that the club was actively endorsing the MSP’s services. In 2004, the marketing director of Methodist Hospital explained the value of the hospital’s association with the Houston Texans:

*We track phone calls coming in from new patients . . . The No. 1 driver of our calls is the association with our local teams. People say they heard that Methodist is where the players go, so it must be the best. It’s not a coincidence that we are the best, but there isn’t a better way to convince them. That’s a win-win situation.*²⁸

Finally, it is worth noting that institutional MSPs can be a party to the doctor’s contract with the club to the extent that such an arrangement is necessary for medical malpractice insurance or for practice privileges. In such situations, the contract must include a provision confirming the club’s right to retain the doctor regardless of that doctor’s relationship with the institution.

When asked for its position on medical sponsorship in the NFL, the NFLPA stated only that it “insisted upon changes that minimized conflicts of interest resulting in changes to the NFL’s Medical Sponsorship Policy in 2014/15.” The NFLPA declined to provide further detail on the negotiations or what specific changes it insisted upon, indicating that the discussions were confidential and that the Medical Sponsorship Policy is unilaterally promulgated by the NFL. The NFLPA indicated that its “sole objective” regarding the Medical Sponsorship Policy “is to reduce conflicts of interest and to ensure the best care possible for its members.” Nevertheless, the NFLPA did not indicate that it is opposed to medical sponsorship agreements. In addition, we recognize the medical sponsorship agreements provide clubs, and thus the players, with a lucrative source of revenue.

Below are examples of relationships between MSPs, including doctors, and clubs with a discussion of whether these relationships would be prohibited or permitted by the 2014 Medical Sponsorship Policy. However, it is important to keep in mind that the 2014 Medical Sponsorship Policy is complex and, at times, unclear. Additionally, the document is not collectively bargained and there is no generally available guidance. Thus, what follows is our best interpretation of the Policy as written.

In reviewing a draft of this Report, the NFL stated that it “disagree[d] entirely with the conclusions reached in Table 2-B,”²⁹ without explaining why it reads the plain text of the Policy so differently than we do. The fact that two sets of trained attorneys (those who authored this Report and those at the NFL) interpret the Policy differently demonstrates that it should be clarified. Ideally, the NFL will make the Policy public to allow for further discussion and review.

Table 2-A:
Arrangements Prohibited by Medical Sponsorship Policy

| Description | Explanation |
|---|--|
| Agreement with MSP to provide medical services to club on an exclusive basis. | Policy prohibits agreements with MSPs for the exclusive provision of medical services, thus enabling clubs and players to seek necessary medical care elsewhere. |
| Agreement allowing institutional MSP to select the doctors mandated by the CBA to provide care to the club's players. | Policy prohibits agreements that permit MSP to select CBA-mandated doctors; these doctors must be selected by the club. |
| Agreement with MSP to provide medical services to club on a non-exclusive basis alongside the right to post advertisements in the club's stadium using club trademarks. | Each of these agreements would be permitted on its own, but not jointly; Policy prohibits medical services agreements that are interdependent with Sponsorship Agreements with MSPs. |
| Agreement with MSP to provide medical services to club on a non-exclusive basis alongside naming rights to the club's practice facility. | Each of these agreements would be permitted on its own, but not jointly; Policy prohibits medical services agreements that are interdependent with Sponsorship Agreements with MSPs. |
| Agreement with doctor to provide medical services to club on a non-exclusive basis alongside agreement for his or her institutional MSP to post advertisements in the club's stadium using club trademarks. | Each of these agreements would be permitted on its own, but not jointly; Policy prohibits medical services agreements that are interdependent with Sponsorship Agreements with MSPs. |
| Agreement with doctor to provide medical services to club on a non-exclusive basis but doctor reports to institutional MSP concerning care provided to players. | Policy requires doctors to report directly to the club. |

As these charts demonstrate, while the NFL has made progress in regulating the payment to and from club doctors for sponsorship, on a plain reading of the Policy, there are still a number of ethically fraught arrangements the current Policy appears to leave in place.^d

Despite its gaps, the NFL's Medical Sponsorship Policy appears to be the most robust and protective of player health in professional sports. Major League Baseball's (MLB) medical sponsorship policy prohibits sponsorship arrangements between clubs and medical providers that included "the right of the [sponsor] to be the medical service provider for the Club's players and employees." Nevertheless, MLB has approved sponsorship arrangements with medical providers where "the Club has had a pre-existing relationship with the hospital or doctors prior to the sponsorship, and the terms of the health care agreement were unaffected by the sponsorship."³⁰ The National Basketball Association (NBA) only prohibits sponsorship

arrangements where the selection of healthcare providers is "based primarily on a sponsorship relationship."³¹ Thus, the NBA does not prohibit agreements whereby a healthcare provider pays for the right to be the club doctor and to be a sponsor of the club, provided the sponsorship is not the primary reason for the relationship. The National Hockey League and Major League Soccer refused to provide information to us concerning a possible medical sponsorship policy.

How the leagues compare on this and other important player health issues is the subject of our forthcoming Report, *Comparing the Health-Related Policies and Practices of the NFL to Other Professional Sports Leagues*.

^d In reviewing this Report, the National Athletic Trainers Association stated that "[p]hysician practices paying clubs to serve as team physicians may result in significant conflicts of interest (COI) in the care of the NFL athlete. Health care should be based on best practices."

Table 2-B:
Arrangements Permitted by Medical Sponsorship Policy

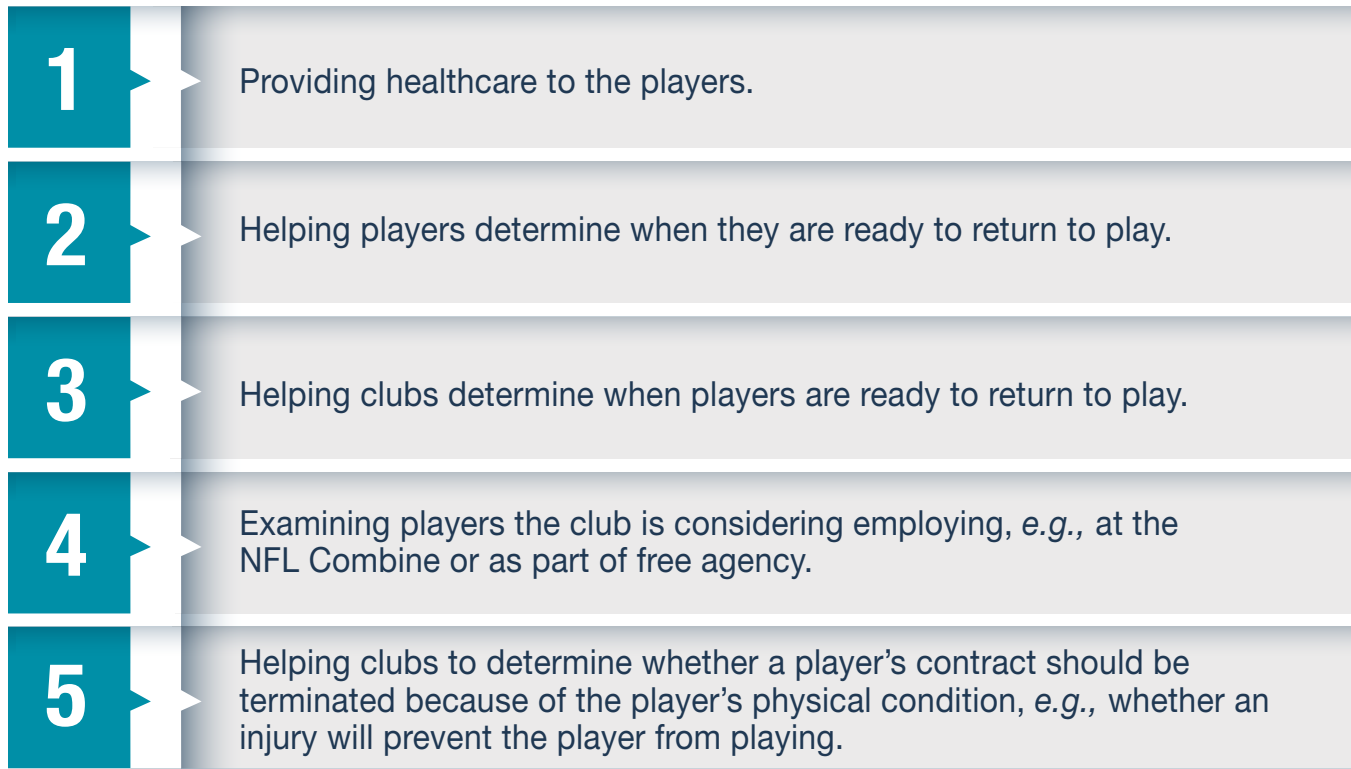
| Description | Explanation | Potential Concerns with Practices Still Permitted |
|--|---|---|
| Agreement with MSP to pay the club to provide medical services to club on a non-exclusive basis. | Policy does not prohibit MSPs from paying for the right to provide medical services. | Club might choose MSP that is willing to pay the most rather than the best MSP. |
| Agreement with MSP to provide medical services to club on a non-exclusive basis, whereby MSP has agreed to no compensation or compensation at rates below the MSP's standard rate and market rates. | Policy does not prohibit MSPs from discounting the costs of their services for the right to provide medical services. | Club might choose MSP willing to charge lowest rates rather than the best MSP. |
| Agreement with MSP to provide medical services to club on a non-exclusive basis and MSP has the right to call itself the "official" doctor or healthcare provider of the club. | Policy expressly permits agreements that permit MSPs to call themselves the "official" doctor or healthcare provider. | MSP will attach monetary value to "official designation," and alter payment structure as a result, leading to clubs choosing MSPs based on reduced rates rather than skills. |
| Agreement with MSP to provide medical services to club on a non-exclusive basis and a separate agreement to post advertisements in the club's stadium using club trademarks. | Policy permits MSPs and clubs to enter into medical services and Sponsorship Agreements so long as they are not "interdependent." | Whether the two agreements are "interdependent" is difficult to enforce. Implied agreements and long-standing practices could result in clubs choosing MSPs based on Sponsorship Agreements rather than skills. |
| Agreement with MSP to pay the club for the right to call itself the "official" healthcare provider of the club and to post advertisements in the club's stadium using club trademarks but does not actually provide any medical services to the club. ^e | Policy expressly permits Sponsorship Agreements with MSPs "so long as these agreements do not involve the provision of medical service to players." | Does not directly affect player health but raises concerns about whether the general public will falsely rely on the MSP's declaration that it is the "official" healthcare provider. |

(B) Introduction to Current Legal Obligations and Ethical Codes

At the outset it is important to restate and clarify the obvious. Club doctors provide care to players while also having some type of contractual or employment relationship with, and thus obligations to, the club. Indeed, club doctors' principal responsibilities are: (1) providing healthcare to the players; (2) helping players determine when they are ready

to return to play; (3) helping clubs determine when players are ready to return to play; (4) examining players the club is considering employing, *e.g.*, at the NFL Combine or as part of free agency; and, (5) helping clubs to determine whether a player's contract should be terminated because of the player's physical condition, *e.g.*, whether an injury will prevent the player from playing.³²

^e While some might find this practice to be misleading, raising other potential legal issues, those issues are not pertinent to player health and thus we do not address them here.

Figure 2-B: The Current Responsibilities of Club Doctors

The first two responsibilities we will refer to as “Services to Player” and the last three responsibilities we will refer to as “Services to Club.” The Services to Player scenario is one in which the club doctor is treating and advising the player, including taking into consideration the player’s athletic goals, whereas the Services to Club scenario is one in which the doctor is exclusively advising the club. As will be discussed in detail below, in theory, club doctors’ legal and ethical obligations vary depending on the two situations. Nevertheless, the club doctor’s two roles are not separated in practice, potentially resulting in tension in the player healthcare system. On the one hand, club doctors engage in a doctor-patient relationship with the player, providing the player care and advice that is in the player’s best interests. On the other hand, clubs engage doctors because medical information about and assessment of players is necessary to clubs’ decisions related to a player’s ability to perform at a sufficiently high level in the short- and long-term. These dual roles for club doctors may sometimes conflict because players and clubs often have conflicting interests, but club doctors are called to serve two parties.

Although it is common to use the word “patient” to describe the player in both of these situations, there are important differences between the Services to Player versus Services to Club setting. The essence of the doctor-patient relationship is the undertaking by a physician to diagnose

and/or treat the person being diagnosed or treated with reasonable professional skill.³³ Thus, the doctor-patient relationship is established when the physician undertakes to diagnose, treat, or advise the patient as to a course of treatment.³⁴ Generally, this is established by mutual consent and can be based on an express or implied contract.³⁵ However, in the Services to Club situation, there is a limited doctor-patient relationship (or none at all), which will explain the different legal and ethical obligations.

In reviewing a draft of this Report, the NFL repeatedly analogized the NFL player healthcare model to other industries where employers provide healthcare for their employees. Indeed, doctors provide care to employees in a variety of occupational settings, such as in the military, law enforcement, and factories and other industrial settings.³⁶ However, the fact that these doctors, like NFL club doctors, may be placed in a position of structural conflict, whereby the doctor can be conflicted between doing what is best for the employee and what is best for the employer, is not helpful. While our review of the legal and ethical literature on occupational medicine did not reveal a one size fits all resolution to this problem,³⁷ our recommendations in this chapter focus on the conflict of interest embedded in the NFL healthcare structure. The fact that these structural conflicts exist elsewhere is not a defense to a problematic structure in the NFL.

Below, we discuss the sources of current legal obligations and current ethical codes and then apply those obligations and codes to both the Services to Player and Services to Club settings. Finally, we conclude this section by discussing some additional ethical considerations.

1) SOURCES OF CURRENT LEGAL OBLIGATIONS^f

Club doctors' legal obligations derive from three sources: (1) common law; (2) statutes and regulations; and, (3) contracts.

Common law^g and statutory obligations are generally determined by state courts (through case law) and legislatures, respectively. Each state generally has a statute setting forth the minimum requirements and qualifications to be a licensed doctor.³⁸ In addition, the states generally have statutes setting forth both generalized and, at times, more specific, treatment prohibitions and obligations.³⁹ The state statutes then empower a board or office to implement and enforce the statutes,⁴⁰ such as New York's Office of Professional Medical Conduct and The Medical Board of California. These medical boards consist largely of healthcare professionals and, for this reason, the medical field is generally considered to be self-regulated.⁴¹ The medical boards have the authority to investigate professional misconduct by physicians and to issue appropriate discipline, which is subject to review by the courts.⁴² In determining whether professional misconduct occurred, the medical boards often consult relevant statutes and regulations, as well as codes of medical ethics.

Club doctors' contractual obligations consist of two types: (1) those obligations mandated by the CBA; and, (2) those obligations mandated by the doctor's professional agreement with the club. Doctors' contractual agreements are private and not readily available; thus this chapter focuses primarily on the CBA-mandated obligations. Section D: Current Practices provides more information on the types of contractual arrangements clubs have with their doctors.

2) SOURCES OF CURRENT ETHICAL CODES

There are a wide variety of ethical codes relevant to club doctors, the most prominent of which is the American Medical Association (AMA) Code of Medical Ethics (AMA Code).⁴³ The AMA is a voluntary organization for doctors

with a mission "[t]o promote the art and science of medicine and the betterment of public health."⁴⁴ As a voluntary organization not all doctors are members of the AMA but the AMA Code nonetheless is still very influential.^h The legal significance of the AMA Code is discussed in Section G: Enforcement.

In addition, NFL clubs retain in some form a wide range of doctors, including but not limited to orthopedists, internists, family medicine specialists, emergency medicine specialists, neurologists, neurosurgeons, cardiologists, and psychologists.⁴⁵ Each of these specialties generally has its own professional societies and organizations that might also have ethical codes or practice guidelines relevant to the specialty and thus also to NFL players. In particular, in 2013, the American Academy of Neurology issued guidelines for the evaluation and management of concussions in sports.⁴⁶ Similarly, there are also codes of ethics specific to doctors working in occupational settings. For example, the American College of Occupational and Environmental Medicine (ACOEM) has a Code of Ethics⁴⁷ as does the International Commission on Occupational Health.⁴⁸ These documents provide important direction on appropriate and best practices. Despite this diversity, nearly all doctors are subject to the AMA Code or a variation thereof. Thus, we only discuss those societies' ethical regulations that exceed or otherwise supplement the requirements of the AMA Code.ⁱ

Finally, doctors working in the sports medicine field have codified their own ethics rules. The leading international sports medicine organization is the Fédération Internationale de Médecine du Sport (FIMS), founded in 1928 in conjunction with the growth of the modern Olympic Games.⁴⁹ FIMS is an international organization comprised of national sports medicine associations across five continents that seeks to maximize athlete health and performance.⁵⁰ The American College of Sports Medicine is the American member of FIMS.⁵¹ FIMS publishes a five-page Code of Ethics that is sports-specific and thus is relevant to this Report in its entirety.⁵² Similar principles are espoused

h The AMA Code was most recently amended in June 2016 and was still in the process of being edited as of the date of publication. Nevertheless, no substantive changes are expected and we believed it was important to use the most recent version of the AMA Code.

i The other professional organizations whose codes of ethics we examined are the American College of Sports Medicine, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Association of Orthopaedic Surgeons, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, American Academy of Physical Medicine and Rehabilitation, American Osteopathic Society, American College of Physicians, American Board of Internal Medicine, American College of Physicians, American Society of Internal Medicine, American College of Emergency Physicians, American Academy of Emergency Medicine, American Association of Neurological Surgeons, American College of Cardiology, American College of Radiology, Radiological Society of North America, Academy for Sports Dentistry, American Dental Association, American Society of Anesthesiologists, National Association of Emergency Medical Technicians, and National Association of EMS Physicians.

f The legal obligations described herein are not an exhaustive list but are those we believe are most relevant to player health.

g Common law refers to "[t]he body of law derived from judicial decisions, rather than from statutes or constitutions." Black's Law Dictionary (9th ed. 2009).

in the *Team Physician Consensus Statement* published collectively by the American College of Sports Medicine, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.⁵³

The NFLPS confirmed during its review of a draft of this chapter that it does not have a Code of Ethics.^j

It is important to point out that, at times, some of the existing ethical codes relevant to club doctors contain statements that appear internally inconsistent, in conflict with relevant laws, or incongruent with modern practices and realities. In particular, the codes are sometimes unclear about whether a player's long-term health should always be the absolute priority, as well as how player medical information should be handled. These issues will be pointed out along the way, but they do not necessarily demand criticism or revision in every instance. Indeed, legitimate and important ethical principles often come into conflict with one another as applied to particular scenarios, and the work is in determining the appropriate balance when principles must be applied to the facts at hand. The principles governing this Report are a perfect example, as the principle of Health Primacy may sometimes conflict with the principle of Empowered Autonomy, but both principles are essential to ethical analysis. Ultimately, the ethical codes applicable to club doctors should be as consistent and realistic as possible, avoid ambiguity where feasible, and be more than merely aspirational. Achieving that standard, of course, does not mean they will never contain any internal conflicts, but such conflicts should be minimized and where they persist they should be purposive.

(C) Current Legal Obligations and Ethical Codes When Providing Services to Player

As discussed above, club doctors' legal and ethical obligations generally differ depending on whether they are providing services to the player or to the club. Below, we discuss the Services to Player scenario, and later we discuss the realities of this distinction between possible roles. In the following sections, we will discuss a club doctor's obligations concerning (1) medical care, (2) disclosure and autonomy, (3) confidentiality, and (4) conflicts of interest when the club doctor is providing Services to Player.

^j By contrast, the Professional Football Athletic Trainers Society (PFATS), the professional organization for NFL club athletic trainers, does have a Code of Ethics.

1) MEDICAL CARE

a) Current Legal Obligations

The topic of the legal liability and obligations of doctors is vast and would require book length treatment in its own right to be exhaustive. In what follows we highlight the main elements of this regulatory and liability structure.

Under common law, doctors have an obligation to provide medical care within an acceptable standard of care in the medical community or be subject to a medical malpractice claim.⁵⁴ Generally, the elements of a medical malpractice claim are: (1) a duty owed by the doctor to the plaintiff to abide by the prevailing standard of care; (2) a breach of that standard of care by the doctor; and, (3) the breach was the proximate cause of the plaintiff's injury.⁵⁵ The first element, the duty to provide care, is generally established by a physician-patient relationship but such a relationship is not necessarily a requirement for a medical malpractice action, as will be discussed in more detail below.⁵⁶

Many states require a doctor with the same board certification or similar expertise as the doctor against whom the claim is brought to opine as to the appropriate standard of care.⁵⁷ Thus, in the event a club doctor were sued for medical malpractice, the claim likely could not proceed without a similarly qualified doctor—whether it be an orthopedist, neurologist or a doctor specializing in sports medicine—opining that the club doctor deviated from the applicable standard of care in the particular treatment provided (or not provided). Appendix H includes summaries of all of the medical malpractice cases against club doctors revealed by our research.

By virtue of the self-regulatory system, doctors' statutory obligations concerning medical care are effectively the same as their common law obligations: not to commit professional misconduct as judged by the state medical board.

The CBA also speaks to its conception of the club doctor's standard of care:

[E]ach Club physician's primary duty *in providing medical care* shall be not to the Club but instead to the player-patient. This duty shall include traditional physician/patient confidentiality requirements. In addition, all Club physicians and medical personnel shall comply with all federal, state, and local requirements, including all ethical rules and standards established by any applicable government and/or other authority that regulates or governs the medical profession in the Club's city.⁵⁸ (Emphasis added.)

This CBA provision is susceptible to multiple interpretations. On a generous reading (*i.e.*, one that does not give the italicized language any special emphasis), club doctors' primary duty is to the player at all times. On a less generous reading, the CBA provision demands a primary duty to the player-patient *only* in situations where the club doctor is "providing medical care," and thus is inapplicable when the club doctor is rendering services to the club. Importantly, however, the way club doctors are currently situated within the club precludes the two roles from being truly separated, and thereby precludes club doctors from having their exclusive duty be to the players. This is because at the same time that the club doctor is providing care to the player, he is simultaneously performing duties for the club by judging the player's ability to play and help the club win.

Thus, the club doctor is required by the CBA to provide medical care that puts the player-patient's interests above the club's (in the event these interests conflict), which is as it should be. However, in most instances, and as seemingly recognized by the CBA, it is impossible under the current structure for the club doctor to *always* have a primary duty to the player-patient over the club, because sometimes the club doctor is not providing care, but rather is advising the club on business decisions, *i.e.*, fitness-for-play determinations. In other words, the club doctor cannot always hold the player's interests as paramount and at the same time abide by his or her obligations to the club. Indeed, a club doctor could provide impeccable player-driven medical care (treating the player-patient as primary in accord with the CBA), while simultaneously hurting a player's interests by advising the Club that the player's injury will negatively impact his ability to help the Club. Thus, under any reading of the CBA provision, players lack a doctor who is concerned with their best interests at all times.

Relatedly, the CBA provision also seems to require that the care relationship between players and club doctors be afforded "traditional" confidentiality protections. However, clubs request or require players to execute collectively bargained waivers, effectively waiving this requirement, and players we interviewed indicated that no player refuses to sign the waiver.^k A copy of this waiver is included as Appendix L. The circumstances under which these waivers are executed is an area worthy of additional attention. For example, questions might be raised as to

whether the players are providing meaningful and voluntary informed consent in their execution. Players are being compelled to waive certain legal rights concerning their health without meaningful options. There is no doubt that players execute the waivers because they fear that if they do not, they will lose their job. Indeed, the waivers (which are collectively bargained between the NFL and NFLPA)⁵⁹ permit the athletic trainer and club doctors to disclose the player's medical information to club employees, such as coaches and the general manager. Thus, it is unclear what work this CBA language is doing. Of course, given this communication, it is inevitable that players will be less than forthcoming about their medical needs, lest it negatively affect their career prospects.

The club doctor cannot always hold the player's interests as paramount and at the same time abide by his or her obligations to the club.

In reviewing a draft of this Report, the NFL rejected our claim that the CBA provision "requires the traditional patient-physician confidentiality requirements of a private system,"⁶⁰ even though the provision in question specifically says club doctors have a duty to provide "traditional physician/patient confidentiality requirements." The CBA provision does not qualify the club doctor's duty in the context of the employer-employee relationship. The NFL should abide by its obligations under the CBA.

The American Psychological Association's Specialty Guidelines for Forensic Psychology provide a useful analogy. These guidelines acknowledge that a situation in which a psychologist is providing both treatment and evaluative services "may impair objectivity and/or cause exploitation or other harm." Consequently, the psychologists in such a situation "are encouraged to disclose the potential risk and make reasonable efforts to refer the request to another qualified provider."⁶¹

Finally, the NHL CBA contains a standard of care provision similar, but potentially superior, to the NFL's:

^k Current Player 5: "[O]ur first day back in camp, we sign a ton of stuff. I believe one of them is medical release form that allows our team doctors to discuss medical conditions with team officials . . . I've seen some guys question some of the documents we have to sign but when you're given a stack of papers and it's you sign this and you play football or you don't sign it and you don't, everybody signs it. I don't know anybody who hasn't."

The primary professional duty of all individual health care professionals, such as team physicians, certified athletic trainers/therapists (“ATs”), physical therapists, chiropractors, dentists and neuropsychologists, shall be to the Player-patient *regardless of the fact* that he/she or his/her hospital, clinic, or medical group is retained by such Club to diagnose and treat Players. In addition, all team physicians who are examining and evaluating a Player pursuant to the Pre-Participation Medical Evaluation (either pre-season and/or in-season), the annual exit examination, or who are making a determination regarding a Player’s fitness or unfitness to play during the season or otherwise, shall be obligated to perform complete and objective examinations and evaluations and shall do so on behalf of the Club, subject to all professional and legal obligations vis-a-vis the Player-patient.⁶² (Emphasis added.)

While the NFL’s standard of care fails to account for the club doctor’s obligations to the club—namely to perform fitness-for-play evaluations—the NHL’s provision seemingly resolves this concern in part, by requiring without limitation to the circumstances of providing medical care that the club doctor be subject to his or her obligations to the player “regardless of the fact that he/she . . . is retained by such Club[.]” Nevertheless, we have concerns about this approach, for reasons discussed in detail in Section H: Recommendations Concerning Club Doctors.

Finally, it is important to clarify how it is that the NFL CBA’s standard of care provision might impose legal obligations on the club doctor. For reasons discussed in Section G: Enforcement of Legal and Ethical Obligations, players would have difficulty enforcing this provision against club doctors directly. Club doctors are not a party to the CBA and thus this provision generally cannot be enforced against them. Instead, clubs, as signatories to the CBA, are the party against whom CBA violations can be enforced. Nevertheless, club doctors are effectively bound by the CBA provision. The NFL and NFLPA, through the CBA, have legislated the required standard of care for club doctors. If a club doctor violated this standard of care, the NFLPA could challenge the club doctor’s ability to remain in the position via certain CBA procedures discussed in Section G. In addition, it is possible that the club doctor’s agreement with the club obligates the doctor to comply with all NFL policies and procedures, including the CBA. Thus, if a club doctor did not follow the CBA, he or she might be in violation of his or her agreement with the club.

b) Current Ethical Codes

The AMA Code’s first principle is that “[a] physician shall be dedicated to providing competent medical care, with compassion and respect for human dignity and rights.”⁶³ Similarly, the AMA Code’s eighth principle declares that “physicians shall, while caring for a patient, regard responsibility to that patient as paramount.”⁶⁴ Note that this mirrors the CBA language described above, but in the context of the AMA Code, it is important to recognize that many doctors do not have such stark dual obligations as club doctors. Additionally, Opinion 1.1.6–Quality, prescribes that “physicians individually and collectively share the obligation to ensure that the care patients receive is safe, effective, patient centered, timely, efficient and equitable.” This obligation requires doctors, among other things, with:

- (a) Keeping current with best care practices and maintaining professional competence.
- (b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.
- (c) Monitoring the quality of care they deliver as individual practitioners—*e.g.*, through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.
- (d) Demonstrating a commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.
- (e) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.⁶⁵

Moreover, Opinion 1.1.1–Patient-Physician Relationship, dictates:

The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above the physician’s own self-interest and above obligations to others, to [use] sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.⁶⁶

FIMS’ Code of Ethics reiterates these concepts:

The same ethical principles that apply to the practice of medicine shall apply to sports medicine.⁶⁷

Always make the health of the athlete a priority.⁶⁸

Never do harm.⁶⁹

The basis of the relationship between the physician and the athlete should be that of absolute confidence and mutual respect. The athlete can expect a physician to exercise professional skill at all times. Advice given and action taken should always be in the athlete's best interest.⁷⁰

2) DISCLOSURE AND AUTONOMY

a) Current Legal Obligations

There is broad support for a patient's right to autonomy, the right to make his or her own choices concerning health and healthcare.⁷¹ The concept is particularly important in the context of NFL player health, where treatment also includes helping players make a determination about when and whether to return to play. All patients have certain rights commensurate with their autonomy, including the rights to refuse care and to go against a doctor's recommendations. However, in this section we focus on a doctor's obligations concerning patient autonomy. With that in mind, implicit in a patient's right to make his or her own decisions is the obligation of the doctor to disclose certain relevant medical information. Our list of governing principles for this Report recognizes this by pressing for not just autonomy but also *Empowered Autonomy*.

When discussed in the legal context, these issues of disclosure and autonomy are generally framed as a patient's right to informed consent. Where a doctor fails to obtain a patient's informed consent before proceeding with a medical treatment or procedure, he is potentially subject to liability. There are two common law standards for establishing informed consent in medical cases: a professional/physician-based disclosure standard; and a patient-based standard. State courts are basically evenly split as to which standard to apply.⁷²

The physician-based standard measures the physician's duty to disclose against what the reasonable medical practitioner similarly situated would disclose.⁷³ Jurisdictions that follow this standard ordinarily require the plaintiff to offer medical testimony to establish: (1) that a reasonable medical practitioner in the same or similar community would make the disclosure in question; and, (2) that the defendant did not comply with this community standard.⁷⁴

The patient-based standard, in contrast, measures the physician's duty to disclose against what a reasonable patient would find material. Information is material when "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to it."⁷⁵ The question of whether a physician disclosed risks that a reasonable person would find material

is for the trier of fact, *e.g.*, a jury, and technical expertise is not required.⁷⁶

More than half of the states have enacted legislation dealing with informed consent, largely in response to various "malpractice crises."⁷⁷ In many states, a consent form or other written documentation of the patient's verbal consent is sufficient to establish that the patient consented to the treatment at issue.⁷⁸

Finally, as will be addressed further in our recommendations, the CBA also imposes disclosure requirements on club doctors:

All Club physicians are required to disclose to a player any and all information about the player's physical condition that the physician may from time to time provide to a coach or other Club representative, whether or not such information affects the player's performance or health. If a Club physician advises a coach or other Club representative of a player's serious injury or career threatening physical condition which significantly affects the player's performance or health, the physician will also advise the player in writing. The player, after being advised of such serious injury or career-threatening physical condition, may request a copy of the Club physician's record from the examination in which such physical condition was diagnosed and/or a written explanation from the Club physician of the physical condition.⁷⁹

Additionally, club doctors are obligated to permit a player to examine his medical records once during the preseason and once after the regular season.¹ Club doctors are also obligated to provide a copy of a player's medical records to the player upon request in the offseason.⁸⁰

b) Current Ethical Codes

The relevant provision of the AMA Code, Opinion 8.6—Promoting Patient Safety, describes a doctor's obligations to disclose medical information to patients:

Patients have a right to know their past and present medical status, including conditions that may have resulted from medical error. Open communication is fundamental to the trust that

¹ In 2014, the NFL instituted an electronic medical record (EMR) system, consisting of all of the athletic trainers' and doctors' diagnosis and treatment notations, including any sideline examinations performed on the player. The EMR system also includes a player portal that permits the player to access his medical records at any time, including after his career is over. This information was provided by the NFLPA. Thus, the CBA provision requiring that club doctors permit players to examine their medical records once during the preseason and then once after the regular season has become anachronistic.

underlies the patient-physician relationship, and physicians have an obligation to deal honestly with patients at all times, in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician's honesty with the patient.⁸¹

Similarly, FIMS' Code of Ethics directs that “[t]he sports medicine physician will inform the athlete about the treatment, the use of medication and the possible consequences in an understandable way and proceed to request his or her permission for the treatment.”⁸²

FIMS' Code of Ethics also places a great deal of emphasis on autonomy:

A basic ethical principle in health care is that of respect for autonomy. An essential component of autonomy is knowledge. Failure to obtain informed consent is to undermine the athlete's autonomy. Similarly, failure to give them necessary information violates the right of the athlete to make autonomous choices. Truthfulness is important in health care ethics. The overriding ethical concern is to provide information to the best of one's ability that is necessary for the patient to decide and act autonomously.⁸³

* * *

Never impose your authority in a way that impinges on the individual right of the athlete to make his/her own decisions.⁸⁴

Finally, the ACOEM Code of Ethics calls autonomy a “fundamental bioethical value,” and declares that “this value respects the idea that the individual best understands his or her own best interests.”⁸⁵

3) CONFIDENTIALITY

a) Current Legal Obligations

The flip-side of disclosure by doctors is disclosure by patients, which is of course also key to the treatment relationship. Doctors have both common law and statutory obligations to keep patient information confidential.⁸⁶ “Most states provide a private common law cause of action against licensed health care providers who impermissibly disclose confidential information obtained in the course of the treatment relationship to third parties.”⁸⁷ “Depending on the jurisdiction, the claim may be phrased as a breach of contract, as an act of malpractice, as a breach of fiduciary duty, [or] as an act of fraud/misrepresentation[.]”⁸⁸

Below we discuss statutory requirements concerning the confidentiality of medical information. As will be explained in more detail below, current practices concerning the confidentiality of player medical information do not appear to violate relevant laws because of waivers executed by the players, and potentially applicable exceptions to the laws. As stated above, clubs request or require players to execute waivers permitting the player's medical information to be disclosed to and used by a wide variety of parties, including but not limited to the NFL, any NFL club, and any club's medical staff and personnel, such as coaches and the general manager. These waivers have been collectively bargained between the NFL and NFLPA.⁸⁹ Players sign these waivers without much (if any) hesitation out of fear that behaving otherwise could cost them their job.^m Thus, one key aspect of patient confidentiality is rendered moot, at least with regard to club employees, although information must still be protected as against other third parties.

From a statutory perspective, the federal Health Insurance Portability and Accountability Act (HIPAA) likely governs club doctors' requirements concerning the confidentiality of player medical information.⁹⁰ HIPAA requires healthcare providers covered by the law to obtain a patient's authorization before disclosing health information protected by the law.⁹¹ The waivers executed by players provide the authorization required by HIPAA.

Even without the authorizations, NFL club doctors are likely permitted by HIPAA to provide health information about players to the clubs. Covered entities under HIPAA include: “(1) A health plan[;] (2) A health care clearinghouse[; and,] (3) A health care provider who transmits any health information in electronic form.”⁹²

Club doctors meet the third criteria to be considered a covered entity under HIPAA.ⁿ A “[h]ealth care provider” is defined by HIPAA as anyone who “furnishes . . . health care in the normal course of business.”⁹³ And “health care means care, services, or supplies related to the health of an individual” including “[p]reventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an

m A copy of this waiver is included as Appendix L. The circumstances under which these waivers are executed is an area worthy of additional attention. For example, questions might be raised as to whether the players are providing meaningful informed consent in their execution.

n On a related point, it is not clear whether clubs would be considered covered entities under HIPAA. The application of HIPAA in this context turns on complicated questions of who is creating and receiving personal health information and the various relationships between employees and contractors of the clubs. See Memorandum Opinion and Order, In re: Nat'l Hockey League Players' Concussion Injury Litigation, 14-md-2551 (D. Minn. July 31, 2015), ECF No. 196 (discussing, but not resolving, whether NHL clubs were covered entities under HIPAA).

individual or that affects the structure or function of the body.”⁹⁴ Club doctors provide healthcare within the meaning of HIPAA and thus must comply with its requirements.

However, HIPAA permits healthcare providers to provide health information about an employee to an employer without the employee’s authorization when: (1) the healthcare provider provides healthcare to the individual at the request of the employer; (2) the health information that is disclosed consists of findings concerning a work-related illness or injury; (3) the employer needs the health information to keep records on employee injuries in compliance with state or federal law; and, (4) the healthcare provider provides written notice to the individual that his or her health information will be disclosed to the employer.⁹⁵

According to the above criteria, NFL club doctors might be permitted to provide health information about players to the clubs where: (1) club doctors provide healthcare to players at the request of the employer; (2) almost every time club doctors disclose medical information to the club it is related to the player’s job as an NFL player; and, (3) NFL clubs are required by law to keep records of employee injuries. For example, the Occupational Safety and Health Act requires employers with more than 10 employees to maintain records of work-related injuries and illnesses.⁹⁶ As for the fourth prong, our discussions with players make it seem unlikely that athletic trainers are providing written notice to players that their health information is being disclosed to the club at the time of injury, but it is possible that documents provided to the players before the season provide such notice.

It should also be noted that HIPAA permits an employee’s health information to be disclosed to the extent necessary to comply with state workers’ compensation laws.⁹⁷ Moreover, while a violation of HIPAA’s Privacy Rule subjects the doctor to significant civil penalties and/or criminal liability, there is no private cause of action or remedy for the patient.⁹⁸

In addition to the federal HIPAA, some states have passed laws restricting the disclosure of medical information by healthcare providers.⁹⁹ However, the nature and scope of these laws vary considerably in terms of restriction, disclosure exceptions, and the type of healthcare practitioners governed by the law.¹⁰⁰

Furthermore, despite these common law and statutory obligations, 22 states in which NFL clubs play or practice have statutes that permit healthcare providers to provide employers with an employee’s medical records and/or

information.^{101,o} The reasons that disclosure is permitted are generally related to potential or actual workers’ compensation claims and procuring payment. However, the state laws vary as to whether a healthcare provider is permitted to disclose medical information only where a workers’ compensation claim is possible as opposed to already filed. Some states only permit disclosure after a claim has been filed.

Finally, the 2011 CBA requires the application of, but does not amend or supplement, the common law and statutory confidentiality obligations discussed above: “each Club physician’s primary duty in providing player medical care shall be not to the Club but instead to the player-patient. This duty shall include traditional physician/patient confidentiality requirements.”¹⁰²

The bottom line is that by and large it seems club doctors are legally permitted to share player-patient medical information with the players’ employers, the clubs, due to waivers or by statute.

22 states in which NFL clubs play or practice have statutes that permit healthcare providers to provide employers with an employee’s medical records and/or information.

Some might question whether the waivers discussed herein should be more limited, in other words, whether club doctors should only have access to a player’s medical information insofar as the medical information is related to the player’s ability to play football.^p From a clinical perspective, doctors we have spoken with indicated such an arrangement would not be acceptable, as a treating doctor needs to know the totality of a patient’s conditions and medications to provide appropriate medical care. Nevertheless, whether all medical information, such as information about sexually

o NFL clubs play and practice in 23 states. Wisconsin is the only state in which an NFL club plays or practices that does not have a statute permitting healthcare providers to provide employers with an employee’s medical records and information.

p Indeed, the waiver indicates that disclosure of the player’s medical information is “[f]or purposes relating only to my actual or potential employment in the National Football League[.]” See Appendix L. Nevertheless, the waiver permits the use and disclosure of medical information “relating to any injury, sickness, disease, mental health condition, physical condition, medical history, medical or clinical status, diagnosis, treatment or prognosis” *Id.*

transmitted diseases or mental health, is football-related and thus available to the club is still questionable.

b) Current Ethical Codes

The fourth principle of the AMA Code directs that “[a] physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.” Moreover, the AMA Code includes multiple Opinions concerning patient confidentiality relevant to NFL players:

Opinion 3.1.5—Professionalism in Relationships

with Media: To safeguard patient interests when working with representatives of the media, all physicians should:

- (a) Obtain consent from the patient or the patient’s authorized representative before releasing information.
- (b) Release only information specifically authorized by the patient or patient’s representative or that is part of the public record.
- (c) Ensure that no statement regarding diagnosis or prognosis is made except by or on behalf of the attending physician.
- (d) Refer any questions regarding criminal activities or other police matters to the proper authorities.¹⁰³

Opinion 3.2.1—Confidentiality: Patients need to be able to trust that physicians will protect information shared in confidence. They should feel free to fully disclose sensitive personal information to enable their physician to most effectively provide needed services. Physicians in turn have an ethical obligation to preserve the confidentiality of information gathered in association with the care of the patient.¹⁰⁴

FIMS’ Code of Ethics similarly declares that “[t]he athlete’s right to privacy must be protected.”¹⁰⁵ FIMS’ Code of Ethics goes on to declare that “[n]o information about an athlete may be given to a third party without the consent of the athlete.”¹⁰⁶ However, FIMS’ Code of Ethics also declares that “[w]hen serving as a team physician, the sports medicine physician assumes the responsibility to athletes as well as team administrators and coaches . . . [and that] [i]t is essential that each athlete is informed of that responsibility and authorizes disclosure of otherwise confidential medical information, but solely to the specific responsible persons and for the expressed purpose of determining the fitness of the athlete for participation.”¹⁰⁷

4) CONFLICTS OF INTEREST

a) Current Legal Obligations

A doctor has a legal obligation to act in the best interests of the patient at all times that there is a doctor-patient relationship.¹⁰⁸ Thus, whatever other interests a doctor may have must be secondary to the interests of the patient.

The 2011 CBA appears to take a clear position about the club doctor’s obligations concerning any potential conflicts of interest where the club doctor is providing care to players, as noted above:

[E]ach Club physician’s primary duty in providing player medical care shall be not to the Club but instead to the player-patient.¹⁰⁹

However, also as discussed above, this CBA provision is limited to situations where the club doctor is “providing . . . medical care,” and thus would be inapplicable to the Services to Club scenario (to the extent the scenarios could actually be separated).

b) Current Ethical Codes

In situations where the doctor is providing treatment to a patient, the AMA Code is clear that the doctor’s principal obligation must always be to the patient:

AMA Code, Principle VIII: A physician shall, while caring for a patient, regard responsibility to the patient as paramount.

* * *

Opinion 11.2.2—Conflicts of Interest in Patient Care:

The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.¹¹⁰

* * *

Opinion 1.1.1—Patient-Physician Relationship: The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above the physician’s own self-interest and above obligations to others, to [use] sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.¹¹¹

The AMA Code also contains a sport-specific provision requiring doctors to put the athlete's interests ahead of their own or anyone else's:

Opinion 1.2.5—Sports Medicine: Many professional and amateur athletic activities, including contact sports, can put participants at risk of injury. Physicians can provide valuable information to help sports participants, dancers, and others make informed decisions about whether to initiate or continue participating in such activities.

Physicians who serve in a medical capacity at athletic, sporting, or other physically demanding events should protect the health and safety of participants.

In this capacity, physicians should:

- (a) Base their judgment about an individual's participation solely on medical considerations.
- (b) Not allow the desire of spectators, promoters of the event, or even the injured individual to govern a decision about whether to remove the participant from the event.¹¹²

Moreover, the AMA Code contains guidance for doctors where they might be employed or supervised by nonphysicians (as may be the case in the NFL at times):

Opinion 10.2—Physician Employment by a Nonphysician Supervisee: Accepting employment to supervise a nonphysician employer's clinical practice can create ethical dilemmas for physicians Physicians who are simultaneously employees and clinical supervisors of nonphysician practitioners must:

- (a) Give precedence to their ethical obligation to act in the patient's best interest.
- (b) Exercise independent professional judgment, even if that puts the physician at odds with the employer-supervisee.¹¹³

FIMS' Code of Ethics also contains considerable guidance for club doctors concerning conflicts of interest:

Always make the health of the athlete a priority.¹¹⁴

* * *

The physician's duty to the athlete must be his/her first concern and contractual and other responsibilities are of secondary importance. A medical decision must be taken honestly and conscientiously.¹¹⁵

* * *

The highest respect will always be maintained for human life and well-being. A mere motive of profit shall never be permitted to be an influence in conducting sports medicine practice or functions.¹¹⁶

* * *

Advice given and action taken should always be in the athlete's best interest.¹¹⁷

* * *

To enable the sports medicine physician to undertake this ethical obligation the sports medicine physician must insist on professional autonomy and responsibility for all medical decisions concerning the health, safety and legitimate interest of the athlete. No third party should influence these decisions.¹¹⁸

As mentioned earlier, most medical societies' codes of ethics track and thus do not exceed the requirements of the AMA Code. However, the American Board of Physician Specialties (ABPS)^q Code of Ethics includes one provision that could be problematic for NFL club doctors. The ABPS Code of Ethics forbids doctors from "[a]ccept[ing] personal compensation from any party that would influence or require special consideration in the provision of care to any patient."¹¹⁹ Arguably, NFL clubs can "influence or require special consideration" when a doctor is treating a player-patient. If so, doctors, according to the ABPS, would be forbidden from being compensated by the club.

The American Academy of Orthopaedic Surgeons and American Association of Orthopaedic Surgeons (AAOS), a voluntary organization, also has Standards of Professionalism that might be particularly relevant to the NFL Medical Sponsorship Policy discussed above:

An orthopaedic surgeon shall not enter into any contractual relationship whereby the orthopaedic surgeon pays for the right to care for patients with musculoskeletal conditions.

An orthopaedic surgeon shall make a reasonable effort to ensure that his or her academic institution, hospital or employer shall not enter into any contractual relationship whereby such institution

q ABPS is a non-profit organization that certifies physicians in 18 different specialties, such as general surgery, orthopedic surgery, and internal medicine. See *What is the ABPS?*, Am. Bd. of Physician Specialties, <http://www.abpsus.org/abps> (last visited Aug. 7, 2015), archived at <http://perma.cc/4Z2P-F8Z4>. ABPS is the smaller of two organizations that certify physician specialties, the larger being the American Board of Medical Specialties. The American Board of Medical Specialties does not have a Code of Ethics.

pays for the right to care for patients with musculoskeletal conditions.

An orthopaedic surgeon or his or her professional corporation shall not couple a marketing agreement or the provision of medical services, supplies, equipment or personnel with required referrals to that orthopaedic surgeon or his or her professional corporation.¹²⁰

An orthopedic surgeon who pays for the right to work with an NFL club would potentially be violating the AAOS Standards. Nevertheless, according to the NFL, currently no doctors pay for the right to provide care.^r Additionally, AAOS' only enforcement mechanism is either to order the doctor's compliance or revoke the doctor's membership.¹²¹

(D) Current Legal Obligations and Ethical Codes When Providing Services to Club

Having discussed club doctors' obligations in the situation in which they are, at least in theory, only providing Services to Player, we now turn to their legal and ethical obligations where they are providing Services to Club. It is important to point out as a preliminary matter that the CBA is silent as to a club doctor's legal and ethical obligations in the Services to Club scenario.

As in the Services to Player section above, we discuss a club doctor's obligations concerning (1) medical care, (2) disclosure and autonomy, (3) confidentiality, and (4) conflicts of interest when the club doctor is providing Services to Club.

1) MEDICAL CARE

a) Current Legal Obligations

Courts have generally held that doctors performing medical examinations for non-treatment purposes have a limited patient-physician relationship.¹²² However, it is also important to note that in the cases analyzing this issue, the doctors performing the medical examinations did not also have a simultaneous treatment relationship with the patient, whereas club doctors generally do have such a treatment relationship with current NFL players (though not at the NFL Combine, as discussed below). Thus, these court opinions do not address or adequately encompass the

complexities of the club doctor-player relationship. Nevertheless, in the abstract these rulings are consistent with the AMA Code as is discussed below. In light of the limited relationship, doctors only performing medical examinations, such as those who evaluate fitness-for-play, have duties to exercise care consistent with their professional training and expertise so as not to cause physical harm by negligently conducting the examination.¹²³

Courts have also recognized that evaluation examinations are often conducted under adversarial circumstances.¹²⁴ Consequently, some courts have held that the doctors performing such examinations have no duty to diagnose the examinee's medical conditions.¹²⁵ However, other courts have held that doctors performing evaluation exams have a duty to advise the individual of potentially serious illnesses.¹²⁶

The CBA does not supplement club doctors' obligations when performing fitness-for-play evaluations. Instead, the CBA contains a general provision requiring club doctors to "comply with all federal, state, and local requirements, including all ethical rules and standards established by any applicable government and/or other authority that regulates or governs the medical profession in the Club's city."¹²⁷

b) Current Ethical Codes

As an initial matter, AMA Code Opinion 1.2.6—Work-Related & Independent Medical Examinations clearly acknowledges the issue at hand:

Physicians who are employed by businesses or insurance companies, or who provide medical examinations within their realm of specialty as independent contractors, to assess individuals' health or disability face a conflict of duties. They have responsibilities both to the patient and to the employer or third party.¹²⁸

Opinion 1.2.6 goes on to explain that "[s]uch industry-employed physicians or independent medical examiners establish limited patient-physician relationships. Their relationships with patients are limited to the isolated examination; they do not monitor patients' health over time, treat them, or carry out many other duties fulfilled by physicians in the traditional fiduciary role."¹²⁹ This Opinion would seem to apply to club doctors when they are performing fitness-for-play evaluations except that this Opinion is limited to situations where the medical examination is an "isolated" incident. Club doctors' examinations of current players are not isolated as there is typically an ongoing treatment

^r As discussed earlier in Section A(1): The NFL's Medical Sponsorship Policy, the NFL also takes the position that the Medical Sponsorship Policy prohibits club doctors from paying for the right to provide treatment to players. For the reasons discussed in that section, we disagree.

relationship as well. Thus, the application of this provision to club doctors' practices and obligations is questionable.^s

Nevertheless, assuming Opinion 1.2.6 does apply or at least lends useful guidance, in such a situation, the doctor has the following obligations:

- (a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
- (b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.
- (c) Protect patients' personal health information in keeping with professional standards of confidentiality.
- (d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.¹³⁰

The ACOEM goes one step further and seemingly does not consider there to be any patient-physician relationship where doctors are employed in occupational settings.¹³¹ The ACOEM Code of Ethics refers to "individuals" rather than patients.^t

In reviewing a draft of this Report, one comment from the NFL seemed to indicate that it does not believe club doctors and players are in a patient-doctor relationship. The NFL asserted that the above ACOEM position "reflects the essence of the employer-provided health care relationship."¹³² The NFL's position in this regard seems to be in contradiction with the CBA, other comments from the NFL, and comments from the NFLPS. As discussed above, Article 39 of the CBA requires that "each Club physician's primary duty in providing medical care shall be not to the

Club but instead to the player-patient."¹³³ The NFL reiterated this CBA provision in its comments, stating that "Club Physicians are required to put the player-patient's interests first."¹³⁴ In other comments, the NFL proposed that players "principally rely on Club Physicians" for their care "because of the quality of the care they receive from Club Physicians[.]"¹³⁵ Similarly, in a forthcoming commentary as part of a Special Report to The Hastings Center Report, the NFLPS maintained that "NFL physicians are accomplished medical professionals who abide by the highest ethical standards in providing treatment to all of their patients, including those who play in the NFL." Given that club doctors are clearly providing care and treatment to player, and statements acknowledging that fact in other places, we find the NFL's embrace of the ACOEM position perplexing. To be clear, we believe there is a doctor-patient relationship between club doctors and players.

2) DISCLOSURE AND AUTONOMY

a) Current Legal Obligations

As discussed above, a doctor's legal obligations when performing fitness-for-play evaluations are generally to exercise care consistent with the doctor's professional training and expertise so as not to cause physical harm by negligently conducting the examination.¹³⁶ The duties of a doctor performing a fitness-for-play evaluation are less robust than of the duties of a doctor treating a patient, but even for fitness-for-play evaluations it is indispensable that the doctor obtain the individual's informed consent for the examination, just as the doctor would when treating a patient of his or her own.¹³⁷

b) Current Ethical Codes

As discussed above, AMA Code Opinion 1.2.6 controls a doctor's ethical responsibilities when performing "isolated" evaluation examinations. Again, assuming that Opinion 1.2.6 applies or guides club doctors when providing Services to Club, on the issues of disclosure and autonomy, Opinion 1.2.6 requires doctors to:

- (a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
- (b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.

^s See also Tee L. Guidotti et al., *Occupational Health Services: A Practical Approach* 66 (2d ed. 2013) ("[W]hen there is no provider-patient relationship, the occupational health professional still has an obligation to meet professional and legal standards: inform the worker that no practitioner-patient relationship exists, obtain consent for the examination, tell the worker about significant findings, recommend medical follow-up when something abnormal is found, and manage any medical emergencies that arise during the course of an evaluation, although there is no obligation to treat the patient otherwise.")

^t See *id.*, citing the ACOEM Code of Ethics. See also *id.* at 65–66 ("When the worker is being assessed and treated by the physician for an occupational injury, for example, a physician-patient relationship exists. When that same physician is conducting an evaluation for the employer for fitness to work . . . a physician-patient relationship does not exist, because the service is being performed in the interest of a third party.")

- (c) Protect patients' personal health information in keeping with professional standards of confidentiality.
- (d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.¹³⁸

3) CONFIDENTIALITY

a) Current Legal Obligations

Generally, a doctor-patient relationship is required for a doctor to be subject to common law and statutory confidentiality requirements.¹³⁹ Given the limited doctor-patient relationship in the Services to Club scenario, it is thus questionable when a state's common law or statutory obligations concerning confidentiality might apply. Nevertheless, as discussed above, the law generally makes exceptions permitting doctors to disclose medical information to employers. In light of the fact that the club doctors in the Services to Club scenario are tasked explicitly with gathering medical information for the clubs, it makes sense that they are permitted to provide medical information to the club but cannot provide it to any other party (see Section (C)(3)(a) above, discussing club doctors' confidentiality obligations).

The ACOEM declares that while the employer is entitled to the doctor's professional opinion as to the employee's "fitness to perform a specific job," the doctor "should not provide the employer with specific medical details or diagnoses unless the employee has given his or her permission."

b) Current Ethical Codes

AMA Code Opinion 3.2.3—Industry-Employed Physicians & Independent Medical Examiners provides guidance on a club doctor's confidentiality obligations:

Physicians may obtain personal information about patients outside an ongoing patient-physician relationship. For example, physicians may assess an individual's health or disability on behalf of an employer, insurer, or other third party. Or they may obtain information in providing care specifically for a work-related illness or injury. In all these situations, physicians have a responsibility to protect the confidentiality of patient information.

When conducting third-party assessments or treating work-related medical conditions, physicians may disclose information to a third party:

- (a) With written or documented consent of the individual (or authorized surrogate); or
- (b) As required by law, including workmen's compensation law where applicable.

When disclosing information to third parties, physicians should:

- (c) Restrict disclosure to the minimum necessary information for the intended purpose.
- (d) Ensure that individually identifying information is removed before releasing aggregate data or statistical health information about the pertinent population.¹⁴⁰

However, the application of this provision to club doctors is unclear. Opinion 3.2.3 seems to apply to those situations where there is not "an ongoing patient-physician relationship." Club doctors and players on the other hand generally are in an ongoing patient-physician relationship.

Importantly, Opinion 3.2.3 acknowledges that there may be laws, as discussed above, that permit a doctor retained by an employer to provide the employer with medical information about an employee. Similarly, also as discussed above, FIMS' Code of Ethics seems to recognize the need for medical information to be provided to clubs. While FIMS' Code of Ethics declares that "[n]o information about an athlete may be given to a third party without the consent of the athlete,"¹⁴¹ it also declares that it is "essential" that athletes authorize the doctor to disclose "otherwise confidential medical information" to certain club officials "for the expressed purpose of determining the fitness of the athlete for participation."¹⁴²

Similarly, while ACOEM's Code of Ethics directs that "[o]ccupational and environmental health professionals should keep confidential all individual medical, health promotion, and health screening information," the Code of Ethics also directs that "occupational and environmental

health professionals should recognize that employers may be entitled to counsel about an individual's medical work fitness."¹⁴³

However, the ACOEM also declares that while the employer is entitled to the doctor's professional opinion as to the employee's "fitness to perform a specific job," the doctor "should not provide the employer with specific medical details or diagnoses unless the employee has given his or her permission."^u

4) CONFLICTS OF INTEREST

a) Current Legal Obligations

As discussed above, a doctor's legal obligations when performing fitness-for-play evaluations are generally to exercise care consistent with the doctor's professional training and expertise so as not to cause physical harm by negligently conducting the examination.¹⁴⁴ Assuming the doctor meets that standard of care, the doctor is free to perform the fitness-for-play evaluation consistent with his or her obligations to the club.

b) Current Ethical Codes

As discussed above, AMA Code Opinion 1.2.6 potentially guides a doctor's obligations in the Services to Club scenario. In such a situation, the doctor has the following obligations:

- (a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.
- (b) Explain that the physician's role in this context is to assess the patient's health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.

^u *Confidentiality of Medical Information in the Workplace*, Am. Coll. of Occupational and Env'tl. Med., http://www.acoem.org/Confidentiality_Medical_Information.aspx (last visited Aug. 7, 2015), *archived at* <http://perma.cc/N7D4-3RDD>. See also Tee L. Guidotti et al., *Occupational Health Services: A Practical Approach* 62 (2d ed. 2013) ("The occupational health professional who is working on behalf of an employer . . . has an obligation to report such information as is directly pertinent to the employee's work capacity or accommodations that are needed, but no more. The employer is entitled to a determination of "fit," "unfit," and "fit with accommodation" . . . but not to the diagnosis or medical history of the employee."); *id.* ("Employers have an obligation to respect the confidentiality of personal medical information of their employees. Unless informed consent is given by the worker, confidential medical information must stay within the occupational health service and cannot be shared, for example with human resources, or with management, or with coworkers."); *id.* at 288 ("The fitness-for-duty opinion is communicated to the employer, without disclosing any medical information, using medical terminology, or providing diagnosis. The employer only receives the final determination, which is expressed as fit, unfit, or fit subject to specific accommodations (specified).").

- (c) Protect patients' personal health information in keeping with professional standards of confidentiality.
- (d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.¹⁴⁵

FIMS' Code of Ethics also contains guidance for club doctors concerning conflicts of interest:

It is the responsibility of the sports medicine physician to determine whether the injured athlete should continue training or participate in competition. The outcome of the competition or the coaches should not influence the decision, but solely the possible risks and consequences to the health of the athlete.¹⁴⁶

* * *

At a sport venue, it is the responsibility of the sports medicine physician to determine when an injured athlete can participate in or return to an event or game. The physician should not delegate this decision. In all cases, priority must be given to the athlete's health and safety. The outcome of the competition must never influence such decisions.¹⁴⁷

(E) Additional Ethical Obligations

FIMS' Code of Ethics declares that "[p]hysicians who care for athletes of all ages have an ethical obligation to understand the specific physical, mental and emotional demands of physical activity, exercise and sports training."¹⁴⁸

Additionally, a player's right to obtain a second opinion is often an important consideration. Although the 2011 CBA provides a player the right to obtain a second medical opinion, it does not obligate the club doctor to inform or remind the player of that right.¹⁴⁹ In contrast, FIMS' Code of Ethics specifically obligates "[t]he team physician [to] explain to the individual athlete that he or she is free to consult another physician."¹⁵⁰

AMA Code Opinion 1.2.3—Consultation, Referral & Second Opinions also directs a doctor to cooperate with a patient's right to a second opinion:

Physicians' fiduciary obligation to promote patients' best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care.

When physicians seek or provide consultation about a patient's care or refer a patient for health care services, including diagnostic laboratory services, they should:

- (a) Base the decision or recommendation on the patient's medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.
- (b) Share patients' health information in keeping with ethical guidelines on confidentiality.
- (c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service . . .

* * *

Physicians may not terminate a patient-physician relationship solely because the patient seeks recommendations or care from a health care professional whom the physician has not recommended.¹⁵¹

Similarly, the American Board of Physician Specialties obligates doctors to “[c]ooperate in every reasonable and proper way with other physicians and work with them in the advancement of quality patient care.”¹⁵²

Doctors also have ethical obligations concerning their role within the club's entire healthcare staff. As discussed in Chapter 3, athletic trainers are vital contributors to the player healthcare system. However, athletic trainers are not licensed doctors and thus it is important that they not perform any tasks which are reserved for doctors. Thus, doctors must not encourage or allow athletic trainers to undertake responsibilities that are outside the scope of their license.

On this point, AMA Code Opinion 10.2–Physician Employment by a Nonphysician Supervisee declares:

Physicians' relationships with midlevel practitioners must be based on mutual respect and trust as well as their shared commitment to patient well-being. Health care professionals recognize that clinical tasks should be shared and delegated in keeping with each practitioner's training, expertise, and scope of practice. Given their comprehensive training and broad scope of practice, physicians have a professional responsibility for the quality of overall care that patients receive, even when aspects of that care are delivered by nonphysician clinicians.¹⁵³

(F) Current Practices

As discussed above, clubs retain a wide variety of doctors. The current practices we discuss below are generally those of the head club doctor. In discussing club doctor's current practices, it is important to reiterate that some of the problems we describe are principally the result of the conflicted structure in which club doctors operate, as opposed to moral or ethical failings on the part of the doctors. Finally, it is important to recognize that there may be a good deal of variation among clubs. Without a full survey of the experience of players and doctors at each club, we cannot fully capture the nuances of local variations.

Two former NFL club doctors wrote books about their experiences which provide insight into the practices of club doctors during the doctors' tenures in the 1980s and 1990s. We fully recognize that these books cover practices from an earlier time period than present day football. Nevertheless, as is explained below, while it appears some practices have changed substantially since the time these books were written, others have not. We also recognize that these books, although they are the most complete and comprehensive coverage of the subject in existence, represent the perspectives of only two former club doctors, and that the practice and experiences of club doctors even during this time period was not uniform.

As discussed in the background of this chapter, the NFL denied our request to interview club doctors as part of this Report. Without being able to interview club doctors, where possible, we have supplemented facts discussed in the books written by former club doctors with more contemporary factual accounts, including news reports, academic and professional literature, and formal and informal interviews with NFL and NFLPA representatives, many current and former players, sports medicine professionals, contract advisors, financial advisors, and player family members. Nevertheless, the limitations discussed above are important ones and we are hopeful that we or others will be provided the necessary access and information in future work to establish a broader set of data on the experience of club doctors.

The first book, “*You're Okay, It's Just a Bruise*”: *A Doctor's Sideline Secrets About Pro Football's Most Outrageous Team*, was published in 1994 by former Los Angeles Raiders club doctor Rob Huizenga. Huizenga, who was with the Raiders from 1982 to 1990, was extremely critical of the Raiders' approach to player medical issues, with particular criticism focused on Raiders'

then-owner Al Davis and the Raiders' then-orthopedist and head doctor, Robert Rosenfeld. The title of the book is something Huizenga claimed Rosenfeld once told a Raiders player who had recently suffered a neck injury that had resulted in temporary paralysis, a diagnosis with which Huizenga and several other doctors disagreed.¹⁵⁴

Rosenfeld, according to Huizenga, downplayed players' injuries and unabashedly placed the Raiders' interests ahead of the players'.¹⁵⁵ As Huizenga put it, "Rosenfeld lived for the Raider job. I suspected he would do whatever it took to keep Al Davis happy."¹⁵⁶ The book in many respects is an account of Huizenga's self-described efforts to balance his ethical obligations as a doctor and to the players with his obligations to the Raiders.¹⁵⁷ Ultimately, citing the Raiders' culture and Rosenfeld's questionable practices, Huizenga resigned his position in 1990.¹⁵⁸

Then, in 2001, former Seattle Seahawks club doctor Pierce Scranton published *Playing Hurt: Treating and Evaluating the Warriors of the NFL*. Scranton was the Seahawks' club doctor from 1980 to 1998. Scranton generally believed that NFL players received outstanding care from club doctors but acknowledged the potential conflicts in the position, explaining that if a club doctor "decides to play it safe and hold [a player] out of the next game, he might feel subtle pressure from the player, his team, the player's agent, the coaches, and management."¹⁵⁹ "The doctor is caught in the middle, forced to distinguish between the usual aches and pains of football versus the pain of an injury that could make that player more vulnerable to serious harm."¹⁶⁰

Scranton also discussed his view of the club doctor's obligations to the club and relationship with coaches. Scranton asserted that "[a] sports-medicine physician must place the interests of the team above his own. He recognizes that the team needs instant attention to injuries in order to be successful."¹⁶¹ Moreover, Scranton had a close relationship with and operated on Seahawks head coach Tom Flores.^v Nevertheless, Scranton lamented the control

coaches had over player medical issues, explaining that coaches would try to exclude doctors from team activities and make decisions about whether players were medically cleared to play.^w Scranton further claimed that coaches would direct players not to consult the athletic trainers or doctors during the game, because "they'll take you out of the game."¹⁶²

Below, we discuss current practices concerning club doctors from several perspectives and situations: (1) selection and payment of club doctors; (2) the NFL Combine and Draft; (3) seasonal duties; (4) game day duties; (5) relationships with coaches and club executives; and, (6) relationships with players.

1) SELECTION AND PAYMENT OF CLUB DOCTORS

Each NFL club's medical staff is chosen by the club's executives.¹⁶³ Club doctors are affiliated with a wide variety of private practice groups, hospitals, academic institutions, and other professional sports leagues. Some of these institutions have long-standing relationships with clubs, which often help lead to the doctor being retained by the club. The NFLPA plays no role in the selection of club doctors other than ensuring they have the qualifications required by the CBA and are properly licensed in the relevant state(s), via Synernet, a third-party vendor jointly selected by the NFL and NFLPA.¹⁶⁴ Synernet provides reports on these matters to both the NFL and NFLPA.¹⁶⁵ Additionally, of the NFL's 32 head club doctors, 2 are employees and 30 are independent contractors.¹⁶⁶

Also, while it is our understanding that club doctors' contracts are generally reviewed and renewed on an annual basis, there is very little turnover among club doctors.

It is difficult to ascertain actual figures and practices of club doctor compensation. In the course of our research, we were informed by some familiar with the industry that club

v Flores: "When I came to Seattle, I tore the cartilage in my knee, and Dr. Pierce Scranton performed the surgery in 1989. [...] In 1994 and 1995, I tore my right rotator cuff and then my left. Drs. Scranton and Auld, the two team physicians for the Seattle Seahawks, performed the surgery. In all of my surgeries, I was fortunate to have doctors whom I trusted and respected."

Flores: "During my years in the NFL as a head coach and general manager, I always had a close relationship with our doctors. I felt it was necessary to get to know each one, not only as a doctor, but as a person. It was important to me that our team doctors have strong feelings about our team's health and loyalty to the entire organization. When our doctors came into the training room, I didn't want the feeling that outsiders were invading us. They had to feel part of the family, and we had to treat them as such." Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL* viii (2001).

w "A third reason that agents insist on outside surgery for their players is that many clubs have, in effect, neutered their team physicians. Injuries are the one thing that coaches can't control, and they drive control-freak coaches crazy. Coaches hate it when the doctor tells them that a star player will be out for four to eight weeks, maybe more. The solution to this maddening intrusion? Remove the doctor from the team. The doctors are intentionally excluded from team activities. They have to eat separately, they can't ride to the game on the team bus, and the coach will take the injury report from the trainer only. In other words, for a player who is wondering whether he can play hurt or not, the control-freak coaches want the player to ask *them* that question, not the doctor. The conventional doctor-patient relationship is nonexistent, and the trust naturally fostered by such a relationship is consciously undermined by the organization. This puts the team physicians at greater risk for malpractice." *Id.* at 174.

doctors are generally paid in relatively nominal amounts compared to what one might expect (\$20,000–\$30,000).^x In reviewing a draft of this Report, the NFL stated that this estimate “grossly underestimates compensation to Head Team Physicians, Head Team Orthopedists and Head Team Internists.”¹⁶⁷ Nevertheless, the NFL did not provide alternative compensation figures.

The NFLPA plays no role in the selection of club doctors other than ensuring they have the qualifications required by the CBA and are properly licensed in the relevant state(s).

In addition, despite the relatively high scrutiny club doctors face, it is our understanding that their contracts with the clubs do not include any type of indemnification whereby the club would pay for the defense, settlement, or verdict of a medical malpractice claim.

Despite the various challenges, club doctors have a variety of reasons for being interested in the position. Many of them are sports fans and thus the opportunity to work up close and personal with some of the best athletes in the world is exciting. From a business perspective, a doctor’s association with an NFL club could be powerful in terms of professional respect and name recognition, resulting in more patients in their practice.

We will next walk through a club doctor’s typical season to provide context for the club doctor’s relationships with various individuals.

2) THE NFL COMBINE AND DRAFT

Before reaching the preseason or regular season, club doctors attend the NFL Scouting Combine (Combine). The Combine is an annual event each February in which approximately 300 of the best college football players undergo medical examinations, intelligence tests, interviews and multiple football and other athletic drills and tests.¹⁶⁸ NFL club executives, coaches, scouts, doctors and athletic trainers attend the Combine to evaluate the players for the upcoming NFL Draft (usually in April).¹⁶⁹ The Combine began in the early 1980s and has been held in Indianapolis since 1987.¹⁷⁰

Although called the NFL Scouting Combine, the event is actually organized by National Football Scouting, Inc., a Delaware corporation that is not owned or legally controlled by the NFL.¹⁷¹ Nevertheless, the NFL exercises considerable control over the event, including involvement in decisions about the drills players perform at the Combine, selling public tickets, and broadcasting the Combine on television.^{172,y} The NFL claimed that “[t]he NFLPA also exercises considerable discretion over the Combine. For example, the NFLPA prohibited the Combine medical team(s) from conducting cardiac echocardiograms on every attendee citing the potential adverse financial impact of a false positive.”¹⁷³

As an initial matter, in order to participate in the NFL Combine, players must execute waivers permitting the Combine, the NFL, and a wide variety of related parties, such as club medical staff, to obtain, use, and release the player’s medical information (without any date limitation) for purposes relating to the player’s potential or actual employment in the NFL. These waivers are included as Appendices in our forthcoming law review article, *Evaluating NFL Player Health and Performance: Legal and Ethical Issues*.¹⁷⁴

According to Jeff Foster, the President of National Football Scouting, Inc., all 32 NFL clubs consider the medical examinations to be the most important part of the Combine.¹⁷⁵ Indeed, former NFL club executive Bill

^x In 2001, the Minnesota Vikings paid their three club doctors \$4,000, \$19,600 and \$47,500 per year, respectively. The amounts varied based on the extent of the doctors’ obligations. See Memorandum and Order, *Stringer v. Minn. Vikings Football Club*, No. 02-415, 20–23 (Minn. Dist. Ct. Apr. 25, 2003).

^y It is possible that the NFL avoids direct control of the NFL Combine to avoid having to comply with the Americans with Disabilities Act (ADA). The ADA prohibits pre-employment medical examinations to determine whether a prospective employee has a disability. See 42 U.S.C. § 12112(d)(2)(A) (2012). The definition of “disability includes any “physical or mental impairment that substantially limits one or more major life activities,” 42 U.S.C. § 12102(1). This definition of disability could arguably include any prior injury by a prospective NFL player and thus the medical examinations at the NFL Combine are potentially pre-employment medical examinations which are barred by the ADA. For more on this and related issues, see our law review article, *Evaluating NFL Player Health and Performance: Legal and Ethical Issues*, U. Penn. L. Rev. (forthcoming 2017).

Polian said that “the one and only reason for the combine is the medical tests.”¹⁷⁶ A battery of medical tests are initially performed by doctors affiliated with IU Health,¹⁷⁷ a healthcare system affiliated with Indiana University School of Medicine.¹⁷⁸ IU Health doctors have been working at the Combine since it moved to Indianapolis in 1987.¹⁷⁹ The IU Health doctors perform X-rays and more than 350 magnetic resonance imaging (MRI) diagnostic tests each year.^{180,z}

After the tests are performed by IU Health doctors, “examinations are conducted by the physicians in the NFL Physicians Society.”¹⁸¹ The NFL explained that “Club medical teams each perform one element of a comprehensive evaluation and share their findings with all other clubs. In other words, a combine attendee undergoes one comprehensive examination (performed by different practitioners), not 32 comprehensive examinations.”¹⁸² According to the NFLPS, the role of the club doctor at the Combine “is to obtain a comprehensive medical and orthopaedic assessment of every player that is going to be part of the NFL Draft.”¹⁸³ Also according to the NFLPS, “the team physicians along with their athletic training staff assess every player who is going to be available for the NFL Draft and provide a report back to the scouting department, the head coach, the general manager and the front office about the medical condition of each player. This information becomes very important in a team’s assessment of whether or not a player will be drafted.”¹⁸⁴ These examinations might create concerns for club doctors, as discussed below. In particular, the nature and purpose of the doctor’s role might not be clear to the player being examined.^{aa}

Former Seahawks club doctor Pierce Scranton discussed the Combine at length in his book. Scranton attended the Combine on behalf of the Seahawks each year to perform medical examinations on prospective NFL players. According to Scranton, “each team relies heavily on doctors in

determining that its high picks are healthy and capable of contributing to the team and dominating on the field.”¹⁸⁵ Scranton’s description comports with former Los Angeles Raiders club doctor Rob Huizenga’s, who described the Combine examinations as “[d]etective medicine.”¹⁸⁶ All indications are that club doctors’ responsibilities at the Combine have not changed since the period described by Scranton and Huizenga.

Scranton expressed misgivings about the Combine. He believed these examinations presented a “moral quandary” for the club doctors on whether to tell a player about medical problems he may have.¹⁸⁷ While Scranton felt a “responsibility to protect that athlete’s health and welfare,”¹⁸⁸ he believed that his primary responsibility was to make sure players with relatively poor injury histories or medical conditions are not drafted by the Seahawks.^{ab} It is uncertain whether Scranton’s feelings are consistent with those of today’s club doctors. Ultimately, Scranton said he found the “examinations . . . more dehumanizing than interesting.”¹⁸⁹

Nevertheless, Scranton, like all club doctors, used his medical examinations from the Combine and other pre-Draft examinations to help the club make decisions about which players to draft. According to Scranton, Mike McCormack, the Seahawks general manager from 1982 to 1989, demanded Scranton provide “an accurate assessment from the team’s perspective on player health and career longevity.”¹⁹⁰

It is also important to note that the NFL Combine exams do include tests for conditions that could have serious health implications for players, including “sickle cell anemia, heart conditions, and other congenital conditions.”¹⁹¹ Although these tests can offer benefits to players, they (and other examinations conducted at the Combine) could implicate certain laws, including the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA), as discussed in our forthcoming law review article mentioned above.¹⁹²

z Our research has also revealed that there have been approximately 31 published medical studies using players’ medical information obtained from the examinations conducted at the NFL Combine, some involving thousands of prospective NFL players. Although some of the studies describe having received approval from an Institutional Review Board, many do not. Either way, we have concerns about whether the players voluntarily and knowingly consented to have their medical information used in these studies (to the extent consent was required).

aa In reviewing a draft of this Report, the NFL argued that the fact the “Combine attendees sign medical record release and waiver forms” indicates that players do understand the role of doctors at the Combine. NFL Comments and Corrections (June 24, 2016). We disagree. Signing a complicated legal document is far different from understanding it. Moreover, the waivers authorize the use and disclosure of the player’s health information by and to a variety of parties. Nowhere does the document explain why the club doctor is performing the examination or how the results of the examination might be used.

ab “At the combines, a doctor can’t escape the nagging sense that something’s not right. As surgeons, we embody the ethical heritage of a profession that for centuries has assessed injury, made diagnoses, and provided healing treatment. Our task is to inform our patients of their condition and the relative risks of the cure. In this combine environment, however, we are only employees of a team. We may examine someone who has a life-threatening condition, but our only job is to make sure that *our* team doesn’t wind up with *that* guy on its roster.” Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL* 22 (2001).

3) SEASONAL DUTIES

Club doctors' duties are perhaps most intense during the preseason. Club rosters are much larger in the preseason (beginning with 90 active players as compared to 53 during the regular season), meaning there are many more players requiring medical care. As a result, club doctors are often at the club's training facility at least four hours a day every day. According to the NFL, for approximately the last 10 years, each club's medical staff has held a preseason meeting with players to discuss health and safety issues.¹⁹³ Beginning with the 2015 season, "[t]he content was developed by the League's medical committees, in consultation with the NFLPA's medical director."¹⁹⁴ The content of the presentation "include[s] information regarding heat management, concussions, infectious disease, mental health, helmet testing, controlled substances and steroids."¹⁹⁵

Club doctors' daily involvement with the club actually decreases during the regular season. Club doctors generally have their own private practice where they spend most of their time.¹⁹⁶ In a 2008 arbitration decision, club doctors' availability and obligations to the club were described as follows:

*In general, the Club's physicians are available to address the players' injuries and problems, are present in the training room on Mondays and Wednesdays, and maintain Friday office hours for meeting with the players. They also are available on the field two hours before each game, whether at home or away, for any player who needs care. They are also in constant communication with the Club's head trainer and training staff concerning the status of players in order to implement medical plans and share notes with each other with respect to the players' progress.*¹⁹⁷

Club doctors' visits to the club on Monday are generally for evaluating the extent of player injuries from the previous day's game, including ordering X-rays and MRIs.^{ac} The club doctor generally returns on Wednesday to reevaluate the players and assess their progress.^{ad} Nevertheless, it is important to remember there is heterogeneity in club doctor's actual practices and these descriptions are offered as general practices.

Club doctors principally rely on the athletic trainers (*see* Chapter 3) to monitor and handle the player's care during the week. According to the NFLPS:

The athletic trainer is often the first person to see an injured player at the game, practice, training camp, mini-camp, etc. The trainer must be accurate in the identification of injuries and must communicate (sic) well with the team physician. There is a constant source of dialogue between the athletic trainers and the team physicians in all aspects of the player's care, whether it's preventative care, managing current injuries or medical problems, or the entire rehabilitation process.¹⁹⁸

Club doctors then attend the club's game each week, discussed in more detail below.

At the conclusion of the season, the club doctors perform end of season physicals for every player on the roster. While the physicals can benefit the players by revealing injuries or conditions in need of care, they also provide important benefits to the club. These physicals can provide the club with a record that at the end of the season the player was healthy so that if the player's contract is terminated during the offseason, the player cannot claim that his contract was terminated because he was injured and then try to obtain additional compensation either through an Injury Grievance or the Injury Protection benefit.^{ae} Additionally, the club will want an assessment of each player's health in deciding whether or not to retain that player for next season.^{af}

According to the NFL, it "proposed a standard two-day post season physical examination which would include mental health evaluations and relevant player programming (career transition, substance abuse and financial education) which was rejected by the NFLPA."¹⁹⁹ In response, the NFLPA stated that "[t]he standard post-season physical proposal originated with the NFLPA in an effort to further player health. The NFL's counter-proposal was not acceptable to player leadership [and that] [t]hese discussions are ongoing."²⁰⁰

ac *See, e.g., id.* at 85 ("Our injury clinic was at the Seahawk headquarters in Kirkland every Monday at 7:30 AM. This early start gave us a jump on ordering emergency MRIs for hurt players.").

ad *See id.* at 87 ("Wednesday the players would put their pads back on. That afternoon, I'd come cover for the afternoon injury clinic. I'd check the progress of all our recent injuries and find out if there was anything new. Who was getting better? Who would be reclassified in that evening's injury report to coach? Who could he count on next Sunday?").

ae *See id.* at 90 ("The release physical became a legal document. Our intention was to ensure that no one was released hurt. We also wanted to make sure no one demanded compensation for an injury when none had occurred.").

af *See id.* at 39–40 (discussing 'Buyer-Beware' Players, including a linebacker that was "[a]n 11-year veteran who is always in the training room," a punter with "[c]hronic back spasms [and who is] [a]lways in the training room," and another linebacker who is "[a]lways on injured reserve or on an airplane for a second opinion.").

Table 2-C:
Game Day Medical Staff

| For Both Clubs | For Each Club |
|---------------------------------|-----------------------------|
| Neurotrauma Consultants (2) | Athletic Trainers (4) |
| EMTs (2) | Orthopedists (2) |
| Athletic Trainer (1) | Primary Care Physicians (2) |
| Ophthalmologist (1) | Chiropractor (1) |
| Dentist (1) | |
| Radiology Technician (1) | |
| Airway Management Physician (1) | |

4) GAME DAY DUTIES

Game days include a wide variety of medical professionals. Each club generally has four athletic trainers, two orthopedists, two primary care physicians and one chiropractor present.²⁰¹ In addition, pursuant to the Concussion Protocol (see Appendix A), each club is designated an Unaffiliated Neurotrauma Consultant to assess possible concussions.^{ag} In addition, there are a variety of medical professionals available to both clubs, including one independent athletic trainer who views the game from the press box to spot possible injuries (the “spotter”),^{ah} an ophthalmologist, a dentist, a radiology technician to handle the stadium’s X-ray machine, an airway management physician, and an emergency medical technician (EMT)/paramedic crew. In

total, an NFL game generally involves 27 medical personnel on site.²⁰²

Club doctors generally arrive at the game three to four hours before kickoff.²⁰³ Players who are questionable for the game, will warm up on the field early, under the supervision of the club doctors.²⁰⁴ The club doctor will then decide whether the player will play that day.²⁰⁵ The club has until 90 minutes before kickoff to submit its Active List for the game, *i.e.*, decide which players are not eligible to play.²⁰⁶

In or about 2013, the NFL instituted a new policy requiring the club’s head doctor to meet with the head referee prior to each game so that the referee knows for whom to look and with whom to talk in the event of a major injury.²⁰⁷

The club doctor’s principal obligation during the games is to respond to player injuries.²⁰⁸ The club doctor and athletic trainer will mutually evaluate the player and the club doctor ultimately is responsible for determining whether the player can return to play.²⁰⁹

If the player has suffered a possible concussion in a game,^{ai} he must go through the Concussion Protocol (see Appendix A) to determine if he can return to play. Generally, the Concussion Protocol requires that the player undergo a Sideline Concussion Assessment, including the Standardized Concussion Assessment Tool (SCAT3), which consists of a series of scored symptom, cognitive, and physical assessments by the club doctor, with the potential assistance of the unaffiliated neurotrauma consultant assigned to the game.^{aj} The player’s score on the SCAT3 is then compared to his SCAT3 scores from a preseason baseline examination. Coupled with the doctors’ other professional

ag The Concussion Protocol does not explain how the Unaffiliated Neurotrauma Consultant is chosen, but requires that the consultant “be a physician who is impartial and independent from any Club, is board certified or board eligible in neurology, neurological surgery, emergency medicine, physical medicine and rehabilitation physician, or any primary care CAQ sports medicine certified physician and has documented competence and experience in the treatment of acute head injuries.” The Unaffiliated Neurotrauma Consultant also prepares a report after each game detailing any examinations performed.

ah “The spotter is a seasoned athletic trainer who is selected, trained and paid by the N.F.L. and who also has at his or her disposal “a video monitor and a video operator who can instantly replay a game sequence to scrutinize the mechanism of a potential head injury.” “The spotter watches both teams and can communicate directly with the athletic trainers and doctors on the field via telephones that ring on the benches and walkie-talkies that are wired to earpieces.” Bill Pennington, *Concussions by the New Book*, N.Y. Times, Nov. 29, 2014, http://www.nytimes.com/2014/11/30/sports/football/nfl-teams-now-operate-under-a-concussion-management-protocol.html?_r=0, archived at <https://perma.cc/79YM-R7SN?type=pdf>. In 2015, the NFL enacted a rule permitting the spotter to stop play if he or she believes a player has suffered a concussion. Darin Gantt, *Injury Timeout Proposal Unanimously Approved by NFL Owners*, ProFootballTalk (Mar. 24, 2015, 1:38 PM), <http://profootballtalk.nbcsports.com/2015/03/24/injury-timeout-proposal-unanimously-approved-by-nfl-owners/>, archived at <http://perma.cc/N927-X2WL>. The rule change occurred in part because, according to the NFL, during the 2014 season there were 25 incidents in which a player should have been removed from a game but was not. Mike Florio, *NFL Found 25 Failures to Remove Players from 2012 through 2014*, ProFootballTalk (Mar. 27, 2015, 8:35 PM), <http://profootballtalk.nbcsports.com/2015/03/27/nfl-found-25-failures-to-remove-players-from-2012-through-2014/>, archived at <http://perma.cc/4BEJ-9PW9>. The NFL then announced that no spotter could have worked for an NFL club within the prior 20 years. Mike Florio, *NFL Moves on from ATC Spotters with Team Affiliations*, ProFootballTalk (Apr. 25, 2015, 6:32 AM), <http://profootballtalk.nbcsports.com/2015/04/25/nfl-moves-on-from-atc-spotters-with-team-affiliations>, archived at <http://perma.cc/RX9M-EXWD>.

ai The Concussion Protocol includes a list of observable signs or player-reported symptoms that might indicate a player has suffered a concussion. See Appendix A.
aj The Concussion Protocol is unclear as to whether the unaffiliated neurotrauma consultant must be consulted when a Club doctor is examining a player for a potential concussion.

judgments, a determination is then made as to whether the player has in fact suffered a concussion. If the player has suffered a concussion, he cannot return to the game. The Concussion Protocol declares that “[t]he responsibility for the diagnosis of concussion and the decision to return a player to a game remains exclusively within the professional judgment of the Head Team Physician or the Team physician assigned to managing TBI.” According to the NFL, there have there have never been any problems or disagreements between club doctors and the unaffiliated neurotrauma consultants.²¹⁰

An interesting situation occurs when a visiting player is injured. Because the visiting club’s doctor is often not licensed to practice in the state in which the club is playing, the home club’s doctor is responsible for the visiting player’s care.^{ak} To address this problem, beginning in 2015, each club is assigned a Visiting Team Medical Liaison.²¹¹ The Visiting Team Medical Liaison is a local doctor who can help provide care, medications and advice concerning local medical facilities.²¹²

Additionally, legislation has been introduced to clarify the obligations of doctors and athletic trainers in these situations. In February 2015, a proposed federal law, entitled the Sports Medicine Licensure Clarity Act, was introduced that would deem medical services provided by club doctors and athletic trainers in states in which they are not licensed to have been provided in the states in which they are licensed.²¹³ As of the date of publication, no action has been taken since the bill’s introduction.

ak “[I]f a visiting team’s player went down, say with a severe concussion, we Seahawk physicians would assume responsibility for that player’s care.” Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL* 72 (2001).

5) RELATIONSHIPS WITH COACHES AND CLUB EXECUTIVES

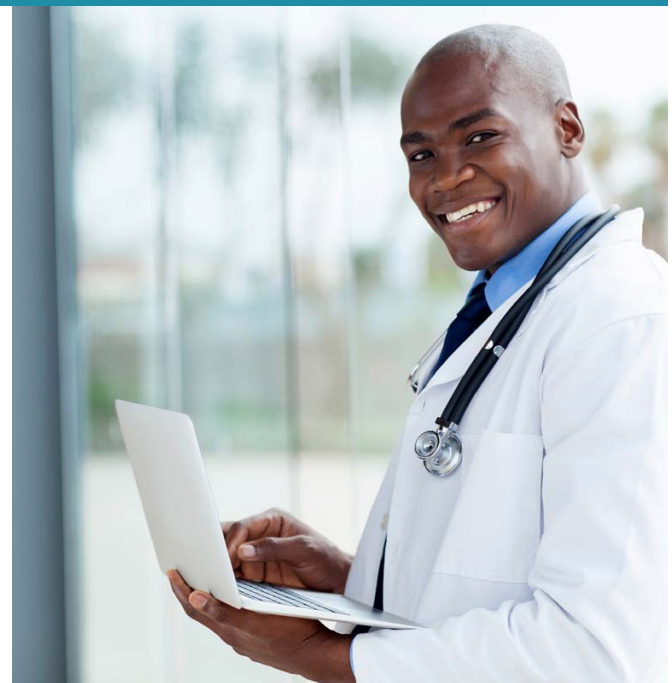
Based on conversations with sports medicine professionals it is our understanding that there is much variance in the relationships between club doctors and coaches. In general, most medical information concerning a player is passed from the club doctor to the coaching staff through the athletic trainer. Athletic trainers are employees of the club and spend nearly every waking hour with the club. Thus, many club doctors might only meet with the head coach once a week to discuss the health status of players.^{al} Nevertheless, there are still concerns that some club doctors have much closer relationships with, and sometimes can be pressured by, the coaching staff.

As noted above, clubs generally require players to execute waivers (which have been collectively bargained) before each season permitting the player’s medical information to be disclosed to and used by a wide variety of parties, including but not limited to the NFL, any NFL club, and any club’s medical staff and personnel, such as coaches and the general manager. Consequently, it is believed that club doctors provide any player medical information that might be relevant to the coaches or club executives.

Club doctors generally have minimal contact with club executives, such as general managers. The club doctors assist the club’s front office during the Combine and prior to the NFL Draft by examining and evaluating the health of prospects. The club doctors might provide similar analysis

al *See id.* at 86 (“After we saw the game’s injured players, Jimmy and I took the injury report up to the head coach. He had to know who was okay, who might need X-ray studies, who needed surgery, and who might not practice but would still be able to play on Sunday.”).

Because the visiting club’s doctor is often not licensed to practice in the state in which the club is playing, the home club’s doctor is responsible for the visiting player’s care.



during the preseason but otherwise are unlikely to communicate with club executives during the season.

St. Louis Rams club doctor and former President of the NFL Physicians Society Matthew Matava maintains that a club's on-field success bears no relation to the club doctor's obligations or status with the club:

Physician jobs are not dependent on wins and losses . . . I've survived 1–15, 2–14 and 3–13 seasons with the Rams. We can go 0–16, and my job does not change one iota . . . Obviously we know that we want to have the guys back on the field as quickly as they can be in a safe fashion—and we can be creative in the ways we do so—but there are no competitive issues involved in our decision to return to play.^{214,am}

Nevertheless, it is possible that these pressures have subtle influences that even the doctors do not themselves fully recognize. This would not be surprising as the existing literature on conflicts of interest in the medical sphere emphasizes that many doctors are influenced by incentives and other forms of judgment distortion, while strictly denying this to be the case—peoples' judgments are often compromised by conflicts they fail to recognize in themselves.²¹⁵ We discuss the problems with structural conflicts of interest in the club doctor role and our recommendations in greater depth below.

6) RELATIONSHIPS WITH PLAYERS

As discussed above, players and club doctors have regular but minimal interaction as compared to athletic trainers. Players typically only see the club doctors if they are currently being treated for an injury, in which case they might see the club doctor a few times a week. However, players typically only see the club doctor if the athletic trainer has determined the injury to be serious enough to require the club doctor's involvement. Athletic trainers are the players' first line of medical care and almost all interactions with the club doctor are facilitated through the athletic trainer.

Among the players and contract advisors we interviewed, there was a general consensus that the care provided by club doctors has gradually improved in recent years. Current Player 3 said that “team doctors for the most part . . . do a good job.” Current Players 7, 8 and 10 also thought their club doctors provide good care. As one contract advisor stated, “I think that team doctors more than ever are understanding that they're an advocate for the player more

than they are an advocate for the team.” Another contract advisor explained one reason why he believes the care has improved: “It seems to me that because of the high level of scrutiny involved in the concussion melodrama and drama that's occurred over the past years that there is now some sense . . . on the part of the trainers and the medical staff, there is extreme pressure on them to not mess it up.” Other people we interviewed confirmed that increased scrutiny about these issues, including from the NFLPA, has likely led club doctors to be more careful about their practices.

Trust is also an important factor in the relationship between club medical staff and players. A 2016 *Associated Press* survey of 100 current NFL players addressed this issue. The survey asked players whether “NFL teams, coaches and team doctors have players' best interests in mind when it comes to injuries and player health.”²¹⁶ 47 players answered yes, 39 answered no, and 14 players were either unsure or refused to respond.^{217,an}

We also interviewed several former and current players to get a better understanding about NFL player health issues.^{ao} It is important to note that that these interviews were intended to be illustrative but certainly not representative of all players' views and should be read with that limitation in mind. The players we spoke to generally indicated that the current structure of club medical staff often caused players to distrust club doctors, although this feeling is not universal:

- **Current Player 1:** *“I do trust our team doctors. Any time that I've dealt with them, they've been very upfront with me and gave me all the information I needed about my injuries. I never got the impression that they were hiding anything from me or putting me into a dangerous situation.”^{ap}*

an The study also found discrepancies in the responses based on the player's experience level. Of the 34 players interviewed who had between 1 and 3 years of experience, 71 percent answered “yes.” Of the 66 players interviewed who had 4 or more years of experience, only 35 percent answered “yes.”

ao The protocols for the interviews were reviewed and approved by a Harvard University Institutional Review Board and consisted of approximately 30-minute interviews with 10 players active during the 2015 season and 3 players who recently left the NFL (the players' last seasons were 2010, 2012, and 2012 respectively). The players interviewed were part of a convenience sample identified through a variety of methods—some were interested in The Football Players Health Study more generally, some we engaged through our Law & Ethics Advisory Panel and Football Players Health Study Player Advisors, and some interviews were facilitated by a former player now working for the NFLPA. The players interviewed had played a mean of 7.5 seasons, with a range of 2 to 15 seasons, and for a mean of between 3 and 4 different clubs, with a range of 1 to 10 clubs. In addition, we interviewed players from multiple positions: one quarterback; two fullbacks; one tight end; three offensive linemen; two linebackers; one defensive end; two safeties; and, a special teams player. We aimed for a racially diverse set of players to be interviewed: seven were white and six were African American. Finally, the players also represented a range of skill levels, with both backups and starters, including four players who had been named to at least one Pro Bowl team.

ap It is worth noting that Current Player 1 had only two years of experience in the NFL, and several other current players explained that players become wiser, and thus less trusting, as they get older. Nevertheless, Current Player 10 had played 10 seasons in the NFL and believed he received good care from the club doctors: “[G]enerally, I think I'd go with team doctors if I'm going to do certain surgeries.”

am In reviewing this Report, a representative of the National Athletic Trainers Association stated that “I agree that some physicians possibly g[e]t caught up in the business decision rather than the best practices for proper medical care of the athletes.”

- **Current Player 2:** *“I certainly think that there are a number of players that do not trust club doctors, and for various reasons. They feel as though those doctors work for the team and they do what’s in the best interests of (A) the coach, and (B), ownership. And I think that a lot of times players feel as though these doctors maybe don’t disclose the full extent of their injuries [and] give them a hard time about getting second opinions.”*
- **Current Player 3:** *“I think that there are some instances where they don’t trust the team doctors because they don’t like the team, and the team doctor just wants them to get back on the field . . . I think sometimes the doctors may . . . not tell you the full extent of what’s going on . . . about a certain injury. [But] I think there is sometimes team doctors where the players trust them and the doctors are great and very trustworthy.”^{aq}*
- **Current Player 4:** *“I do not trust team doctors. I’ve had multiple occasions where I’ve had a team doctor tell me one thing and then I go and have a second opinion and I get a completely different answer . . . [T]he club doctor has the same mentality as the club itself. More than anything, they want a player on the field . . . I feel like the team doctor only has the best interest of the team in mind and not necessarily the player.”*
- **Current Player 5:** *“My trust level with [my former club doctor] was very high. I know a lot of guys respected him. But I know there was a number of guys that had disagreements with him . . . But I think generally the guys that have a problem with the doctors are guys that have had some sort of injury that affects their career and their ability to make money and support themselves and their families.”*
- **Current Player 7:** *“[T]hey’re doing and saying what’s best to get you back on the field as soon as possible.”*
- **Current Player 8:** *“I don’t feel like they are diagnosing, or at least treating us like they would want to be treated or how they would treat their kids . . . [T]hey’re going to lean towards what keeps you on the field.”*
- **Current Player 9:** *“I’ve seen times when the medical staff has lied about injuries.”*
- **Current Player 10:** *“I’ve always had good relationships and good positive vibes from the doctors that have been out on the field . . . I think players trust them, I think the agents don’t.”*

^{aq} Current Player 3 also stated as follows: “Sometimes they want you out there and they want to see if you can push through certain pain if the doctor feels like, okay, it’s not going to get any worse if you play. You just have to deal with the pain. Can you push through that pain? I think sometimes they want to see those types of things.”

- **Former Player 2:** *“[T]hese doctors are good. I wouldn’t say they are great. You know, at the end of the day . . . the organizations are paying the doctors . . . I would say probably 65 percent of the team trusts the doctor and probably 35 percent of the team does not.”^{ar}*
- **Former Player 3:** *“My experience has always been very positive . . . I know that players are told, or maybe just a little bit skeptical or suspicious of docs, thinking that they have the team’s interest in mind first before the player’s, but I never had an experience where I thought that was the case.”*

In addition, comments from Calvin Johnson, a perennial Pro Bowl wide receiver who retired in 2016 after nine seasons, are also informative:

The team doctor, the team trainers, they work for the team. And I love them, you know. . . . They’re some good people. They want to see you do good. But at the same time, they work for the team. They’re trying to do whatever they can to get you back on the field and make your team look good.²¹⁸

On this point, Contract Advisor 4 even stated that when assessing a player’s injury, “the club doctor has nothing to do with it . . . the club doctor’s input means nothing to us.”^{as} Moreover, players seem to be increasingly aware of the potential conflicts of interest club doctors face in treating players.^{at} For example, many question whether club doctors are telling players everything they are telling coaches or other club employees, despite an obligation to do so in the CBA.²¹⁹ In addition, players are aware of the value club doctors receive in being associated with the club; as one former player said, “I know they can go out making tremendous amounts of money . . . having that team name next to their practice.”

To be sure, not all share this view of the relationship between players and club doctors, and of course, as we acknowledge, the situation varies across clubs and over time. For example, during his time as an NFL executive, peer reviewer Andrew Brandt believes that the club doctors with whom he worked “always put the player’s best interests first, erring on the side of caution in treatment.” At the

^{ar} Former Player 2 also said he believes getting the job as club doctor “is more about who you know than what you know.”

^{as} Contract Advisor 4: “[T]he team doctor is there to advise the team on how they should approach a player. The team doctor has nothing to do as far as I’m concerned with how the player should approach his own health . . . The team doctor is a medical advisor to the team.”

^{at} Contract Advisor 5: “[T]he younger generation of players absolutely, unequivocally do not trust [the club doctors].” Contract Advisor 6 similarly described the level of trust between players and club doctors as “close to zero.”

same time, Brandt indicated his belief that this was not the case with at least some NFL clubs.²²⁰

Several players told us that players often hide injuries from club medical staff.^{au} They told us that players generally believe that there is no confidentiality between them and the medical staff and that the medical staff would regularly, if not immediately, inform coaches and executives about the injury status of players, which has the potential of negatively affecting the player's status with the club. Former Player 1:

[C]ertainly not like a modern doctor-patient relationship where confidentiality is expected. That's never going to happen . . . [U]ltimately, they had to do their jobs and they had to disclose everything to the higher ups and to the decision makers . . . they're writing down every single little thing that you do and what happened, everything that you tell him. The first thing they're doing is sending that email or making the phone call up to the top and telling them what's going on with this guy and there's no doubt about what their motives and their intentions are, and I know a lot of it is job security and it's just part of the business, but, and you know at the end of the day, regardless of how they came across, they were all pretty much doing the same thing, just some went about it in maybe a better fashion.^{av}

As discussed above, these impressions are likely correct, as players sign waivers permitting the club medical staff to share their health information with other club employees.

An additional important aspect of the player-club doctor relationship is the club doctor's cooperation with the player obtaining a second opinion, which is discussed at length in Chapter 4: Second Opinion Doctors.

Some players expressed more concerns about athletic trainers' practices as compared to club doctors.^{aw} Athletic trainers spend significantly more time with players and

are directly employed by the club, whereas club doctors are generally independent contractors. One current player described multiple incidents in which an athletic trainer did not disclose a player's actual diagnosis (in one case a fracture and a torn ligament in another), only to have the diagnosis revealed later by the club doctor.^{ax} The same player also indicated that he believes athletic trainers are pressured by the club and coaches to have players on the field.

(G) Enforcement of Legal and Ethical Obligations^{ay}

The 2011 CBA provides three options for players dissatisfied with the care provided by an NFL club doctor. Nevertheless, as is explained in greater depth below, these options provide remedies that do not seem adequate.

First, a player could submit a complaint to the Accountability and Care Committee (ACC). The ACC consists of the NFL Commissioner (or his designee), the NFLPA Executive Director (or his designee), and six additional members "experienced in fields relevant to health care for professional athletes," three of whom are appointed by the Commissioner and three by the NFLPA Executive Director.²²¹ According to the NFL, the ACC then investigates the matter and submits a report to the NFL and/or the club.²²² According to the CBA, "the complaint shall be referred to the League and the player's Club, which together shall determine an appropriate response or corrective action if found to be reasonable. The Committee shall be informed of any response or corrective action."²²³

There is thus no neutral adjudicatory process for addressing the player's claim or compensating the player for any wrong suffered. The remedial process is left entirely in the hands of the NFL and the club. It is questionable whether either has an adequate incentive to find that a club doctor acted inappropriately and to compensate the injured player in any way.

Second, a player could request the NFLPA to commence an investigation before the Joint Committee on Player Safety and Welfare (Joint Committee). The Joint Committee consists of three representatives chosen by the NFL and three

au Current Player 5: "[G]uys might have existing injuries . . . and they try to keep that hidden and fear that they might not be given the opportunity to show that they can still play with the injury. I think some guys are on a team and you have a history of a certain injury and it starts acting up again. You don't want to be labeled as a chronic whatever injury. So, you might want to try to treat that on your own and conceal it from the team." Current Player 7: "[W]hen you know something's worse, and you want to keep playing, you kind of look out for yourself in a sense. Okay, if I tell them all this, I can't play. So let me see if I can get through it, and I'll tell them what it is minimal." However, as discussed in Chapter 1: Players, players do have an obligation under the CBA and their contract to advise the club medical staff of their condition at certain times.

av Current Player 2: "I think the only reason that guys usually don't disclose injuries is from fear of losing their job."

aw Current Player 1: "[P]layers do trust the doctors. But I think it's more the trainers that they don't trust as much."

ax The same player complained that the athletic training staff uses outdated treatment methods, effectively using ice and electrical stimulation regardless of the injury. The player indicated that, as a result, players are less likely to report injuries so they do not have to report to practice early to undergo a minimally effective treatment they could perform at home.

ay Appendix K is a summary of players' options to enforce legal and ethical obligations against the stakeholders discussed in this Report. In addition, for rights articulated under either the CBA or other NFL policy, the NFLPA and the NFL can also seek to enforce them on players' behalves.

chosen by the NFLPA.²²⁴ “The NFLPA shall have the right to commence an investigation before the Joint Committee if the NFLPA believes that the medical care of a team is not adequately taking care of player safety. Within 60 days of the initiation of an investigation, two or more neutral physicians will be selected to investigate and report to the Joint Committee on the situation. The neutral physicians shall issue a written report within 60 days of their selection, and their recommendations as to what steps shall be taken to address and correct any issues shall be acted upon by the Joint Committee.”²²⁵

This remedial option faces significant limitations. While a complaint to the Joint Committee results in a neutral review process, the scope of that review process’ authority is vague. The Joint Committee is obligated to act upon the recommendations of the neutral physicians, but it is unclear what it means for the Joint Committee to “act” and there is nothing obligating the NFL or any club to abide by the neutral physicians’ or Joint Committee’s recommendations. Moreover, there is no indication that the neutral physicians or Joint Committee could award damages to an injured player.

In 2012, the NFLPA commenced the first and only Joint Committee investigation.²²⁶ The nature and results of that investigation are confidential per an agreement between the NFL and NFLPA,²²⁷ and we have therefore been unable to evaluate its adequacy.

As a third remedial option, a player could commence a Non-Injury Grievance.^{az} The 2011 CBA directs certain disputes to designated arbitration mechanisms^{ba} and directs the remainder of any disputes involving the CBA, a player contract, NFL rules, or generally the terms and conditions of employment to the Non-Injury Grievance arbitration process.²²⁸ Importantly, Non-Injury Grievances provide players with the benefit of a neutral arbitration and the

possibility of a “money award.”²²⁹ It is worth emphasizing that in theory a player could bring a Non-Injury Grievance alleging the doctor violated ethical rules. Section 1(c) of Article 39 of the 2011 CBA requires all club medical personnel to “comply with all federal, state, and local requirements, including all ethical rules and standards established by any applicable government and/or authority that regulates or governs the medical profession in the Club’s city.” And Section 1 of Article 43 permits players to bring Non-Injury Grievances concerning any provision of the CBA. Thus, if a club doctor were to violate an ethical rule, he would also be violating Article 39, Section 1(c). Which ethical rules apply has never been litigated and would likely have to be determined by the arbitrator.

There are, though, several important limitations on Non-Injury Grievances.

First, in cases where the club doctor is an employee of the club—as opposed to an independent contractor as is the case for most club doctors—a player’s claim against the doctor might be barred by the relevant state’s workers’ compensation statute. Workers’ compensation statutes provide compensation for workers injured at work and thus generally preclude claims against co-workers based on the co-workers’ negligence.^{230,bb} This has been the result in multiple lawsuits brought by NFL players against clubs and club doctors.²³¹ Some states follow the “dual capacity doctrine,” which allows medical malpractice lawsuits to proceed against a doctor who is also a co-employee based on the doctor having two different relationships with the allegedly injured co-employee.²³² Nevertheless, as only two current NFL club doctors are employees as opposed to independent contractors, this doctrine is less of an issue.

Second, club doctors are not parties to the CBA and thus likely cannot be the respondent in a Non-Injury Grievance for violations of the CBA.²³³ Instead, the player could seek to hold the club responsible for the club doctor’s violation of the CBA.²³⁴

Third, Non-Injury Grievances must be filed within 50 days “from the date of the occurrence or non-occurrence upon which the grievance is based,”²³⁵ a timeframe that is difficult to meet. This is a relatively short window for players to seek relief, especially during the season. Indeed, several players have commenced arbitrations against clubs (but not doctors) concerning medical care but those claims have often been denied as outside the CBA’s statute of limitations, as discussed in Chapter 8: NFL Clubs.

az The term “Non-Injury Grievance” is something of a misnomer. The CBA differentiates between an Injury Grievance and a Non-Injury Grievance. An Injury Grievance is exclusively “a claim or complaint that, at the time a player’s NFL Player Contract or Practice Squad Player Contract was terminated by a Club, the player was physically unable to perform the services required of him by that contract because of an injury incurred in the performance of his services under that contract.” 2011 CBA, Art. 44, § 1. Generally, all other disputes (except System Arbitrations, *see* 2011 CBA, Art. 15) concerning the CBA or a player’s terms and conditions of employment are Non-Injury Grievances. 2011 CBA, Art. 43, § 1. Thus, there can be disputes concerning a player’s injury or medical care that are considered Non-Injury Grievances because they do not fit within the limited confines of an Injury Grievance.

ba For example, Injury Grievances, which occur when, at the time a player’s contract was terminated, the player claims he was physically unable to perform the services required of him because of a football-related injury, are heard by a specified Arbitration Panel. 2011 CBA, Art. 44. Additionally, issues concerning certain Sections of the CBA related to labor and antitrust issues, such as free agency and the salary cap, are within the exclusive scope of the System Arbitrator, 2011 CBA, Art. 15, currently University of Pennsylvania Law School Professor Stephen B. Burbank.

bb Importantly, whether the worker can recover for the injury in another way, such as by obtaining workers’ compensation benefits from the employer, is a different question.

Additionally, since the execution of the 2011 CBA, there have been no grievances concerning Article 39: Players' Rights to Medical Care and Treatment decided on the merits,²³⁶ suggesting either clubs are in compliance with Article 39 or the Article has not been sufficiently enforced.

Fourth, it is possible that under the 2011 CBA, the NFL could argue that complaints concerning medical care are designated elsewhere in the CBA and thus should not be heard by the Non-Injury Grievance arbitrator.^{237,bc}

And as a fifth limitation to Non-Injury Grievances, in practice, pursuing a grievance against a club doctor would likely end the player's career with that club, and potentially his career altogether.^{bd}

As a fourth remedial option, and one outside of the CBA process, players can attempt to bring civil lawsuits against NFL club doctors, principally asserting medical malpractice. However, the viability of such claims principally depends on the relationship between the club and the doctor. As discussed above, claims against doctors that are employees of the club are likely to be barred by workers' compensation statutes. By contrast, for suits against the majority of club doctors who are independent contractors, the CBA potentially presents the biggest obstacle against any medical malpractice claims. This is because the Labor Management Relations Act (LMRA)²³⁸ bars or "preempts" state common law^{be} claims, such as negligence, where the claim is "substantially dependent upon analysis of the terms" of a CBA, *i.e.*, where the claim is "inextricably intertwined with consideration of the terms of the" CBA."²³⁹ In order to assess a club doctor's duty to an NFL player—an essential element of a negligence claim such as medical malpractice—the court may have to refer to and analyze the terms of the CBA, *e.g.*, the club doctors' obligation, resulting in the claim's preemption.²⁴⁰ In these cases, player complaints must be resolved through the enforcement provisions provided by the CBA itself (*i.e.*, a Non-Injury Grievance against the club), rather than litigation. Thus, preemption may be a problem, although the matter is not crystal clear.

Lawsuits brought against clubs concerning medical care have generally been held to be preempted.²⁴¹ However, claims against doctors have found more success. To understand why, it is important to distinguish between claims brought prior to the 2011 CBA and those that might be brought under subsequent CBAs.

There have been no grievances concerning Article 39: Players' Rights to Medical Care and Treatment decided on the merits, suggesting either clubs are in compliance with Article 39 or the Article has not been sufficiently enforced.

Prior to 2011, the CBA was not particularly robust in its description of the doctors' obligations. Thus, the chances were reduced that courts would find the medical malpractice actions preempted by the CBA, since those actions were less likely to be held inextricably intertwined with the then-existing CBA. Indeed, in the *Jeffers v. Carolina Panthers* arbitration in 2008,²⁴² the NFL argued that "an action in tort for malpractice against a doctor should proceed in state court, while an action against a Club, arising from a duty or obligation imposed by the CBA, must be resolved by arbitration." The arbitrator agreed, stating "that claims based on allegations of malpractice by physicians or other medical care providers deemed to be independent contractors are not arbitrable."

Research revealed 13 fully adjudicated cases brought by NFL players (or their kin) against NFL club doctors, discussed in more detail in Appendix H. All of these cases were filed prior to the 2011 CBA which at least partially explains why the claims were not preempted. Nine of the cases resulted either in settlements or jury verdicts in the player's favor, with several recoveries exceeding \$1 million. In two cases, the claims were dismissed on the ground that the doctor was an employee of the club and workers' compensation laws bar claims against co-employees.²⁴³ Both categories include the *Stringer* case, in which claims against one doctor were settled while claims against two other doctors were dismissed. Finally, in one case, the doctor was found to have been not negligent,²⁴⁴ and, in another, a jury verdict was overturned by the judge.

bc Nevertheless, research has not revealed any arbitration decisions in which the NFL made this argument.

bd Current Player 8: "You don't have the gall to stand against your franchise and say 'They mistreated me.' . . . I, still today, going into my eighth year, am afraid to file a grievance, or do anything like that[.]" While it is illegal for an employer to retaliate against an employee for filing a grievance pursuant to a CBA, *N.L.R.B. v. City Disposal Systems Inc.*, 465 U.S. 822, 835–36 (1984), such litigation would involve substantial time and money for an uncertain outcome.

be Common law refers to "[t]he body of law derived from judicial decisions, rather than from statutes or constitutions." Black's Law Dictionary (9th ed. 2009). The concept of "preemption" is "[t]he principle (derived from the Supremacy Clause [of the Constitution]) that a federal law can supersede or supplant any inconsistent state law or regulation." *Id.*

The revisions to the 2011 CBA, and the new Article 39 in particular, increase the likelihood that medical malpractice actions against club doctors will now be held to be preempted. As discussed throughout this chapter, the 2011 CBA is fairly detailed in terms of club doctors' obligations to players, including an outlined standard of care. It is thus at least plausible that a court would find that analyzing a player's medical malpractice claim against a club doctor would be "inextricably intertwined with consideration of the terms of the CBA" and thus preempted. However, research has not revealed any player who has sued a club doctor for medical malpractice concerning events that took place after the execution of the 2011 CBA.

The revisions to the 2011 CBA, the new Article 39 in particular, increase the likelihood that medical malpractice actions against club doctors will now be held to be preempted.

Finally, during its review of this Report, the NFL informed us that the NFLPS "has designed and implemented a peer review process through which its membership could investigate and discipline members."²⁴⁵ When we asked the NFLPS for more information on its peer review process, the NFLPS explained that it was created in 2014 pursuant to the Healthcare Quality Improvements Act (HQIA).²⁴⁶ The HQIA was enacted in 1986 to improve healthcare by promoting peer review in the medical setting by immunizing such processes from antitrust scrutiny, and creating a national database of actions taken during such peer review processes called the National Practitioner Data Bank (NPDB).²⁴⁷ Healthcare organizations can access the NPDB for consideration in making licensing, hiring, and credentialing decisions but the statute also declares that information reported to the NPDB is confidential.²⁴⁸ However, information that does not reveal the identity of someone is not considered confidential.²⁴⁹ Based on our understanding of the statute, we informed the NFLPS that our understanding was (1) that the remedial actions available as part of the NFLPS' peer review process would be limited to evaluating a club doctor's membership in the NFLPS, and (2) that the NFLPS could disclose to us de-identified aggregate data on the number of enforcement actions the NFLPS had taken under its peer review process.

The NFLPS declined to comment on our understanding of its peer review process. We then explained to NFLPS that it was our belief that the NFLPS has never taken any action under its peer review process and asked them to correct us if we were wrong. The NFLPS again declined to comment.

During its review the NFL also stated that it had "proposed enhancing the enforcement powers of [the NFLPS] by making membership in the NFLPS a prerequisite to serving on a Club's medical staff, but the NFLPA has rejected that proposal."²⁵⁰ According to the NFL, such a requirement "could also serve as a dispute resolution mechanism."²⁵¹ In response, the NFLPA stated that "[t]he NFL's proposal contained a number of issues that were not in the best interest of players, including empowering a group that is not party to the CBA. With or without NFLPA agreement, the NFL and Physician Society are able to establish membership requirements and enforce the same."²⁵² We also note that because the NFLPS has no process by which players can make complaints or have their grievances redressed, the NFL's proposal does not provide a meaningful enforcement mechanism for players.

These options exhaust the remedies that individual players can pursue against club doctors. On the other hand, there is also the potential for actions against the doctors by accreditation bodies—an action that can be initiated by any patient against any doctor. State licensing boards have their own regulations related to violations of ethical standards that may result in disciplinary action (*e.g.*, revoking a physician's license to practice medicine).²⁵³ Many state licensure boards codes of ethics reference or are substantially similar to the AMA Code.²⁵⁴ However, like the AMA Council on Ethical and Judicial Affairs (AMA Council), the state licensing boards have no authority to order compensation to a patient. Additionally, in the words of one of the preeminent authorities on American health law, "[m]ost boards do not have adequate staff to respond to the volume of complaints and to conduct extensive investigations of unprofessional conduct," leading consumer groups to complain about the industry's failure to self-regulate.²⁵⁵

In the event a doctor is accused of violating of the AMA Code, the AMA Council, in conjunction with the AMA President, has the power to appoint investigating juries and to institute disciplinary action against AMA members where appropriate.²⁵⁶ The AMA Council has the authority to "acquit, admonish, censure, or place on probation" the accused doctor or "expel him or her from AMA membership."²⁵⁷

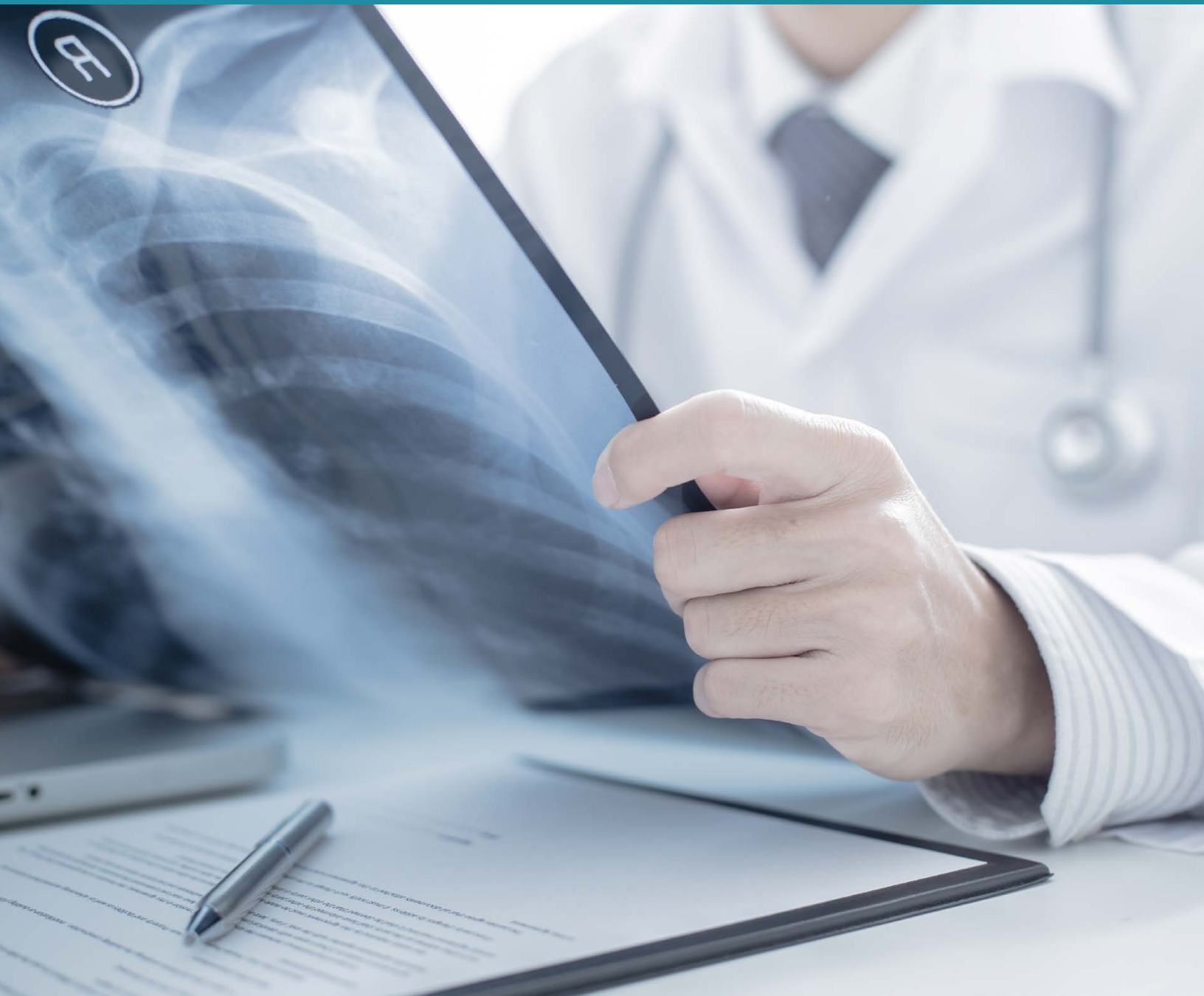
However, the AMA Council generally does not review complaints submitted by the general public because it believes it “is not in a position to investigate allegations of unprofessional or unethical conduct at the local level.”²⁵⁸ Instead, complaints referred to the AMA are usually forwarded by state medical societies and national medical societies. If the AMA Council decides the unethical conduct is “greater than local concern,”²⁵⁹ it may ask the AMA President to appoint an investigating jury to determine whether there is a probable cause of action. Finally, doctors do not need to be members of the AMA to practice medicine.

The AMA Code’s enforcement mechanisms are of little use as remediation to NFL players who received improper care from a team doctor. First, as discussed above, the AMA is unlikely to even review the player’s complaint. Second,

the AMA Code does not provide any method by which the injured patient can be compensated.

Finally, despite having a robust Code of Ethics, FIMS has no enforcement mechanism, other than the vague ability to revoke a doctor’s membership by a vote of two-thirds of its Council of Delegates.²⁶⁰

In summary, although it appears that players have a variety of opportunities to enforce club doctors’ legal and ethical obligations and obtain compensation, realistically, players are significantly limited by the short statute of limitations in the grievance process and by the potential preemption of claims by workers’ compensation statutes and the CBA. Moreover, the remaining options seem unlikely to provide a player with a meaningful remedy.



(H) Recommendations Concerning Club Doctors

Club doctors are clearly one of the most important stakeholders in protecting and promoting player health. Fortunately, evidence suggests that club doctors' relationships with and treatment of players has improved in recent years. Nevertheless, there are still many important ways in which club doctors' practices and the structure in which they operate can be improved. Our recommendations below seek to address these issues.^{bf}

Goal 1: To ensure that players receive the best healthcare possible from providers who are as free from conflicts of interest as possible.

Principles Advanced: Respect; Health Primacy; Empowered Autonomy; Transparency; Managing Conflicts of Interest; and, Justice.

The above-stated goal may seem obvious. Nevertheless, existing ethics codes and legal requirements are insufficient to satisfy the goal of ensuring that players receive healthcare they can trust from providers who are as free from conflicts of interest as is realistically possible. Of course, achieving this goal is legally, ethically, financially, and structurally complicated. We begin by discussing some of these complications before presenting our recommendation for how best to get there.

Club doctors are clearly fundamental to protecting and promoting player health. Yet given the various roles just described, it is evident that they face an inherent structural conflict of interest. This is not a moral judgment about them as competent professionals or devoted individuals, but rather a simple fact of the current organizational structure of their position in which they simultaneously perform at least two roles that are not necessarily compatible. On the one hand, they are hired by clubs to provide and supervise player medical care. As a result, they enter into a doctor-patient relationship with the players and have a legal and ethical responsibility to protect and promote the health of their player-patients, in line with players' interests as defined by the players themselves. This means providing care and medical advice aligned with player goals, and also working with players to help them make decisions about their own self-protection, including when they should play, rest, and potentially retire.

On the other hand, clubs engage doctors because medical information about and assessment of players is necessary to clubs' business decisions related to a player's ability to perform at a sufficiently high level in the short and long term. Additionally, clubs engage doctors to advance the clubs' interest in keeping their players healthy and helping them recover as fully and quickly as possible when they are injured. These dual roles for club doctors may sometimes conflict because players and clubs often have conflicting interests, but club doctors are called to serve both parties.

As discussed earlier in this chapter, in reviewing a draft of this Report, the NFL repeatedly analogized the NFL player healthcare model to other industries where employers provide healthcare for their employees. Again, however, the existence of conflicts in other industries does not excuse the conflict in the NFL setting.

While the practical impact of these conflicts in the NFL almost certainly varies from club to club depending on the club's approach to player health and the medical staff's autonomy, the conflict itself is unavoidable whenever the club doctor is expected to wear both hats, with simultaneous and sometimes conflicting obligations both to players and to clubs. A system that requires heroic moral and professional judgment in the face of a systemic structural conflict of interest is one that is bound to fail, even if there are individual doctors who manage to negotiate this conflict better than others. Moreover, even if a club doctor can successfully manage the conflicts, their mere existence can compromise player trust—a critical element of the doctor-patient relationship. That is why we describe the conflict of interest as inherent; the conflict is as rooted in the perceptions of others as it is in the decisions and actions of the conflicted party. Ultimately, it is the system that deserves blame, and thus, as will be discussed below, our recommendation is focused on improving that system.

^{bf} Additionally, because the roles of the various doctors with whom a player may consult are so intertwined, all recommendations made in Chapter 4: Second Opinion Doctors, Chapter 5: Neutral Doctors, and Chapter 6: Personal Doctors also can be applied to the club doctors.

Recommendations Concerning Club Doctors – continued

Additionally, there have been longstanding concerns about how club doctors are chosen, including the nature of the doctor's compensation (if any) and whether sponsorship^{bg} is involved (even if the sponsorship is part of a separate agreement).

The 2011 CBA appeared to remedy some of these concerns with the addition of the below provision:

[E]ach Club physician's primary duty in providing medical care shall be not to the Club but instead to the player-patient. This duty shall include traditional physician/patient confidentiality requirements. In addition, all Club physicians and medical personnel shall comply with all federal, state, and local requirements, including all ethical rules and standards established by any applicable government and/or other authority that regulates or governs the medical profession in the Club's city.²⁶¹

However, this provision, while seemingly well-intentioned, is flawed or insufficient in several respects, as discussed previously in this chapter.

First, on at least one reading, the provision limits the club doctor's obligations to put the player first only to those situations in which the doctor is "providing medical care." As discussed above, club doctors have obligations to the club that extend beyond "providing medical care," specifically helping the club make determinations about the short- and long-term usefulness^{bh} of a player. Thus, there are many situations in which the club doctor is not required by the above provision to put the player's interests first, because indeed he could not do so.

Second, the provision effectively acknowledges club doctors' divided loyalties when providing medical care by referencing the doctor's "primary" duty as opposed to "exclusive" duty. Clearly, the club doctor's secondary duty would be to the club, and the club's interests are therefore permissibly considered under the terms of this provision. By acknowledging that club doctors have divided loyalties, the provision cannot fully advance player health as a club doctor's primary concern.

Third, the confidentiality provision fails to account for relevant realities. As discussed above, employers are permitted to receive employee health information in many circumstances. Additionally, the club doctor could not simultaneously comply with "traditional physician/patient confidentiality requirements" and the doctor's obligations to advise the club about the health of a player. Finally, all players execute collectively bargained waivers before each season, permitting disclosure of their health information to the club. It is clear that in practice there is no confidentiality when it comes to medical information about players making its way to the club. Nevertheless, for these reasons and others that will be explained further below, the recommendations that we make also do not cloak player medical information in absolute confidentiality.

Finally, and most importantly, to the extent that the provision seeks to provide players with unconflicted healthcare, it falls short because it does not resolve the structural and institutional pressures club doctors face, whether implicitly or explicitly. So long as the club doctor is chosen, paid and reviewed by the club to both care for players and advise the club, the doctor will have, at a minimum, tacit pressures or subconscious desires to please the club by doing what is in the club's best interests.^{262,bi}

In addition, like the CBA provision discussed above, many of the Codes of Ethics that would appear relevant to club doctors appear insufficient when applied to actual scenarios club doctors face. For example, AMA Code Opinion 1.2.5 declares that, in a sports medicine setting, doctors must "base their judgment about an individual's participation solely on medical considerations,"²⁶³ when, in reality, we know players' concerns extend beyond their own health—and we are not prepared to say that this is inappropriate or unacceptable; indeed, it may be completely rational. Club doctors must take into account a player's other interests and goals and, at a certain point, our principle of Empowered Autonomy permits players to not follow a club doctor's recommendations. Similarly, the FIMS' Code of Ethics declares that "[t]he same

bg As described earlier in this chapter, the 2014 Medical Sponsorship Policy defines "Sponsorship Agreements" as "agreements with M[edical Service Provider]s involving the sale or license by the club of commercial assets such as naming rights, stadium signage, advertising inventory within club-controlled media, promotional inventory (e.g., day-of-game promotions), hospitality, and rights to use club trademarks for marketing and promotional purposes."

bh To speak of "usefulness" sounds somewhat dehumanizing. However, the term captures the cost-benefit approach to players that is at the heart of the determinations the clubs are making. To sugarcoat this reality would be to obfuscate.

bi Current Player 3: "I think when it comes down to it, who's paying you? . . . [A]s long as the teams are paying for [the doctors], they're going to have to answer to the team; they're going to have to answer to the coach; they're going to have to answer to the boss. That's who is writing their check."

Recommendations Concerning Club Doctors – continued

ethical principles that apply to the practice of medicine shall apply to sports medicine” but later declares that it is “essential” that athletes be informed about a doctor’s responsibilities to the club and that the player authorize the doctor to disclose “otherwise confidential medical information” to certain club officials “for the expressed purpose of determining the fitness of the athlete for participation.”²⁶⁴ Of course, this dual loyalty is not part of the usual practice of medicine, and so the same ethical principles cannot always apply.

Given the ethics of the doctor-patient relationship, it is clear that club doctors must never sacrifice player health in order to advance *club* interests, for example by recommending treatment that will get a player back on the field quickly but result in substantial harm to the player’s health in the short or long term. However, this is not to say that clubs do not have some legitimate interest in player health and player health information. Player health significantly affects the clubs’ ability to win and therefore the ultimate success of their business. Thus, we acknowledge that clubs must have access to information about player health and medical treatment, including sufficient information to assess whether a player should play. Similarly, clubs have a legitimate interest in understanding a player’s short- and long-term health prospects so it can make informed decisions about the player’s short- and long-term prospects of assisting the club. This is the stark reality of a business driven by physical prowess and ability, but we believe there are preferable mechanisms to acknowledge that reality while accounting for player interests than are offered by the existing system.

As we said above, finding a solution to these problems is not easy. Many commentators before us have recognized the problems at hand, including discussions about conflicts of interest and pressure from the club on club medical staff, player autonomy, and decisions about when a player can return to play.²⁶⁵ Some have also recommended solutions. For example, in a 1984 article, Dr. Thomas H. Murray, current President Emeritus of The Hastings Center, proposed four possible solutions for correcting conflicts of interest in sports medicine: (a) clarifying the nature of the relationship at the outset; (b) club doctors insisting on professional autonomy over the medical aspect of decisions; (c) insulating the club doctor “structurally from illegitimate pressures”; and, (d) professionalizing sports medicine.²⁶⁶ We agree that the first two proposals would help,^{bj} but do not believe they solve the structural conflict of interest that is at the root of the problem. The fourth proposal has seemingly largely come to fruition since the writing of Dr. Murray’s article. And finally, Dr. Murray’s third proposal provides support for our recommendation below.^{bk} Despite the foundational work of others, the problem has not been resolved. There is a spectrum of possible approaches, each with benefits and deficiencies. Below, we discuss some of the possibilities, several of which could be further dissected or combined, before reaching our ultimate recommendation.

- A. Maintain the status quo with increased reliance on personal and second opinion doctors:** Throughout the modern history of the NFL, players have increasingly obtained second opinions to compare against those provided by the club doctor,^{bl} and have also relied on their own personal doctors for care. Nevertheless, interviews we conducted with players and contract advisors indicated that seeking care from a personal doctor is a burdensome process that players are often reluctant to undertake.^{bm} It is far easier for players to simply receive healthcare at the club facility where they are already spending a considerable amount of their time than to seek out a personal doctor with an office off premises, and perhaps a less robust understanding of a player’s professional and physical challenges. This is especially true given how much players travel and move during, after, and between seasons. Consequently, many players, particularly the younger ones, continue to rely solely on the medical opinion of and care provided by the club doctor. It is thus uncertain how effective this approach would be. Moreover, it does not resolve the fact that club doctors would remain in a conflicted position.
- B. Maintain the status quo without the execution of confidentiality waivers:** As discussed above, players execute waivers (which have been collectively bargained between the NFL and NFLPA) permitting the club medical staff to disclose the player’s health information to the club, stripping players of certain protections provided for in relevant laws and ethical codes concerning confidentiality. Players could refuse to execute these waivers and effectively preclude the clubs from knowing the specifics of a player’s

bj Indeed, in Recommendation 2:1-I, we recommend that “club doctors’ roles should be clarified in a written document provided to the players before each season.”

bk In support of his third proposal, Dr. Murray cited a 1982 proposal from the NFLPA that club doctors be chosen jointly by the players and the clubs. See Bart Barnes, *Garvey: Players May Seek 65% of NFL Gross Income, NFLPA Will Seek Base Salary Scales*, Wash. Post, Nov. 25, 1981, available at 1981 WLNR 488341.

bl Players have the right to a second opinion doctor and the surgeon of their choice, the full cost of which must be paid by the club, provided the player consults with the club doctor and provides the club doctor with a report concerning treatment provided by the second opinion doctor. See 2011 CBA, Art. 39, § 4, § 5.

bm This issue is discussed further in Chapter 6: Personal Doctors.

Recommendations Concerning Club Doctors – continued

medical condition. However, it is unrealistic to expect players who are constantly under threat of having their contracts terminated to risk displeasing the club's management by taking this stand on their own; it would have to be a collective approach, supported by the NFLPA. More importantly, however, as discussed herein, employers are arguably entitled to at least some information about an employee's work-related health and the club would still likely at least be entitled to know whether the player was fit to play, which may actually entail quite a wide range of medical information. Thus, the player gains little by refusing to sign the waiver and, again, the institutional and financial pressures concerning medical care provided by the club doctor would remain.

- C. Pay club doctors from a fund to which the NFL and the NFLPA jointly contribute:** The fact that the club pays the doctor (even if only small amounts) to provide services, including treating the player—whose interests may be adverse to the club's—creates an undeniable conflict of interest. A structure whereby the club doctor is paid equally by the NFL and NFLPA has the potential to remove some of the implicit structural pressures that the club doctor might feel to act in the club's best interests. However, so long as the club doctor is still chosen and reviewed by the club, and is retained to simultaneously provide services to players and clubs, the doctor is still potentially under pressure to compromise the player's best interests in favor of the club's.
- D. Choose club doctors, and subject them to review and termination, through a committee of medical experts selected equally by the NFL and the NFLPA:**^{bn} The fact that club doctors are hired, paid and reviewed by the clubs presents the most foundational conflict. One way to avoid this problem is to incorporate the players into the club doctor hiring, review, and termination processes equally with the clubs themselves. A possible approach would be for the NFL and NFLPA to each select three members of a committee, and then have those six members select a seventh neutral member as chair; the committee would be responsible for selection, review, and potential replacement of the club physicians for each of the 32 clubs.^{bo} Additionally, this committee could be responsible for determining the doctor's compensation, taking into account the proposed rates by the doctors interested in the position and market rates in the club's city. The doctor's compensation would still be paid by the club.

Once selected, the doctor would be subject to periodic review (perhaps once during the season and again after the season) in which the interested parties have an opportunity to weigh in on the doctor's performance. This committee could also gather data on the performance of club doctors with the potential to enable the identification of "outliers" and take corrective action. If the committee determined that the doctor's performance was unsatisfactory taking into consideration all of the parties' needs, it should then also have the ability to terminate the doctor.

Adopting this kind of solution would reduce the pressure some club doctors may feel to please the club in their treatment decisions and information disclosure, since they would no longer be linked to only one of the relevant parties. In this way, adding another party might help resolve the conflict of interest we have identified. However, even under this approach, it would remain the case that club doctors would be responsible to provide services to both players and clubs, and that can create conflicting obligations.

- E. Bifurcate doctors' responsibilities between players and clubs:** To truly address the root problem of conflicting obligations, this approach contemplates having a doctor whose sole responsibility is to provide care to the players ("Players' Doctor") and another doctor whose sole responsibility is to evaluate the player's fitness to play and advise the club accordingly ("Club Evaluation Doctor"). This solution avoids the dual loyalty problem by creating two completely separate medical roles each with a single loyalty and a distinct set of responsibilities. Such a split has the potential to ensure that the player is receiving unconflicted medical care at all times, while still allowing the club to receive the guidance it needs. In order for the Club Evaluation Doctor to still be able to perform his or her job, however, he or she would need substantial access to the player and the player's medical information.

From the players' perspective, this proposal has the potential to provide them with care from a doctor who only has their best interests in mind, and for whom they can trust that to be the case. However, if the Players' Doctor were still being selected exclusively by the club, a conflict of interest remains. Additionally, the Club Evaluation Doctor may have a diminished capacity to provide an opinion as to whether the player is fit to play if he or she is not also treating the player personally, with all of the knowledge and understanding the treatment relationship entails.

^{bn} See Arthur L. Caplan & Lee H. Igel, *Chelsea Manager Jose Mourinho Shows Why Teams Shouldn't Hire Doctors*, *Forbes* (Aug. 14, 2015, 4:25 PM), <http://www.forbes.com/sites/leeigel/2015/08/14/chelsea-manager-jose-mourinho-shows-why-teams-shouldnt-hire-doctors/>, archived at <http://perma.cc/CR5D-BVU8> ("In no sport should teams be allowed to hire their own physicians. Each league should hire physicians for the clubs and franchises, with the physicians reporting to a chief medical officer based in the league's headquarters.")

^{bo} The NFL and NFLPA maintain a jointly compiled list of neutral doctors to assist in Injury Grievances, which might be a useful starting point. See 2011 CBA, Art. 44, § 5.

Recommendations Concerning Club Doctors – continued

Figure 2-C: Possible Approaches for Improving the NFL Player Healthcare Environment

| | |
|----------|--|
| A | Maintain the status quo with increased reliance on personal and second opinion doctors. |
| B | Maintain the status quo without the execution of confidentiality waivers. |
| C | Pay club doctors from a fund to which the NFL and the NFLPA jointly contribute. |
| D | Choose club doctors, and subject them to review and termination, through a committee of medical experts selected equally by the NFL and the NFLPA. |
| E | Bifurcate doctors' responsibilities between players and clubs. |

While several of the above scenarios offer improvements over the current situation, each also has deficiencies. Consequently, we believe our recommendation below is the one most likely to promote and protect player health. It combines two of the possible approaches above to achieve an optimal balance. That said, if our preferred recommendation is not adopted, serious consideration should be given to the others listed above, as any would be an improvement over the status quo.^{bp}

Recommendation 2:1-A: The current arrangement in which club (*i.e.*, “team”) medical staff, including doctors, athletic trainers, and others, have responsibilities both to players and to the club presents an inherent conflict of interest. To address this problem and help ensure that players receive medical care that is as free from conflict as possible, division of responsibilities between two distinct groups of medical professionals is needed. Player care and treatment should be provided by one set of medical professionals (called the “Players’ Medical Staff”), appointed by a joint committee with representation from both the NFL and NFLPA, and evaluation of players for business purposes should be done by separate medical personnel (the “Club Evaluation Doctor”).

^{bp} In theory it might be even more desirable to have different teams implement different recommendations, collect data, and then arrive at a more evidence-based recommendation for which possible approach is superior. In practice, though, we think the costs of administering those experiments, concerns about who would without conflict monitor and evaluate those experiments, and the costs of disuniformity for players in the meantime are too high to endorse that approach.

Recommendations Concerning Club Doctors – continued

This recommendation is an amalgamation of two of the possible approaches (D and E) discussed above. It is also important to remember that this recommendation encompasses athletic trainers as well, as discussed further in Chapter 3: Athletic Trainers, Section F: Recommendations. Here is how it would work.

As discussed earlier, the CBA requires clubs to retain several different types of doctors. Currently, the use of these doctors and their opinions are largely filtered through the head club doctor, who is the doctor that visits the club’s practices a few times a week, directs the athletic trainers, and otherwise generally leads the medical staff. This structure and process would largely remain, but with two important distinctions. Doctors and the other medical staff^{bq} for all of the clubs would: (1) be chosen, reviewed, and have their compensation determined by the joint committee of medical experts jointly selected by the NFL and NFLPA (Medical Committee) (but still paid by the club); and, (2) have as their principal obligation the treatment of players in accordance with prevailing and customary medical ethics standards and laws. For shorthand, we refer to the head doctor in this new role as the “Head Players’ Doctor” and to the collection of other doctors (and medical personnel mentioned earlier) as the “Players’ Medical Staff.”

In this role, the Head Players’ Doctor effectively replaces the individual currently known as the club doctor. In many respects, the daily responsibilities of the doctors and athletic trainers do not change under our proposed system. The key change, though, is for whom they now work—the players, as opposed to the clubs. The Head Players’ Doctor would be at practices and games for the treatment of players for the same amount of time as club doctors currently are and would also still be responsible for directing the work of the athletic trainers (also part of the Players’ Medical Staff). The Head Players’ Doctor—and the entire Players’ Medical Staff—would provide care and treatment to the players without any communications with or consideration given to the club, outside of our proposed “Player Health Report” detailed next. Moreover, the Head Players’ Doctor (with input from the player) controls the player’s level of participation in practices and games. Again, even though the Head Players’ Doctor would still be paid by the club, he or she would be selected, reviewed, and potentially terminated by the Medical Committee, thus avoiding a key source of conflict.^{br} Such a review should include a determination of whether the Head Players’ Doctor has abided by all relevant legal and ethical obligations (including the administration of prescription and painkilling medications) on top of an evaluation of their medical expertise.^{bs}

The value of this approach is demonstrated by the current existence of the Unaffiliated Neurotrauma Consultant as part of the Concussion Protocol. As discussed above, each club is assigned an Unaffiliated (*i.e.*, not affiliated with any club) Neurotrauma Consultant to help evaluate players for concussions during the game. In adopting this approach, the NFL and NFLPA have recognized and endorsed the importance of a player receiving healthcare free from actual or potential conflicts of interest. It is our view that player healthcare should be free of conflicts of interest at all times, not only during examination for a possible concussion. Thus, our recommendation employs a structure already in place for Unaffiliated Neurotrauma Consultants and seeks to apply it to more quotidian medical encounters.

To further understand our recommendation, we next review our proposed “Player Health Report”; the club’s access to player medical records; the remaining need for doctors to provide services to the clubs; and, possible objections to our recommendation from both player-centric and club-centric perspectives.

The Player Health Report

Under our recommendation, the club would be entitled to regular written reports from the Players’ Medical Staff about the status of any players currently receiving medical treatment (“Player Health Report”). Clubs—like many employers—have

bq At the beginning of Part 2, we explained there are many types of healthcare professionals that work with NFL clubs and players, including but not limited to physical therapists, massage therapists, chiropractors, dentists, nutritionists, and psychologists. We focus on doctors and athletic trainers because of their systematic and continuous relationship with the club and players. Nevertheless, all of these professionals would be a part of the Players’ Medical Staff we recommend.

br In reviewing this Report, the National Athletic Trainers Association expressed that “[a] coach should not be able to terminate a physician.”

bs One possible model for such evaluations come from The Joint Commission, a healthcare accreditation organization, which has in place processes for evaluating the care of doctors called the Ongoing Professional Practice Evaluation (“OPPE”) and Focused Professional Practice Evaluation (“FPPE”). See Robert A. Wise, *OPPE and FPPE: Tools to help make privileging decisions*, The Joint Comm’n (Aug. 21, 2013), http://www.jointcommission.org/jc_physician_blog/oppe_fppe_tools_privileging_decisions/, archived at <http://perma.cc/5BCR-3UBV>. This is only one potential model, others are possible, and we do not purport to dictate the specific protocols for these evaluations.

Recommendations Concerning Club Doctors – continued

a legitimate business interest (and indeed in many circumstances a legal right) to know about their employees' health insofar as it affects their ability to perform the essential functions of their jobs. The Player Health Report would serve this purpose by briefly describing: (1) the player's condition; (2) the player's permissible level of participation in practice and other club activities; (3) the player's current status for the next game (*e.g.*, out, doubtful, questionable, or probable);^{bt} (4) any limitations on the player's potential participation in the next game; and, (5) an estimation of when the player will be able to return to full participation in practice and games. The Player Health Report would be a summary form written for the lay coaches and club officials, as opposed to a detailed medical document. Generally speaking, we propose that the Player Health Reports be provided to the club before and after each practice and game. Additionally, the club would be entitled to a Player Health Report on days where there is no practice or game if a player has received medical care or testing. The Player Health Reports should also be made available to players as they are issued, perhaps through their electronic medical records. The Players' Medical Staff shall complete the Player Health Report in a good faith effort to permit the club to be properly prepared for its next game.^{bu}

Generating the Player Health Report is substantially similar to club doctors' current duties and requirements. Club doctors and athletic trainers regularly update the club on player health status and are also required to advise the player in writing of any information that the club doctor provides to the club concerning a player's condition "which significantly affects the player's performance or health."²⁶⁷ That player notification requirement would stand.

The important distinction, however, is that under this recommendation, the Players' Medical Staff's determination as to a player's status would control the player's level of participation in any practice or game, excepting the player's right to obtain a second opinion, as explained below.

As an initial matter, in creating the Player Health Report, it is important that the Head Players' Doctor take into consideration the player's desires and not strictly clinical criteria. Players, like all patients, are entitled to autonomy—the right to make their own choices concerning healthcare. Thus, if a player who is fully informed of the risks wishes to play through an injury, the Head Players' Doctor should take that into consideration in completing the Player Health Report and deciding whether the player can play. Nevertheless, players who have suffered concussions or other injuries that might affect the player's cognition at the time of decision-making should be given significantly less deference.^{bv}

If the Head Players' Doctor declares that a player cannot play but the player nonetheless wants to do so, the player could receive a second opinion. The logistics of when and how the player obtained the second opinion would need to be well coordinated; it would likely have to be a local doctor or practice group prepared to handle these situations for the players on short notice. If the second opinion doctor says the player can play, then the player should be allowed to decide if he wants to do so. Recognizing that players may shop for doctors who will clear them to play, it is our recommendation that the Medical Committee create a list of well-qualified and approved second opinion doctors for the players to consult. This compromise also helps resolve concerns that the Head Players' Doctor for one club might be overly conservative as compared to Head Players' Doctors for other clubs.

As will be explained further below, in the event a doctor hired by the club for the purposes of advising the club (*i.e.*, not a member of the Players' Medical Staff) needs clarification from the Head Players' Doctor concerning a player's status, such communication should be permitted, as determined to be reasonably necessary by the Head Players' Doctor. While it is expected that the Players' Athletic Trainers would help create the Player Health Report, non-emergency communications

bt These descriptions match the language historically used on NFL injury reports. However, prior to the 2016 season, the NFL removed the "probable" designation from the injury report and also restricted the use of the "out" designation until two days before the game. Tom Pelissero, *Major change to NFL's injury report will take some getting used to*, USA Today (Aug. 21, 2016, 4:33 PM), <http://www.usatoday.com/story/sports/nfl/2016/08/21/injury-report-probable-bill-belichick-patriots/89080582/>, archived at <https://perma.cc/QT4C-MAA6>. As discussed in Chapter 17: The Media, the injury report is generally meant to advise the opposing club of the status of a club's players, while also preventing the possibility of inside information to be used for gambling purposes. Those are different purposes than for which we have contemplated the Player Health Report, which is designed to advise the Club of the health status of its own players. Thus, we think the Player Health Report should be as descriptive as necessary, and does not need to track the language of the NFL's injury reports.

bu Additional logistics of the Player Health Report are detailed in Appendix G: Model Article 39 of the Collective Bargaining Agreement—Players' Medical Care and Treatment.

bv Our recommendation here does not change the Concussion Protocol with regard to the Unaffiliated Neurotrauma Consultant. Although the Unaffiliated Neurotrauma Consultant can help evaluate players for a concussion during the game, the club doctor's determination is controlling. In Recommendation 2:1-D, we separately recommend that the Unaffiliated Neurotrauma Consultant also be empowered to remove a player from a game.

Recommendations Concerning Club Doctors – continued

between the Club Evaluation Doctor (working solely on behalf of the club as explained below) and the Players' Medical Staff concerning player health should only be with the Head Players' Doctor. Beyond these minimal levels of communication, there should be no need for the Players' Medical Staff (doctors and athletic trainers) to communicate with any club employee, including a coach or general manager. By minimizing the communication in this way, and formalizing it, the goal is to minimize the club's ability to influence the medical care provided to the player, including more subtle forms of influence, *e.g.*, occasional workplace conversations. We say "minimize" because, as we discuss below, our recommendation does still allow for some communications between the Players' Medical Staff and the club. We think that this reduced level of communication is necessary and appropriate to protect player health, but nevertheless acknowledge that the existence of any such communications may cause a player to be less forthcoming to the medical staff, even if designated as the Players' Medical Staff as we recommend.

The above-described processes work well where the player's injury is pre-existing at the time of a practice or game. However, the situation is more complicated when the player suffers an injury during a practice or game. In such situations, the players' treatment clearly takes priority and it is impractical to create a Player Health Report to inform the club of the player's status. If a player suffers an injury during a practice or game, the Head Players' Doctor would retain substantial control over the player's participation, as the club doctor does under the current structure. To minimize communication between the Players' Medical Staff and club personnel, decisions about a player's practice or playing status should be communicated through the Club Evaluation Doctor, discussed below, where possible. It would be expected that the Club Evaluation Doctor would attend every game. However, given current customs, it is likely that the Club Evaluation Doctor would rarely attend practice. Consequently, if a player is injured during practice and the Players' Medical Staff is unable to relay the player's status to the club through the Club Evaluation Doctor, it is necessary and appropriate for the Players' Medical Staff to inform other club officials, including the coaches, about the player's status.

If at any time the Players' Medical Staff declares that the player cannot practice or play, through the Player Health Report or otherwise, the player cannot practice or play (except where the player has received clearance from a second opinion doctor as described above). If the club deviates from the limitations set forth by the Players' Medical Staff, the club should be subject to substantial fines or other discipline under the CBA. The club, of course, would retain the right to not play the player for any number of reasons, including injury or skill.

The Club's Access to Player Medical Records

Importantly, the Player Health Report is distinct from the player's medical records. The Player Health Report is a limited view of the player's current health and provides information on the player's immediate or near-immediate availability to the club. A player's complete medical record provides a fuller picture of the player's health and would provide additional information needed for assessing a player's long-term health, as well as a separate check on the assessment provided in the Player Health Report.

Under our recommendation, in addition to the Player Health Report, the club would also be entitled to the players' medical records, as is the case under the status quo. We reiterate the clubs' legitimate business need for a clear understanding of player health issues. Clubs would obviously and rightfully be interested in understanding a player's medical condition in both the short and long term. While some might believe that clubs should only be entitled to those medical records that are specifically relevant to football, in reality this is not a line that can easily be drawn. Clubs might believe that most of a player's medical issues, including both physical and mental health issues, are relevant to the player's status with the club. That said, as we discuss in a forthcoming article, there may be important legal restrictions on the request for and use of some of that information by an employer, including constraints imposed by the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act.²⁶⁸

Providing clubs access to players' medical records raises additional issues that must be clarified. Athletic trainers are the principal providers of medical care to players under the control of club doctors and also are generally responsible for completing the players' medical records. Athletic trainers would retain these roles but our important corresponding recommendation is that athletic trainers, like the Head Players' Doctor and Players' Medical Staff, be chosen and reviewed by the Medical Committee, and that their principal obligations be to treat the players in accordance with prevailing and

Recommendations Concerning Club Doctors – continued

customary legal and ethical standards. The athletic trainers would likely assist the Head Players’ Doctor in creating the Player Health Report but, like the Head Players’ Doctor, should have minimal, if any, other interaction with the coaches or other club officials.

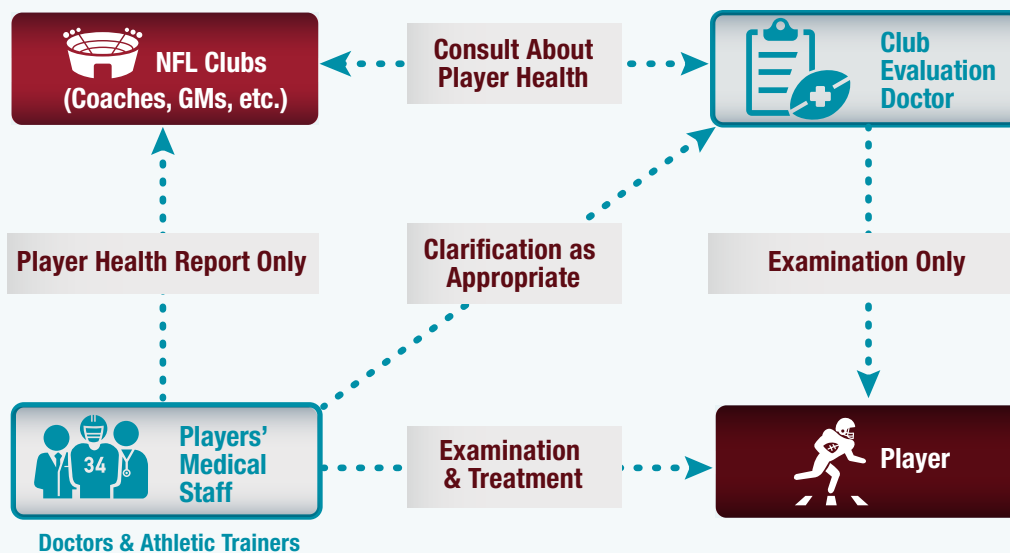
Club Evaluation Doctors

Under this new approach, clubs would be free to retain doctors and other medical professionals, as needed, who work solely for the clubs for the purposes of examining players and advising the club accordingly. These doctors, whom we call “Club Evaluation Doctors,” could perform the pre-employment examinations at the Combine, during the course of free agency, and also examine players during the season. However, they would not *treat* the players in any way. The Standard Player Contract’s requirement that players make themselves available for an examination by the club doctor upon request would largely remain. Additionally, the Club Evaluation Doctor would have the opportunity to review the players’ medical records at any time and communicate with the Head Players’ Doctor about the Player Health Report, if clarification is needed and appropriate. As is explained below, the Player Health Report should substantially minimize the need for duplicative medical examinations. This arrangement would thus permit a Club Evaluation Doctor to provide an opinion as to a player’s short- and long-term usefulness to the Club, without relying on the Players’ Medical Staff’s opinion.^{bw}

The Club Evaluation Doctor would be the only additional doctor required under our proposal. The number of other medical personnel would otherwise stay the same, but their loyalties would now be exclusively to the players.

Figure 2-D below shows the permissible forms of communication concerning player health under our proposal.

Figure 2-D: Permissible Communications Concerning Player Health



Possible Objections to our Recommendation

We understand and acknowledge potential concerns with this recommendation. As we evaluated the options, we sought the opinions of others, including several medical and sports medicine professionals. Indeed, some of the peer reviewers of the Report expressed concern about overly limiting communication between players’ medical staff and the club, resulting in our

^{bw} To avoid confusion between doctors providing care and performing fitness-for-duty evaluations, it may be appropriate for the doctors not providing care to have some kind of feature distinguishing them from the doctors providing care. See, e.g., Rebecca Dresser, *The Ubiquity and Utility of the Therapeutic Misconception*, 19 Soc. Phil. and Pol’y 271, 293 (2002) (recommending that doctors acting as researchers rather than clinicians wear red coats).

Recommendations Concerning Club Doctors – continued

decision to broaden the scope and frequency of permissible communications compared to our original position. On the other hand, some viewed the extent of communication that we allow as too substantial. In this regard, we note that outside of the context of professional sports, personal doctors do occasionally communicate with a patient’s employer in ways sanctioned by that patient (for example, providing information to justify sick leave). Thus, we believe that this final recommendation is the best way to serve the goal of providing players healthcare they can trust from providers who are as free from conflicts of interest as possible, while acknowledging the business realities facing clubs. We recognize that it may need further adjustment as implemented, though we maintain that it is feasible to do so, although perhaps a challenging transition.

Having described our recommendation for improving the structure of player healthcare, we now consider specific possible objections to this recommendation. First, we consider possible objections from a player-centric perspective, a view that might maintain that our recommendation is not sufficiently protective of player interests. Then, we will consider possible objections from a club-centric perspective, a view that might maintain that our recommendation is unworkable or unnecessary.

Possible Objections from a Player-Centric Perspective

We consider five objections from a player-centric perspective.

First, some may question why we have not advocated for a *complete* bifurcation of roles, where there is one set of doctors that provides players with care and has no relationship or communication with the club whatsoever, and another set that provides advisory services to the club, including performing medical examinations of players. In other words, why not extend our above recommendation to prohibit all communication (including the Player Health Report) between the Head Players’ Doctor and the Club Evaluation Doctor? The answer is that we believe such a proposal would not be practical for several reasons: (a) prohibiting all communication between the doctor caring for the player and the club will require the club to perform its own independent assessment of the player for every condition, likely subjecting many players to duplicative examinations, a costly and inefficient process (our Player Health Report minimizes this problem by allowing some flow of information and communication); (b) as discussed earlier, we believe clubs have a legitimate right to a player’s health information and status insofar as it potentially affects his ability to play; and, (c) to the extent clubs would receive information about a player’s health from the player himself, this imposes an unnecessary burden on the players and creates the risk of miscommunication and lost information. Additionally, there are also questions about whether players would adequately track and seek reimbursement for out-of-pocket healthcare expenses.

Second, some may object that our recommendation does not completely eliminate the confidentiality concerns that exist under the current model because the club would still receive medical information concerning players. This objection is true, and it may cause players to still refrain from full disclosure of their ailments to the Players’ Medical Staff. However, despite this confidentiality concern, we anticipate that having a medical staff fully devoted to the players’ interests will facilitate player trust that the care he is receiving has only his best interests—and not the club’s—in mind. Again, with regard to the passing of at least some information to the club, we think it is a necessary business reality.

Third, some might wonder whether it is preferable to have players select the members of the Medical Committee directly, rather than via the NFLPA. Such an approach would give the players more direct input into their medical care. However, in addition to the fact that the NFLPA is the players’ representative, it has experience in these types of neutral selection processes, as many are called for in the CBA (such as for the System Arbitrator, Non-Injury Grievance Arbitrator, and Benefits Arbitrator).²⁶⁹ Additionally, the NFLPA has more time to devote to the selection process, as well as any subsequent issues than players would. Finally, the benefit of developing institutional knowledge over time would be challenging for a player to gather during his career.

Fourth, some might also question why the NFL would be allowed any role in selection of Players Medical Staff, even if part of a balanced Medical Committee. The reason, again, is that clubs have legitimate business-related interests in the health of their players. While these interests likely sometimes conflict with a player’s interests, there is also an alignment of interests: one would generally expect that clubs have an interest in their players receiving the best possible healthcare, if for no other reason than to protect the clubs’ investment in its players. Indeed, clubs invest considerable sums in players

Recommendations Concerning Club Doctors – continued

and the business of the NFL. Moreover, clubs and the NFL already have substantial knowledge about the doctors well-qualified to provide healthcare to NFL players. Consequently, it is appropriate that the NFL be involved as a voice, but not a controlling interest, in the composition of the Medical Committee.

Fifth, some might disagree with the structure of our recommendation insofar as the Head Players' Doctor, Players' Medical Staff, and athletic trainers would all still be paid by the club. Some might believe that receiving a paycheck from the club could cause the Players' Medical Staff to (at least subconsciously) favor the club's interests. In the abstract, there is some merit to this point based on what we know about subtle conflicts of interest.²⁷⁰ However, the conflict here is not really the source of payment, but rather the locus of control over hiring and firing; having the Medical Committee hire and review the doctors and athletic trainers and determine their level of compensation^{bx} is sufficient to manage the structural conflict of interest, and assures that the Head Players' Doctor has every reason to be concerned only about the players' interests. Consequently, it does not seem necessary to introduce the logistical complexity of having a third party pay the Players' Medical Staff.

Possible Objections from a Club-Centric Perspective

We consider four objections that clubs might raise, before also addressing comments on our recommendation provided by both the NFL and the NFLPS.

First, they might object to having to retain in some capacity their own doctors and potentially additional specialists. Clubs currently typically pay for two levels of care: the primary care by the club doctor and then also a second opinion obtained by the player. Our proposed structure does create a potential third layer of medical examination, that of the Club Evaluation Doctor. Nevertheless, we disagree with this objection for several reasons: (1) first and foremost, our proposed structure is essential for players to receive minimally conflicted healthcare; (2) by providing a Head Players' Doctor entirely devoted to the player's interests, players should have an increased level of trust in their primary level of care, which can decrease the need for and cost of second opinions (though we recognize we may not conclusively know the effect on the bottom line until after the system is implemented);^{by} (3) clubs also benefit from our recommended arrangement by having a Club Evaluation Doctor who is entirely devoted to the club's interests; and, (4) at least under the current CBA, some of the costs of medical care, including physical examination costs, are at least partially paid for out of the players' share of revenue, *i.e.*, additional costs for player healthcare can decrease the amount of money available to players in salary.^{bz}

Second, clubs might object by pointing out that players already have access to their own doctors, second opinion doctors, and the surgeon of their choice. While this is true, the level of access to these alternative doctors as compared to the current club doctors is dramatically different. Considering the time demands placed on them by the club, travel schedules, and movement among clubs, it is far easier (and more realistic) for a player to receive his medical care at the club facility from the club doctor now, or from the Players' Medical Staff under our proposed arrangement. Additionally, players' personal doctors and second opinion doctors are not there on the sidelines of games when important medical decisions are often made. Finally, under our recommendation, the Head Players' Doctor would have control over whether a player plays, which is not an authority that a player's personal or second opinion doctor could have.

Third, clubs might believe that coaches and club executives need to be able to speak directly to the Players' Medical Staff to be able to properly understand a player's condition and limitations. We recognize this concern and that the proposed Player Health Report is a substantial departure from existing practices whereby athletic trainers communicate regularly with the coaches and general manager. Consequently, we understand that there will be resistance to change and legitimate logistical challenges in transitioning to a new set of protocols. Nevertheless, we believe that clubs can learn to adjust to a

bx The ways in which the Medical Committee determines the compensation of doctors and athletic trainers will likely need to consider antitrust laws.

by Players might also be more likely to view the Head Players' Doctor as their personal doctor, reducing the fragmentation of care that players currently receive. Also of note, the Visiting Team Medical Liaison, discussed earlier, would still be required under our recommendation to ensure compliance with local laws.

bz The current CBA describes what player healthcare costs are or are not considered Player Benefit Costs, *see* 2011 CBA, Art. 12, § 2, and thus count against the player's share of revenue: "Player medical costs (i.e., fees to doctors, hospitals, and other health care providers, and the drugs and other medical costs of supplies, for the treatment of player injuries) [are considered Player Benefit Costs], but . . . salaries of trainers or other Team personnel, or the cost of Team medical or training equipment" are not considered Player Benefit Costs. 2011 CBA, Art. 12, § 2(x). However, the CBA further states that "player medical costs shall include one-third of each Club's expenses for tape used on players and one-third of each Club's player physical examination costs for signed players[.]" *Id.* We thus recognize it would remain to be determined by the NFL and NFLPA whether the costs for the Club Evaluation Doctors would, like some of these other healthcare costs, be part of Player Benefit Costs, and count against the players' share of revenue.

Recommendations Concerning Club Doctors – continued

new structure—one that is necessary to ensure that players receive healthcare that is as unconflicted as realistically possible. Ultimately, the proposed Player Health Report, with the help of existing NFL club doctors and athletic trainers, can be crafted and implemented in such ways as to provide clubs with the information they need to evaluate a player’s fitness to play. Additionally, to the extent clubs believe they need additional clarification, the new Club Evaluation Doctor can communicate with the Head Players’ Doctor or athletic trainers, or examine a player directly, as appropriate.^{ca}

Fourth, clubs and club doctors might argue that our recommendation does not resolve all trust concerns between players and club medical staff, since the club would still be receiving player medical information. We acknowledge this fact. As a result, some players will probably still withhold information about their conditions at certain times, to avoid that information being relayed to the club. We do not believe there is any realistic system that could resolve this issue given the club’s business interest in player health. Yet, we believe that minimizing the structural conflict of interest by bifurcating the current club doctor role into two is a meaningful step forward in the player healthcare environment. Even if players are not always fully forthcoming, it is an improvement that they will know the care recommendations they receive from Players Medical Staff are as unconflicted as possible.

Moreover, we see no downside to our recommendation. It should impose little to no additional costs to the club and will not unreasonably delay the flow of any necessary information. Again, we welcome the involvement of the relevant stakeholders, such as the clubs and club medical staff, to resolve any logistical complexities. In the absence of a meaningful shortcoming, our recommendation offers an unquestionable improvement over the status quo.

We turn now to comments from the NFL and the NFLPS, which focus on objections to the concepts underlying the proposal. The NFL asserted that “[t]here has been no evidence of a ‘conflict of interest’ presented.”²⁷¹ Similarly, in a commentary provided by the NFLPS as part of a forthcoming Special Report of The Hastings Center Report, the NFLPS argued that the conflict of interest discussed here is merely “theoretical.” Moreover, both the NFL and NFLPS seem to take issue with what they regard as an unfair attack on highly qualified and ethical club doctors. We disagree with these viewpoints.

The existing literature on conflicts of interest in the medical sphere emphasizes that many doctors are influenced by incentives and other forms of judgment distortion while strictly denying this to be the case; judgments are often compromised by conflicts they fail to recognize in themselves.²⁷² Unfortunately, the NFL and the NFLPS failed to recognize that we took great care to explicitly state that the problem is structural and that we do not mean to place any fault at the feet of individual club doctors, or to denigrate the quality of care they currently provide. The NFL’s and the NFLPS’ refusal to recognize that there is an inherent conflict of interest contradicts an overwhelming body of literature on the issue.²⁷³

The NFL and the NFLPS dismiss the conflicts of interest at hand as not real, instead of acknowledging the structural nature of the problem. To see why this is erroneous, consider an analogy to the way in which structural conflicts of interest are avoided in organ donation. Both law and ethics require two separate care teams: one to care for dying patients and pronounce them dead, and one to conduct the transplant and care for the recipient.²⁷⁴ If a single medical team served both roles, it would face the structural problem of dual loyalty to both the dying patient and the patient in need of transplant, even though the interests of both parties may conflict—in particular, the donor has an interest in not being declared dead prematurely and the recipient has an interest in the donor’s death being declared quickly enough that the organs are not rendered unusable for transplant. Note that in the organ context, this bifurcation of roles is well-established and mandatory even if, for example, an individual doctor would swear that he or she is not influenced in declaring a donor’s death by the desire to get the patient an organ, and even though it would be impossible in any particular case to prove or disprove such influence. Moreover, anything short of eliminating such conflict completely would deeply undermine the public’s trust and peoples’ willingness to consider organ donation. In the NFL and NFLPS’ worldview, however, neither party would recognize the conflict of interest. Indeed, the NFLPS dismissed the conflict as “theoretical.” It simply strains credulity

^{ca} In addition to the above possible concerns, club doctors might also be concerned about how medical malpractice insurance might be affected by our recommendation. Information and data about current club doctors’ medical malpractice insurance arrangements and costs is not publicly available. Consequently, it is difficult to assess how our proposed recommendation might affect those arrangements and costs. However, we acknowledge that it is essential that concerns about insurance coverage or costs (as well as salary and any other monetary issues) do not prevent players from receiving treatment from the best possible medical practitioners, *i.e.*, that the best possible Head Players’ Doctors would not be scared off. Thus, while we are not in a position to conduct such an analysis, medical malpractice insurance and other financial issues must be considered alongside our recommendation.

Recommendations Concerning Club Doctors – continued

for the NFL and the NFLPS to suggest that club doctors, who are hired, reviewed, and terminated by the club, and who communicate with and advise the club regularly about player health matters, are not placed in a position that inherently creates a conflict of interest between the interests of the club and the interests of the player. This is the equivalent of asking a single doctor to simultaneously advance the interests of both the organ donor and organ recipient.

Finally, both the NFL and the NFLPS also take issue with the methodology and sample size of players we interviewed, arguing that it was insufficient to determine that there is a problem with the current structure of NFL player healthcare. We agree that the interviews cannot serve that purpose, but that is not why we conducted them. Importantly, it is our view that even if we had not engaged in *any* interviews at all, simply examining the structure of NFL clubs' medical staff would be sufficient for our analysis, as the structure itself presents a clear conflict of interest. Nevertheless, as explained in this Report, we interviewed 10 current players and 3 players who recently left the NFL as part of a convenience sample to add the lived experience of players in their own words, explicitly noting that these interviews were intended to be illustrative but not representative of all players' views. We also engaged in informal interviews and discussions with many other current and former NFL players about NFL player healthcare, as well as other important stakeholders with insight on this issue, including contract advisors, financial advisors, and family members. Again, without making claims that these discussions were representative, they support the belief that at least some players have qualms about their ability to trust club medical staff as a result of both the perception and reality of dual loyalty.

Finally, in Recommendation 7:1-D in Chapter 7: The NFL and NFLPA, we recommend that the NFL and NFLPA publicly release the latest empirical data on this subject.

* * *

Outside of the player- and club-centric perspectives, there might also be other concerns with our recommended approach. The Head Players' Doctor may be a fan of the club, or begin to idolize the players in some way, either of which could affect the care and advice provided to the player. This is an issue the Medical Committee would have to evaluate. Additionally, players can always hide their conditions in an effort to convince the Head Players' Doctor to permit them to play. Nevertheless, we believe this recommendation could substantially resolve the major concern about the current club doctor arrangement—*i.e.*, the problem of dual loyalty and structural conflict of interest—by providing players with a medical staff dedicated solely to the interests of the players. The Head Players' Doctor would be almost entirely separated from the club and the pressures implicit in being employed by the club, while being held accountable to a neutral Medical Committee. At the same time, this recommendation does not interfere with the clubs' legitimate interests. For these reasons, we believe that this recommendation is critical to improving player health and among the most important set forth in this Report. Accordingly, it and all of its intricacies should be set forth in the CBA.

Included as Appendix G is a model CBA provision setting forth our proposal here. In addition, this recommendation is the subject of a forthcoming Special Report from The Hastings Center Report. Included with the Special Report are commentaries from a diverse group of experts, including professors, bioethicists, a former player, a former player who is now a doctor, a current player who is also a medical student in the offseason, and the NFLPS.

* * *

What follows are additional recommendations concerning club doctors. *Some of these might not be necessary or would need be altered if Recommendation 1-A above were adopted.* Nevertheless, we make all recommendations we believe can improve player health under the current structures and set of practices, even if they would become partially redundant or inconsistent if other primary recommendations are adopted.

Recommendations Concerning Club Doctors – continued

Recommendation 2:1-B: The NFLPS should adopt a code of ethics.

Club doctors have many codes of ethics relevant to their practice. However, none of them are specific to their unique role as doctors for NFL clubs. Club doctors face a variety of complex situations that are not adequately contemplated or addressed by existing codes of ethics, most notably balancing their obligations to provide care to the player while also advising the club about players' health. A code of ethics adopted by NFLPS would supplement the club doctors' existing codes of ethics by providing guidance and tenets for the unique and competitive environment in which they must operate. Additionally, a clear code of ethics could help prevent ambiguous claims of malpractice and also foster transparency and trust in the doctor-player relationship. Importantly, the code of ethics should avoid vague aspirational language and seek to address specific situations with clear guidance and a meaningful enforcement mechanism. The code of ethics should address all of the issues discussed in this chapter, including but not limited to standards of medical care, obligations to the club, obligations in performing medical examinations on behalf of the club, handling the club doctor's dual roles, confidentiality of player medical information, player autonomy, disclosure of medical information to the player, and administration of painkillers and prescription medications. The 2013 Team Physician Consensus Statement, discussed earlier in this chapter, addresses many of these issues and would provide a useful starting point for an NFLPS code of ethics.

Finally, enforcement is essential. Violations of a professional code of ethics should include meaningful punishments, ranging from warnings and censures to fines and suspensions. In order to be effective, the enforcement and disciplinary schemes might need to be included in the CBA.

Recommendation 2:1-C: Every doctor retained by a club should be a member of the NFLPS.

While many (if not most) doctors retained by clubs are members of the NFLPS, the 2011 CBA's addition of the several different types of doctors required to be retained by clubs makes it likely that at least some doctors treating NFL players are not members of the NFLPS. In order for our recommendation that the NFLPS adopt a code of ethics to have an impact, the doctors treating players must be members of the NFLPS.

As mentioned earlier, the NFL wrote in its comments to this Report that it had "proposed that membership in the NFLPS be required for a physician to serve on a Club's medical staff to give the NFLPS enforcement authority over its membership, but that proposal was rejected by the NFLPA."²⁷⁵ The NFLPA countered by explaining that "[t]he NFL's proposal contained a number of issues that were not in the best interest of players, including empowering a group that is not party to the CBA. With or without NFLPA agreement, the NFL and Physician Society are able to establish membership requirements and enforce the same."²⁷⁶

Recommendation 2:1-D: The Concussion Protocol should be amended such that if either the club doctor or the Unaffiliated Neurotrauma Consultant diagnoses a player with a concussion, the player cannot return to the game.

The Concussion Protocol requires the presence of an Unaffiliated Neurotrauma Consultant to help identify and diagnose potential concussions. However, the Concussion Protocol also declares that "[t]he responsibility for the diagnosis of concussion and the decision to return a player to a game remains exclusively within the professional judgment of the Head Team Physician or the Team physician assigned to managing TBI." Thus, the possibility exists that even if the Unaffiliated Neurotrauma Consultant diagnoses a player with a concussion, if the club doctor does not, the player can return to play.

Recommendations Concerning Club Doctors – continued

While there is no evidence this scenario has taken place, the possibility that it could is unacceptable and unnecessary. If the Unaffiliated Neurotrauma Consultant is to have meaningful impact, he or she must have the same rights and duties concerning possible player concussions as the club doctor. If a player has been diagnosed by the Unaffiliated Neurotrauma Consultant with a concussion, he should not be able to return to play, regardless of what the club doctor believes. While we acknowledge that the club doctor is likely to have greater familiarity with the player and can thus better determine whether a player has suffered a concussion, this is a common sense protection that errs on the side of player health.

Recommendation 2:1-E: The NFL and NFLPA should reconsider whether waivers providing for the use and disclosure of player medical information should include mental health information.

In Appendices L and M we provide copies of the broad confidentiality waivers that all players execute at the request of their clubs. The first waiver authorizes the club, the NFL, and other parties to use and disclose the player’s “entire health or medical record” expressly including “all records and [protected health information] relating to any mental health treatment, therapy, and/or counseling, but expressly exclude[ing] psychotherapy notes.” The second waiver authorizes all of the players’ “healthcare providers,” including “mental health providers” to disclose player health information and records to the NFL, NFL clubs, and other parties.

These waivers are collectively bargained between the NFL and NFLPA but are nevertheless troubling. While we acknowledge, as discussed above in Recommendation 2:1-A, that clubs have a legitimate interest in player health information, mental health information is potentially different. As explained in Chapter 1: Players, players have strong reason to believe they are entitled to confidential mental healthcare because the NFL’s insurance plan explicitly states that the submission of claims by players or their family members for mental health, substance abuse, and other counseling services provided for under the insurance program “will not be made known to [the] Club, the NFL or the NFLPA.” This declaration suggests that the NFL and NFLPA have recognized a particular interest in enabling players to seek mental healthcare without fear that the club will terminate or otherwise alter their employment, thereby encouraging players to seek care. However, the breadth of the waivers executed by players undermines the promise of confidentiality. As a result, players may be reluctant to seek needed mental health treatment. To effectuate the goal of unencumbered access reflected in the insurance provisions, we recommend that the NFL and NFLPA re-assess whether the collectively bargained waivers executed by the players are overly broad.

Lastly, we note that while this recommendation is directed at the NFL and NFLPA, the content and issues surrounding these waivers were discussed in this chapter, and thus we thought this chapter was the best place for this recommendation.

Recommendation 2:1-F: Club doctors should abide by their CBA obligation to advise players of all information they disclose to club representatives concerning the players.

The CBA contains a requirement regarding this issue:

All Club physicians are required to disclose to a player any and all information about the player’s physical condition that the physician may from time to time provide to a coach or other Club representative, whether or not such information affects the player’s performance or health. If a Club physician advises a coach or other club representative of a player’s serious injury or career threatening physical condition which significantly affects the player’s performance or health, the physician will also advise the player in writing.²⁷⁷

Recommendations Concerning Club Doctors – continued

However, we have learned that in practice some players believe club doctors regularly disclose information to the club that is not disclosed to the player.^{cb} In addition, many players do not believe they are ever advised about their conditions in writing, despite the CBA's requirement. As a result, players may be unaware of the full extent of their medical conditions and also how the club might take adverse employment action against the player due to his medical condition. In particular, club doctors might not be providing players with a copy of medical evaluations that he or she has provided to the club. Players are entitled by the CBA and by their status as patients to this information. It is thus imperative that club doctors comply with the CBA and that the NFLPA enforce this provision against club doctors who do not. A standard form for these types of disclosures would help to ensure compliance with this CBA provision. In addition, to the extent these disclosures are not already recorded in a player's electronic medical record (EMR), they should be.

Recommendation 2:1-G: At any time prior to the player's employment with the club, the player should be advised in writing that the club doctor is performing a fitness-for-play evaluation on behalf of the club and is not providing any medical services to the player.

Players are often confused about whether club doctors are providing care for their benefit or for the club's. This confusion sows distrust, which interferes with the effectiveness of the doctor-player relationship. This confusion and distrust begins before players are even a member of the club, including at the NFL Combine where club doctors extensively examine players. To avoid confusion and to make sure everyone's role is properly understood, players should be advised that the doctor is working only on behalf of the club in such situations. The document should clarify the role and ethical obligations of doctors in that situation.

Recommendation 2:1-H: The NFL's Medical Sponsorship Policy should prohibit doctors or other medical service providers (MSPs) from providing consideration of any kind for the right to provide medical services to the club, exclusively or non-exclusively.

The Medical Sponsorship Policy appropriately prohibits clubs from trading the right to treat a club's players in exchange for sponsorship money. This prohibition prevents clubs from choosing an MSP based on which MSP is willing to spend the most in terms of endorsement money. However, the Policy does not address, and thus permits, the open sale of the rights to provide medical services to the club (but only on a non-exclusive basis). For example, an MSP could pay \$5 million for the right to treat the club's players (in addition to other MSPs). While the MSP might not obtain the right to use club trademarks or to post advertisements in the stadium, the MSP would generally be permitted to advertise the fact that it provides medical services to the club, a potentially significant reputation benefit. In reviewing a draft of this chapter, the NFLPS stated that no MSP currently pays for the right to provide medical services to players. Nevertheless, the incentive exists for MSPs to pay for the right to provide medical services, even if this not currently the practice.

If the incentive exists for MSPs to pay for the right to provide medical services, clubs would likely prefer to sell these services to the highest bidder.^{cc} This scenario again raises the problematic question of whether clubs might choose MSPs based on their qualifications or instead on the amount they are willing to pay. While the NFLPS says no MSPs are currently paying for the right to provide medical services, we know that the practice existed in the past. Consequently, it is possible that the practice could return or proliferate. To ensure that clubs are choosing MSPs based solely on whether or

cb Current Player 2: "I think that a lot of times players feel as though these doctors maybe disclose the full extent of their injuries." Current Player 3: "I think sometimes the doctors may . . . not tell you the full extent of what's going on . . . everything about a certain injury." Current Player 7: "We assume that if there's something [an injury], they [the medical staff] go and tell them [club officials]."

cc Current Player 6 believes his club recently changed MSPs because the MSP "wrote an open check and said, 'Whatever you need, we'll give you.'" Current Player 9 expressed similar concerns: "I've come to realize that [there are] certain medical organizations, hospitals, that will pay a fee to be the official medical care of certain teams because it helps them do well. So you're not necessarily getting the best treatment for a certain injury as far as the expertise of the medical professional."

Recommendations Concerning Club Doctors – continued

not they will do the best job in providing care to the players, it is appropriate to strictly prohibit MSPs from providing consideration of any kind—whether in the form of payment or free/discounted services—for the right to provide medical services to the club, exclusively or non-exclusively.

As discussed earlier, the NFL claims that the Medical Sponsorship Policy does prohibit MSPs from paying for the right to provide medical services and from offering discounted or free services. We disagree with the NFL’s reading. While the NFL may enforce the Medical Sponsorship Policy in such a way, we disagree that the plain text of the Policy prohibits such arrangements. In any event, it appears that the NFL agrees with us that the Policy *should* prohibit any club doctor from paying for the right to pay for the right to provide healthcare to players. If the Policy is intended to prohibit club doctors from paying for the right to provide medical services to players, the text of the Policy should be clarified.

Recommendation 2:1-I: Club doctors’ roles should be clarified in a written document provided to the players before each season.

As discussed throughout this chapter, club doctors play two roles: providing care to players; and, providing services to the club. When the players are under contract with the club, the club doctor is often performing both roles at the same time. Even if the club doctor is principally concerned with providing an injured player the best possible care, he cannot erase the player’s injury from his mind when discussing the health status of players with the athletic trainer or coaches during the season or helping the club determine whether to retain the player at season’s end. The overlap is unavoidable under the current system. Yet it causes confusion and distrust among the players that should be avoided.

Prior to the season, the club doctor should advise the players as to: (1) how often the club doctor communicates with the coaches and executives; (2) what information the club doctor communicates to the coaches and executives; (3) the doctor’s relationship to the athletic trainer with an explanation of the athletic trainer’s role; and, (4) the club’s access to player medical records. Beyond just the preseason, this distinction should be publicized more generally to ensure the players’ understanding. Finally, disclosing the club doctor’s compensation might also be appropriate.

While we recommend disclosure, we recognize it is not a complete solution given the social science research on the failures of mandated disclosure of conflicts of interest.²⁷⁸

Goal 2: To provide a fair and efficient process for resolving disputes between players and club doctors.

Principles Advanced: Respect; Collaboration and Engagement; and, Justice.

Recommendation 2:2-A: The NFL, NFLPA, and club doctors should consider requiring all claims concerning the medical care provided by a doctor who is a member of the NFLPS and is arranged for by the club to be subject to binding arbitration.

As discussed in Section G: Enforcement, there are challenges to adjudicating club doctors’ legal obligations to players. Arbitration is a favored dispute resolution system; it generally minimizes costs for all parties and leads to faster and more

Recommendations Concerning Club Doctors – continued

accurate resolutions of legal disputes.^{cd} The CBA contains many arbitration mechanisms for almost every reasonably possible scenario involving NFL players and almost always argues in court that a player's claims must be resolved through the CBA's arbitration mechanisms. The one exception appears to be the NFL's position that club doctors can be sued in court and not through arbitration.²⁷⁹ However, changes to the 2011 CBA likely increase the chances that a player's civil court claims would be preempted by the terms of the CBA and create confusion about players' rights and enforcement options. Moreover, because club doctors are not parties to the CBA, a Non-Injury Grievance against them would be unlikely to proceed. A robust arbitration process is the fairest and most efficient way of ensuring that players have the same legal rights as regular patients. It is our intention that such a system would provide players with roughly comparable remedies to those currently available to them in civil litigation, only now in a private and more efficient forum.

To the extent that the NFL is not comfortable constructing an entire medical malpractice arbitration infrastructure, including qualified arbitrators, it could use a third-party system. For example, JAMS, a worldwide leader in arbitration and mediation services, includes personal injury (including medical malpractice) as part of its services.²⁸⁰

We have recommended limiting this arbitral mechanism to NFLPS-member doctors for two reasons: (1) to create a more cohesive universe of doctors providing care to NFL players and who thus might obtain NFL-specific training or guidance and be subject to the code of ethics proposed above; and, (2) to facilitate the agreement to arbitrate. Club doctors are not signatories of the CBA and generally are not club employees, which prevents players from enforcing CBA provisions against them directly (as opposed to the club). The NFL and NFLPA would have to reach an agreement with NFLPS and its members to arbitrate medical malpractice claims. Additionally, the parties might consider requiring that all doctors who treat NFL players on behalf of a club be a member of NFLPS (which is also proposed above).

There are additional practical considerations worth mentioning. First, the arbitration mechanism should include a statute of limitations of 2 to 3 years, comparable to the statutes of many states. Second, the arbitration mechanism might require the submission of an affidavit of merit from another doctor attesting that the claim is meritorious, a common state statutory mechanism that permits doctors to obtain dismissal of medical malpractice cases at an early juncture. And third, the club doctors who are employees of the club as opposed to independent contractors might need additional consideration to agree to be a part of such an arrangement since, as employees of the club, workers' compensation laws generally bar lawsuits against them for the injuries of co-workers.

cd See Keith N. Hylton, *Agreements to Waive or to Arbitrate Legal Claims: An Economic Analysis*, 8 Sup. Ct. Econ. Rev. 209 (2000); Steven Shavell, *Alternative Dispute Resolution: An Economic Analysis*, 24 J. Legal Stud. 1 (1995). We recognize that arbitration also raises potential concerns for claimants, including the upfront costs of the arbitration and bias in favor of repeat parties, typically the defendant. See David Shieh, *Unintended Side Effects: Arbitration and the Deterrence of Medical Error*, 89 N.Y.U. L. Rev. 1806 (2014). However, these concerns are not present in arbitrations involving NFL players where the NFL and NFLPA (and not the player) generally bear the costs of the arbitration equally, the NFL and NFLPA are involved in nearly all of the arbitration proceedings and both generally retain the ability to remove arbitrators with whom they are dissatisfied.



(I) The Special Case of Medications

Like all of us, NFL players take a variety of medications to cure, mitigate, treat, or prevent a host of medical conditions. At the outset, it is important to explain what we mean by the umbrella term “medications.” Medications are also generally known as pharmaceuticals or drugs. As a legal term of art, a drug is defined under the Federal Food, Drug, and Cosmetic Act (FDCA) as:

(A) articles recognized in the official United States Pharmacopœia, official Homœopathic Pharmacopœia of the United States, or official National Formulary, or any supplement to any of them; and (B) articles intended for use in the diagnosis, cure, mitigation, treatment, or prevention of disease in man or other animals; and (C) articles (other than food) intended to affect the structure or any function of the body of man or other animals; and (D) articles intended for use as a component of any article specified in clause (A), (B), or (C).²⁸¹

While club doctors do still prescribe medications to players (as would be expected), prescriptions are filled in a regular, commercial pharmacy and delivered to the player, with appropriate notation in the player’s electronic medical record. According to the NFL, clubs no longer store or provide controlled substances to players.

Generally speaking, this section of the Report discusses drugs as defined in the FDCA. However, to avoid confusion with performance-enhancing drugs or recreational drugs (some of which are regulated by the FDCA and some of which are not), in this section we use the term “medications.”^{ce}

Medications are generally available in one of two ways: over-the-counter, *i.e.*, by ordinary retail purchase, without

the need for a prescription; or, through a prescription from a licensed and authorized medical professional. As will be discussed further below, certain medications meet additional criteria and are classified as “controlled substances” under the Controlled Substances Act (CSA).²⁸² Nevertheless, many prescription medications are not controlled substances and not all controlled substances are available through a prescription (heroin, for example).

The concept of “painkillers” is also important in the context of this discussion. “Painkillers” is a generalized term for those medications that help reduce or eliminate a person’s pain. Some painkillers are available as over-the-counter medications, while others are only available through a prescription. Additionally, some (but not all) painkillers are controlled substances.

Clearly there is a complex web of terminology and regulation. In this section we refer to medications generally and intend for the term to include over-the-counter medications, prescription medications, controlled substances, and painkillers. Where necessary, we will use more specific terminology.

We can now turn to the impetus for this section. In recent years, the use of medications in the NFL or by NFL players has received considerable attention. Several news reports indicate that many former NFL players have misused or abused medications. Indeed, there is ongoing litigation against the NFL concerning its medication practices, as discussed below. Moreover, there are many anecdotes of NFL clubs and club doctors having handled medications without the proper degree of care and caution. Fortunately, as will be explained, it appears the NFL’s practices in this regard have substantially improved. Most importantly, while club doctors do still prescribe medications to players (as would be expected), prescriptions are filled in a regular, commercial pharmacy and delivered to the player, with appropriate notation in the player’s electronic medical record.²⁸³ According to the NFL, clubs no longer store or provide controlled substances to players.²⁸⁴

While many of the concerns related to medication practices may be a problem of the past, the management of pain is a recurring problem for NFL players, and thus the use of medications, painkillers specifically, remains an issue that can have a profound impact on player health. Consequently, we discuss it here.

It is unclear both historically and currently how much players’ misuse or abuse of medications can be attributed to club doctors. In the past, clubs, through club doctors, provided and prescribed medications, including painkillers, but players could also obtain and abuse medications on their own (and without the club doctor’s knowledge). For

^{ce} Issues and policies concerning performance-enhancing drugs and recreational drugs are discussed in Chapter 7: The NFL and NFLPA.

this reason, this issue potentially fits into and could have been featured in several different chapters of this Report. However, because club doctors have many legal obligations concerning medications, we chose to include discussion of the special case of medications as part of this chapter.

As a final preliminary point, this section does not discuss at length the NFL-NFLPA Policy and Program on Substances of Abuse (Substance Abuse Policy), and the Policy on Performance-Enhancing Substances (PES Policy). These policies are discussed briefly in Chapter 7: The NFL and NFLPA, and analyzed at length in our forthcoming report *Comparing the Health-Related Policies and Practices of the NFL to Other Professional Sports Leagues*. While our research has not revealed any reliable data on the usage of recreational or performance-enhancing drugs by NFL players, some medications can fit into these categories. Further discussion on this point is discussed below.

1) BACKGROUND

NFL practices concerning medications appear to have substantially changed in recent years. Nevertheless, to fully understand the issue, we provide background and historical information about medication practices in the NFL.

Over the years, there have been references to a variety of medications being made readily available by NFL clubs and their medical staff to NFL players in “candy jar”-like fashion²⁸⁵ — meaning without a specific prescription or individualized access. Although the “candy jar” practice reportedly ceased during the late 1980s and 1990s,²⁸⁶ questions about the use of medications in the NFL persisted even recently.^{287,cf}

cf For example, in 2016, recently retired player and perennial Pro Bowler Calvin Johnson, who played from 2007 to 2015, explained his experiences with medications: “I guess my first half of my career before they really, you know, before they started looking over the whole industry, or the whole NFL, the doctors, the team doctors and trainers, they were giving them out like candy[.]” Des Bieler, *Calvin Johnson says painkillers were handed out ‘like candy’ to NFL players*, Wash. Post, July 6, 2016, <https://www.washingtonpost.com/news/early-lead/wp/2016/07/06/calvin-johnson-says-painkillers-were-handed-out-like-candy-to-nfl-players/>, archived at <https://perma.cc/H6HS-YVTM>. Additionally, in 2010, there were allegations that both the New Orleans Saints and San Diego Chargers medical staffs were not handling medications properly. The facts of the cases are complex and do not seem to reflect modern practices, thus we do not discuss the details here. For more information, see Glenn Guilbeau, *Geoff Santini Speaks Out On Saints’ Vicodin Case*, Shreveport Times (LA), May 12, 2010, <http://archive.shreveporttimes.com/article/20100512/SPORTS/5120317/Geoff-Santini-speaks-out-Saints-Vicodin-case>, archived at <http://perma.cc/LJE9-WTGR>; Sally Jenkins & Rick Maese, *Pain and Pain Management in NFL Spawn a Culture of Prescription Drug Use and Abuse*, Wash. Post, Sept. 6, 2013, available at 2013 WLNR 22243231; Brent Schrottenboer, *DEA: Chargers MD Wrote 108 Prescriptions to Self*, San Diego Union-Tribune, Jul. 15, 2010, available at 2010 WLNR 14315028; Sally Jenkins & Rick Maese, *NFL Medical Standards, Practices Are Different Than Almost Anywhere Else*, Wash. Post, Mar. 16, 2013, http://www.washingtonpost.com/sports/redskins/nfl-medical-standards-practices-are-different-than-almost-anywhere-else/2013/03/16/b8c170bc-8be8-11e2-9f54-f3fd70acad2_story.html, archived at <http://perma.cc/AJ9Y-EAGY>.

One important study that attempted to understand the scope of the issue with one particular painkilling medication was conducted by doctors from the United States Air Force and the Denver Broncos (called the “Tokish Study” for lead author, Dr. John Tokish).²⁸⁸ The Tokish Study sent questionnaires to every NFL club head doctor and head athletic trainer²⁸⁹ concerning the club’s use of ketorolac tromethamine, more commonly known by its brand name Toradol, during the 2000 season.

The Tokish Study described Toradol as “an effective NSAID [non-steroidal anti-inflammatory drug] for short-term relief of acute pain.” The Tokish Study was motivated by concerns raised by doctors concerning Toradol’s complications, “including renal failure and increased risk of bleeding.”²⁹⁰ The National Institutes of Health has also identified stroke, heart attack, ulcers, and holes in the stomach or intestine as potential risks of Toradol usage.²⁹¹

The Tokish Study found that in 2000:

- 28 out of the 30 clubs that responded used Toradol;
- Clubs that used Toradol treated an average of 15 players during the season, with a range of 2 to 35;
- 26 out of 28 clubs that responded used Toradol on the day of a game;
- 24 of 27 clubs responding⁹⁹ would allow a player as much as one injection per week throughout the season;
- 13 of 26 clubs responding found that Toradol reduced a player’s pain by 51 percent or greater;
- 13 of 26 clubs responding found that Toradol reduced a player’s pain by 50 percent or less; and,
- Only six clubs reported an adverse outcome related to Toradol usage during the season.

In sum, the Tokish Study concluded that “most team providers feel that ketorolac is safe when the team physician directs its use.” Nevertheless, Toradol has remained a subject of study and scrutiny, as discussed below.

One category of painkillers that has received substantial attention in this context (and others) is opioids. According to the Centers for Disease Control and Prevention:

Opioids are synthetic versions of opium. They have the ability to reduce pain but can also suppress breathing to a fatal degree when taken in excess. Examples of opioids are oxycodone

cg For reasons that are unclear, not all clubs responded to all questions.

(OxyContin), hydrocodone (Vicodin) and methadone. There has been at least a 10-fold increase in the medical use of opioid painkillers during the past 20 years because of a movement toward more aggressive management of pain. Because opioids cause euphoria, they have been associated increasingly with misuse and abuse.²⁹²

In 2010, Washington University School of Medicine, in a study funded by ESPN, sought to examine prescription opioid use among former NFL players (“Washington/ESPN Study”).²⁹³ The Washington/ESPN Study conducted 20-minute telephone interviews with 644 former NFL players who were members of what the study referred to as the “Retired NFL Football Players Association,”²⁹⁴ and retired between 1979 and 2006.

NFL practices concerning medications appear to have substantially changed in recent years.

The Washington/ESPN Study found that 52 percent of these players reported having used prescription opioids during their playing career. 71 percent of those who used prescription opioids reported having “misused” the drugs.²⁹⁵ In total, 37 percent of all players studied reported having misused prescription opioids during their playing careers.

Moreover, in a 2014–2015 survey of 763 former players by *Newsday*, about 65 percent of former players responding said they used “prescription painkillers” during their career.²⁹⁶ To be clear, however, not all use constitutes abuse. There are also several limitations to the *Newsday* survey: (1) the survey was sent via email and text message by the NFLPA to more than 7,000 former NFL players, thus eliminating former players that were less technologically savvy and also possibly skewing the sample toward those former players closer to the NFLPA; (2) the response rate for the survey was low (approximately 11 percent); and, (3) the study does not discuss the demographics of those that responded, making it difficult to ascertain whether those who responded are a representative sample of all former players. Importantly, the Football Players Health Study seeks to collect more data on issues such as this.

2) CURRENT LEGAL OBLIGATIONS CONCERNING MEDICATIONS

As indicated in the beginning of this section, the regulatory framework for medications depends on what type of medication is being discussed. We will discuss over-the-counter drugs, prescription drugs, and controlled substances. Again, painkillers can fit into any of these categories.

Over-the-counter drugs are those that the Food and Drug Administration has determined “to be safe and appropriate for use without the supervision of a health care professional such as a physician, and they can be purchased by consumers without a prescription.”²⁹⁷ Advil and Tylenol are common examples of over-the-counter painkillers. Players can obtain over-the-counter drugs on their own, without any assistance from club doctors, by purchasing them at a local pharmacy or grocery store. Club doctors can also provide players with over-the-counter medications, provided the provision of the medications and any recommend usage is within the appropriate standard of care.

Under the FDCA, a prescription drug is one that “because of its toxicity or other potentially for harmful (sic) effect, or the method of its use, or the collateral measures necessary to its use, is not safe for use except under the supervision of a practitioner licensed by law to administer such drug[.]”²⁹⁸ In other words, a prescription drug is one “for which adequate directions for use cannot be written, because laypersons lack the scientific understanding needed to diagnose their disease or to use the drug in treating it.”²⁹⁹ Ibuprofen at certain doses and Toradol are examples of prescription painkillers (but are not controlled substances, as will be discussed below³⁰⁰). Generally speaking, club doctors can prescribe prescription medications to players provided the prescription of the medications and any recommended usage is within the appropriate standard of care.

As mentioned earlier, the CSA³⁰¹ “is the statutory framework through which the federal government regulates the lawful production, possession, and distribution of controlled substances.”³⁰² Controlled substances are those drugs that have a “strong potential for abuse.”³⁰³ The CSA divides controlled substances into five schedules, depending on the substance’s medical use, potential for abuse, and likelihood of dependence.³⁰⁴ The substances considered the most dangerous are classified as Schedule I, including heroin, marijuana, LSD and ecstasy.³⁰⁵ Schedule V substances, considered the least dangerous, contain limited quantities of certain narcotic and stimulant drugs and include over-the-counter cough medicines such as Robitussin.³⁰⁶

The Drug Enforcement Administration (DEA) is the federal agency primarily responsible for enforcing the CSA. “[T]he DEA is responsible for ensuring that all controlled substance transactions taken place within the ‘closed system’ of distribution established by [the CSA]. Under this ‘closed system,’ all legitimate handlers of controlled substances—manufacturers, distributors, physicians, pharmacies, and researchers—must be registered with DEA and maintain strict accounting for all distributions.”³⁰⁷ Generally, controlled substances that are not illegal drugs cannot be possessed or dispensed without an individual prescription.³⁰⁸

NFL club doctors, like many doctors, prescribe controlled substances—including such powerful painkillers as Vicodin, Percocet and OxyContin (all Schedule II)³⁰⁹—and thus must comply with the CSA.³¹⁰ The CSA and DEA requirements with which NFL club doctors must comply cover: registration with the DEA; the location of the doctor’s registration; security of controlled substances; recordkeeping of controlled substances; and, dispensing of controlled substances, among other things.

Generally, “every person who manufactures, distributes,³¹¹ dispenses,³¹² imports, or exports any controlled substance” must register with the DEA.³¹³ According to the CSA, distributors of controlled substances should be granted DEA registration unless “such registration is inconsistent with the public interest.”³¹⁴ One of the enumerated considerations as to whether registration would be inconsistent with the public interest is whether registration would be consistent with state law.³¹⁵ State laws generally do not allow for the prescription and distribution of controlled substances except by licensed medical professionals, such as physicians, dentists, veterinarians, and pharmacists.³¹⁶ Thus, generally, only licensed medical professionals will receive DEA registration.³¹⁷

Doctors must obtain a separate DEA registration for each “principal place of business or professional practice” where they “dispense[.]” controlled substances,³¹⁸ and must “provide effective controls and procedures to guard against theft and diversion of controlled substances.”³¹⁹

3) CURRENT ETHICAL OBLIGATIONS CONCERNING MEDICATIONS

AMA Code Opinion 9.6.6—Prescribing & Dispensing Drugs and Devices dictates that doctors should prescribe drugs . . . based solely on medical considerations, patient need, and reasonable expectations of the effectiveness for the particular patient.”³²⁰ Thus, generally doctors have an obligation to prescribe and administer prescription medications consistent with their obligation to provide medical care within an acceptable standard of care.

Of particular importance is the doctor’s obligation to obtain the patient’s informed consent, as discussed in Chapter 2, Section C(2)(a). Informed consent in the context of medications would importantly include advising the player about the risks of taking the medication, as well as benefits and alternatives.

4) CURRENT PRACTICES CONCERNING MEDICATIONS

As discussed earlier, medications have been misused or abused by at least some NFL clubs and NFL players in the past. Again, however, it is important to remember that players can likely obtain medications from sources other than club doctors. Moreover, the NFL’s practices concerning medications have changed in recent years.

According to the NFL and NFLPS, as of February 2015, NFL clubs do not store or provide controlled substances to players.³²¹ Club doctors can still prescribe controlled substances to players, but the prescription is then filled at a local pharmacy.³²² Some players retrieve the prescription themselves but, according to the NFL, “[m]any players . . . request that their clubs assist them by picking up their prescriptions from a local pharmacy for them, and in many cases the clubs agree to accommodate those requests as a matter of convenience for the player.”³²³ The prescription is recorded in the player’s electronic medical records.³²⁴

Clubs’ practices concerning prescription medications that are not controlled substances, *e.g.*, Toradol, are less clear. The NFL stated that it did not know whether NFL clubs or club doctors store prescription medications that are not controlled substances at stadiums and/or club facilities.³²⁵ The NFL explained that “this practice varies from club to club and the NFL does not monitor such practices.”³²⁶

When it comes to over-the-counter painkillers, *i.e.*, those that do not require a prescription, club practices again vary.³²⁷ The NFL explained that “[s]ome clubs do not provide such medications at all. Other clubs provide them at the doctors’ discretion. At other clubs, ibuprofen and/or aspirin are available in the club physician’s office and athletic training room and available for the players to take themselves.”³²⁸

One useful change was made beginning with the 2015 season. As of that season, each club is assigned a Visiting Team Medical Liaison,³²⁹ a local doctor who can help prescribe medications as well as advice concerning local medical facilities.³³⁰

Some of the advances in the NFL's practices concerning painkillers and prescription medications are likely related to the increased scrutiny of the usage of Toradol (a prescription drug, but not a controlled substance). In 2012, the NFLPS commissioned a study on the use of ketorolac (brand name Toradol) in the NFL.³³¹ The study stated that since the Tokish Study in 2002, "it is widely believed by NFL team physicians that the use of [Toradol] has increased in prevalence not only in the NFL but also in NCAA Division I football," though there was no "objective documentation proving this hypothesis."³³²

The 2012 NFLPS study examined the pharmacological properties of Toradol, its beneficial uses (killing pain) and its possible side effects (gastrointestinal, renal, hemostasis, and cardiovascular). The study then made nine recommendations for Toradol use by NFL players, including that it only be administered under the direct supervision of a Club doctor, that it not be used prophylactically, that it be given in the lowest effective dose, and that it should be given orally except in certain situations.³³³

"[I]f we do get painkillers, they're prescribed to us by the doctors. And they definitely go through the whole process . . . they're not just handing out a bunch of painkillers unnecessarily to guys."

The recommendations have since been adopted by NFL clubs as guidelines on the use of Toradol. Nevertheless, it has been made public that at least one club doctor began in 2012 to require players to execute a waiver for the administration of Toradol.^{334, ch} The waiver included the following provisions: (1) the player's request to be treated with Toradol; (2) information about Toradol's benefits and risks; (3) the NFLPS' recommendations concerning Toradol; (4) the player's acknowledgement of having reviewed the NFLPS' study and other websites concerning Toradol; (5) the player's history of conditions related to Toradol side effects; (6) the player's acknowledgement that he had the opportunity to consult with his own doctor and an attorney about Toradol and the waiver; and, (7) a release of any

possible claims the player might have against the club and the doctors related to Toradol.

As a result of the new Toradol guidelines and a grievance initiated by the NFLPA (discussed below), Toradol usage in the NFL is believed to have significantly decreased in recent years. According to St. Louis Rams club doctor and former President of the NFLPS, the practice of giving players shots of Toradol before a game has been "eliminated."³³⁵ Current Player 1 shared his impression that painkilling medications are no longer widely dispensed:

[I]f we do get painkillers, they're prescribed to us by the doctors. And they definitely go through the whole process . . . they're not just handing out a bunch of painkillers unnecessarily to guys—you definitely have to have a reason for it. And even when they do, they're reluctant, to give you any more than the prescribed dosage.

Current Player 5 concurred that painkillers were prescribed but also stated that "when you have a team doctor for a long time, if you build a relationship with him, then sometimes I think you have a lot of leeway in being able to get more painkillers, more drugs than he would normally prescribe." Current Player 5 also explained that painkiller misuse does still occur on some level in the NFL: "I don't think it's rampant. . . . But I think that there's probably a small percentage of guys that are actively doing whatever they can to try to get as much painkillers as they can."^{ci}

On the other hand, Current Player 6 complained that his club's doctors were too conservative in providing painkillers, which is also an important concern:

I understand not wanting to give out pain medications just freely to people who don't need it but in cases where people were in severe pain, I guess it was their call not to give out hydrocodone or pain medication that if somebody was sick in the hospital, they would be given. And instead they give them a stronger and stronger dose of Advil.^{cj}

The DEA has also expressed interest in the administration of painkillers by NFL club doctors. At the 2010 NFL Combine, the DEA advised club doctors that it would be more closely monitoring the use of controlled substances by NFL clubs.³³⁶ Then, during the 2014 season, DEA agents randomly visited several NFL clubs immediately following

ch According to the NFL, only one club used such a waiver. NFL Comments and Corrections (June 24, 2016).

ci Former Player 2 echoed that players will try to obtain painkillers without the doctor's permission: "Someone's going to have some injury where painkillers are involved. So what do you do? You go up to the guy who's hurt and say, 'Hey, let me get a couple here, maybe a couple there,' and that's how you survive[.]"

cj Former Player 2 believes that players are "not allowed to get shots anymore."

away games.³³⁷ The DEA agents requested to see whether the club doctors were in possession of any controlled substances and the required records.³³⁸ The purpose of the inspections were to determine whether club doctors were prescribing and dispensing controlled substances in states in which they were not licensed to practice (and thus not registered with the DEA), and also to determine whether non-licensed staff members, such as athletic trainers, were handling controlled substances, which would violate the CSA.³³⁹ The selected clubs were found to be in compliance and no further action was taken.³⁴⁰

To fully understand the issues raised by medications in the NFL, it is also important to understand one of the major policies addressing these issues, the NFL-NFLPA Substance Abuse Policy. The Substance Abuse Policy prohibits players “from the illegal use, possession, or distribution of drugs, including but not limited to cocaine; marijuana; opiates and opioids; methylenedioxymethamphetamine (MDMA); and phencyclidine (PCP),” as well as the “abuse of prescription drugs, over-the-counter drugs, and alcohol.”³⁴¹

According to the Substance Abuse Policy, “[t]he cornerstone of th[e] Policy is the Intervention Program.”³⁴² “Under the NFL’s Intervention Program, Players are tested, evaluated, treated, and monitored for substance abuse.”³⁴³ The Intervention Program consists of three possible stages of treatment. If the player complies with his treatment and does not fail any tests, he will be discharged from the Intervention Program. However, if the player does not comply or fails drug tests, he will be advanced into more aggressive stages of treatment and be subject to increasing discipline.

A player can enter the Intervention Program in three ways: (1) a positive test result; (2) “[b]ehavior (including but not limited to an arrest or conduct related to an alleged misuse of Substances of Abuse occurring up to two (2) football seasons prior to the Player’s applicable scouting combine) which, in the judgment of the Medical Director, exhibits physical, behavioral, or psychological signs or symptoms of misuse of Substances of Abuse”; and, (3) “Self-Referral: Personal notification to the Medical Director by a Player of his desire voluntarily to enter Stage One of the Intervention Program prior to his being notified to provide a specimen leading to a Positive Test Result, and prior to behavior of the type described above becoming known to the Medical Director from a source other than the Player.”³⁴⁴

Once in the Intervention Program, the players are referred to the appropriate clinical professionals to develop a treatment plan for the player.³⁴⁵ The Medical Director must then approve the treatment plan.³⁴⁶ Additionally, once in the

Intervention Program, the player is subject to additional testing at the discretion of the Medical Director.³⁴⁷

If a player complies with his treatment plan, he can be discharged from the Intervention Program in as early as 90 days.³⁴⁸ If the Medical Director believes the player needs additional treatment or if the player fails to comply with his treatment plan, such as by failing a test, the player will advance to Stage Two of the Intervention Program.³⁴⁹ In Stage Two, a player can be subject to as many as 10 unannounced drug tests per month.³⁵⁰

If a player complies with his treatment plan in Stage Two, he can be discharged from the Intervention Program in as early as 12 months.³⁵¹ However, again, if the Medical Director believes the player needs additional treatment or if the player fails to comply with his treatment plan, such as by failing a test, the player will advance to Stage Three of the Intervention Program and be subject to additional treatment and evaluation.³⁵²

Players are not disciplined for initial positive test results under the Substance Abuse Policy. Instead, players are entered into the Intervention Program. Provided players comply with their treatment programs under the Intervention Program, they will not be disciplined. If players do not comply, there is a gradually increasing discipline scheme of fines and eventually suspension.

5) ENFORCEMENT CONCERNING MEDICATIONS

If an NFL player believes a club or club doctor has violated their obligations concerning medications, he can seek to enforce the obligations in the same manner as he might seek to enforce other obligations, including through lawsuits, investigations under the CBA, Non-Injury Grievances, and/or complaints to relevant licensing boards, as discussed above.

There has been one particularly noteworthy enforcement effort concerning the administration of medications by club doctors. In December 2012, the NFLPA commenced a Non-Injury Grievance against the NFL concerning the Toradol waiver discussed above.³⁵³ The NFLPA contended the waiver violated three provisions of the 2011 CBA.

First, the NFLPA contended the waiver violated Paragraph 9 of the NFL Player Contract. Paragraph 9 provides that if Player is injured in the performance of his services under this contract and promptly reports such injury to the Club physician or trainer, then Player will receive such medical and hospital care during the term of this contract as the club physician may deem necessary[.]” The NFLPA

argued that clubs and club doctors cannot precondition the provision of medical care they deem necessary on the acceptance of waivers.

Second, the NFLPA contended the waiver violated Article 39, Section 1 of the 2011 CBA. Section 1 provides, in relevant part, that “each Club physician’s primary duty in providing player medical care shall be not to the Club but instead to the player-patient.” The NFLPA argued that the waivers “are obviously not for benefit of the player-patient, but rather solely to relieve the Club and Club physician from any liability for the administration of Toradol.”

Third, the NFLPA argued that the waiver violated Article 39, Section 1(c) and Article 39, Section 3(e). Section 1(c) requires “all Club physicians and medical personnel [to] comply with all federal, state and local requirements, including all ethical rules and standards established by any applicable government and/or authority that regulates or governs the medical profession in the Club’s city.” Section 3(e) requires a club to “use its best efforts to ensure that its players are provided with medical care consistent with professional standards for the industry.” The NFLPA argued that clubs cannot precondition compliance with these provisions on the execution of a waiver.

The Non-Injury Grievance was settled,³⁵⁴ and no NFL clubs currently require players to sign waivers prior to the administration of Toradol.³⁵⁵

Finally, we discuss an ongoing lawsuit against the NFL concerning medications. In May 2014, several former players, led by former Chicago Bear Richard Dent, filed a class action lawsuit alleging that the NFL and its clubs and doctors negligently and fraudulently prescribed and administered painkilling medications during their careers.³⁵⁶ The lawsuit generally focused on three types of medications: opioids, which “act to block and dull pain”; non-steroidal anti-inflammatory medications, such as Toradol, which have “analgesic and anti-inflammatory effects to mitigate pain”; and, local anesthetics, such as lidocaine.^{357,ck} The former players’ alleged that the doctors’ inappropriate administration of the medications caused them a variety of physical and mental ailments, including heart and kidney damage and drug addiction.³⁵⁸

In December 2014, the United States District Court for the Northern District of California dismissed the case, ruling that the players’ claims were preempted by the Labor Management Relations Act (LMRA).³⁵⁹ Effectively, the court found that to determine the validity of the players’ claims would require interpretation of the CBA, and thus the players should have pursued grievances through arbitration as opposed to lawsuits.³⁶⁰ In its ruling, the Court stated:

*In ruling against the novel claims asserted herein, this order does not minimize the underlying societal issue. In such a rough-and-tumble sport as professional football, player injuries loom as a serious and inevitable evil. Proper care of these injuries is likewise a paramount need. The main point of this order is that the league has addressed these serious concerns in a serious way—by imposing duties on the clubs via collective bargaining and placing a long line of health-and-safety duties on the team owners themselves. These benefits may not have been perfect but they have been uniform across all clubs and not left to the vagaries of state common law. They are backed up by the enforcement power of the union itself and the players’ right to enforce these benefits.*³⁶¹

The *Dent* case is currently on appeal to the United States Court of Appeals for the Ninth Circuit.³⁶²

Following the December 2014 ruling in the *Dent* case, the attorneys for the plaintiffs filed a separate lawsuit with new plaintiffs alleging substantially the same allegations, led by former player Chuck Evans.³⁶³ However, the *Evans* lawsuit alleged *intentional* wrongdoing by the clubs, as opposed to merely negligent conduct.³⁶⁴ In addition, in this case the defendants were the 32 individual NFL clubs, and not the NFL.³⁶⁵ In July 2016, the same judge as in the *Dent* case denied the clubs’ motion to dismiss the *Evans* complaint.³⁶⁶ The court noted that the *Evans* plaintiffs, unlike the *Dent* plaintiffs, alleged *intentional* violations of the CSA and the FDCA.³⁶⁷ The Court explained that because parties cannot agree to a CBA that permits illegal behavior (*i.e.*, behavior that violates statutes), the CBA could not preempt plaintiffs’ claims.³⁶⁸ As a result of the Court’s decision, the *Evans* plaintiffs may have the right to investigate and discover information about medication practices in the NFL. The case is ongoing as of the time of this publication.

ck The allegations in the *Dent* lawsuit mirrored revelations from Dr. Rob Huizenga, the Oakland Raiders’ internist from 1983 to 1990. Huizenga, in his 1994 book “You’re Okay, It’s Just a Bruise,” described a practice by which players received pain-killing and anti-inflammatory medications on an almost constant basis. See Rob Huizenga, *You’re Okay, It’s Just a Bruise* 39 (1994) (“Indocin, an Advil-like anti-inflammatory drug, was so widely used by players for aches and pains that I was tempted to put it in the water system.”); *id.* at 44 (“Nearly every athlete who had seen action would request an anti-inflammatory—Indocin or maybe Naprosyn or Feldene—and sometimes a muscle-spasm medicine.”); *id.* at 127 (“In order to play, he needed an injection before each game.”)

6) RECOMMENDATIONS CONCERNING MEDICATIONS

The evidence available to us, though admittedly far from complete, suggests that the misuse and abuse of medications is largely a thing of the past and that, by and large, current practices involving medications comply with legal and ethical obligations. While interviews and surveys discussed above suggest that for many years NFL clubs and club doctors facilitated—or at least failed to protect against—player misuse and abuse of certain medications, this generally no longer seems to be the case. Indeed, NFL clubs no longer even store controlled substances at their facilities. For these reasons, we do not believe a formal recommendation is needed concerning medications.

Nevertheless, it is undoubtedly true that football causes pain and injuries and the use of prescription-strength painkillers and controlled substances will continue to be something many club doctors players will find necessary. Consequently, it is important that the NFL and the club doctors continue to evaluate practices concerning medications, including but not limited to how much they are being used, what types are being used and for what purposes, under what circumstances they are being used, their risks and effectiveness, prescriptions for and documentation of their use, and players' understanding of and consent to their use. Additionally, practices should be compared across the clubs, as discussions with players suggested that clubs' practices concerning medications can vary.

Endnotes

- 1 CBA, Art. 39, § 1.
- 2 CBA, Art. 39, § 1(e).
- 3 NFL Physicians Society Mission Statement, Nat'l Football League Physicians Soc'y, <http://nflps.org/about/> (last visited Aug. 7, 2015), archived at <http://perma.cc/928Z-LVZ4>.
- 4 See Dave Siebert, What Is Medical Care Like on an NFL Sideline?, Bleacher Report (Nov. 15, 2013), <http://bleacherreport.com/articles/1850732-what-is-medical-care-like-on-an-nfl-sideline>, archived at <http://perma.cc/7JR4-HR3G> (quoting then-NFLPS President Matthew Matava describing the "about 177 NFL team physicians"); Team Physicians, Nat'l Football League Physicians Society, <http://nflps.org/team-physicians/> (last visited Feb. 24, 2016), archived at <https://perma.cc/HK8A-QJ9L> (listing 153 club doctors as members of the NFLPS).
- 5 See Frequently Asked Questions—How Often Do All NFLPS Members Meet?, Nat'l Football League Physician's Soc'y, <http://nflps.org/faqs/how-often-do-all-nflps-members-meet/> (last visited Aug. 7, 2015), archived at <http://perma.cc/76P5-DRQX>; Frequently Asked Questions—What Are Typical Topics at Members Meetings?, Nat'l Football League Physician's Soc'y, <http://nflps.org/faqs/what-are-typical-topics-at-members-meetings/> (last visited Aug. 7, 2015), archived at <http://perma.cc/LR79-9AN3> ("The topics at these meetings vary and address any or all of the potential injuries that a NFL player may experience. This can include orthopaedic injuries such as ACL tears, meniscus tears, cartilage injuries to the knee, multiligamentous injuries to the knee, high ankle sprains, fractures, dislocations, foot injuries, surgical techniques, rehabilitation, hip injuries, arthroscopy of the hip, sports hernia challenges, shoulder injuries such as dislocations or labral tears, rotator cuff problems, elbow dislocation, biceps or triceps injuries, wrist injuries, and hand and finger injuries or dislocations. From a medical standpoint, there has been a recent emphasis on heat-related illnesses, cardiac conditions, MRSA infections, sickle cell traits, concussions and the management of acute blunt trauma to the chest or abdomen.").
- 6 This information was provided by NFLPS.
- 7 *Id.* Clubs also likely do not directly hire doctors to comply with the corporate practice of medicine doctrine. The corporate practice of medicine doctrine is a state law concept that generally prohibits entities from practicing medicine or employing physicians to provide professional medical services. The prohibitions vary from state to state (with many exceptions to the general rule) and are found in common law, state statutes, regulations, and administrative opinions. See Mary H. Michal, Meg S.L. Pekarske & Matthew K. McManus, Corporate Practice of Medicine Doctrine: 50 State Survey Summary, Nat'l Hospice & Palliative Care Org. & Ctr. to Advance Palliative Care (2006), <http://www.nhpco.org/sites/default/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf>, archived at <https://perma.cc/G2QD-2EQB?type=pdf>.
- 8 Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).
- 9 *Id.*
- 10 NFL Comments and Corrections (June 24, 2016).
- 11 Memorandum from NFL Commissioner Paul Tagliabue to NFL Club Chief Executives and Presidents re: Hospital and Physician Sponsorship (Sep. 7, 2004) (on file with author).
- 12 *Id.*
- 13 *Id.*
- 14 *Id.*
- 15 Rob Huizenga, You're Okay, It's Just a Bruise 74 (1994) ("No wonder that rumors floated, and Sports Illustrated reported that at least one NFL physician was paying the team for the privilege of being team doctor."); *id.* at 325 (The NFL Physicians Society is currently trying to fight off an invasion from the big business hospital chains. Turns out some health companies are actually bidding for the right to be the official team doctor/team hospital for NFL teams. The hospitals have presumably calculated that getting their hospital logo right next to one of those stadium beer commercials is worth a lot of bucks. It's rumored the bidding may have reached \$1 million.")
- 16 *Id.* See also Sam Eifling, Walk It Off, Champ: Why NFL Team Doctors Are Ethically Compromised, Slate.com (Jan. 30, 2013), http://www.slate.com/articles/sports/sports_nut/2013/01/nfl_team_doctors_the_problem_with_pro_football_s_medical_sponsorship_deals.html, archived at <https://perma.cc/PL2D-8JHV?type=pdf> (quoting Lew Lyon, vice president of the Baltimore Ravens-affiliated MedStar Sports Medicine as saying "[t]he halo effect is huge . . . [f]riends will call me and say, 'Can you get me into see one of the Ravens docs?'").
- 17 Pierce E. Scranton, Jr., Playing Hurt: Treating and Evaluating the Warriors of the NFL 154 (2001).
- 18 Bill Pennington, Sports Turnaround: The Team Doctors Now Pay the Team, N.Y. Times, May 18, 2004, <http://www.nytimes.com/2004/05/18/sports/sports-medicine-sports-turnaround-the-team-doctors-now-pay-the-team.html?pagewanted=1>, archived at <https://perma.cc/JW63-LZ4U?type=pdf>.

- 19 Memorandum from NFL Commissioner Paul Tagliabue to NFL Club Chief Executives and Presidents re: Hospital and Physician Sponsorship (Sep. 7, 2004) (on file with author).
- 20 *Id.*
- 21 Memorandum from NFL Commissioner Roger Goodell to NFL Club Chief Executives and Presidents re: Hospital and Medical Service Provider Sponsorships (Nov. 2, 2012) (on file with author).
- 22 *Id.*
- 23 Memorandum from NFL Commissioner Roger Goodell to NFL Club Chief Executives and Presidents re: League Policy on Club Medical Services Agreements and Sponsorships (May 2, 2014) (on file with author).
- 24 *Id.*
- 25 E-mail with Larry Ferazani NFL, Vice President, Labor Litigation & Policy (Apr. 15, 2015).
- 26 Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).
- 27 *Id.*
- 28 Pennington, *supra* note 18.
- 29 NFL Comments and Corrections (June 24, 2016).
- 30 Email from Jon Coyles, MLB Labor Counsel, to Chris Deubert (Oct. 6, 2014, 15:13 EST) (on file with author).
- 31 NBA CBA, Art. XXII, § 5.
- 32 Under the 2011 CBA, this responsibility is solely the doctor's. See 2011 CBA, App. A: NFL Player Contract ¶ 8 ("If Player fails to establish or maintain his excellent physical condition to the satisfaction of the Club physician . . . then Club may terminate this contract.")
- 33 *Lambley v. Kameny*, 682 N.E.2d 907, 912 (Mass. App. Ct. 1997). See also James L. Rigelhaupt, What Constitutes Physician–Patient Relationship for Malpractice Purposes, 17 A.L.R.4th 132 (1982) (listing jurisdictions that explicitly support the view that a physician's acceptance, or undertaking treatment of a patient creates a physician–patient relationship. States listed include Cal., Ill, Mass, NJ, NY, and Wash., in addition to others.)
- 34 *LoDico v. Caputi*, 517 N.Y.S.2d 640 (N.Y. App. Div. 1987); *Miller v. Sullivan*, 625 N.Y.S.2d 102 (N.Y. App. Div. 1995); *St. John v. Pope*, 901 S.W.2d 420, 423–24 (Tex. 1995); *Gallardo v. U.S.*, 752 F.3d 865 (10th Cir. 2014) (applying Colorado law) (recognizing that a physician's duty arises out of an express or implied contractual relationship when a physician undertakes to treat or otherwise provide medical care to another); *Smith v. Pavlovich*, 914 N.E.2d 1258 (Ill. App. Ct. 2009) (A physician–patient or special relationship may exist even in the absence of any meetings between the physician and patient, where the physician performs services for the patient); *Harper v. Hippensteel*, 994 N.E.2d 1233 (Ind. Ct. App. 2013) (where doctor does not treat, see, or in any way participate in the care or diagnosis of plaintiff–patient, doctor–patient relationship will not be found to exist such that duty owed by physician would arise); *Olson v. Wrenshall*, 822 N.W.2d 336 (Neb. 2012) (a physician's duty to exercise the applicable standard of care arises out of the physician–patient relationship; this relationship is said to arise when the physician undertakes treatment of the patient); *Clarke v. Hoek*, 219 Cal.Rptr. 845 (Cal. Ct. App. 1985) (finding no doctor–physician relationship established when doctor never entered into any contractual relationship with appellant or the proctored physician.). See also, Rigelhaupt, *supra* note 33.
- 35 *Heller v. Peekskill Community Hosp.*, 603 N.Y.S.2d 548 (N.Y. App. Div. 1993); *Lodico*, 517 N.Y.S.2d 640.
- 36 For more on this issue, see Mark A. Rothstein, Jessica Roberts, Tee L. Guidotti, Limiting Occupational Medical Evaluations Under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, 41 Am. J. L. & Med. 523 (2015).
- 37 See, e.g., Tee L. Guidotti et al., Occupational Health Services: A Practical Approach 66 (2d ed. 2013); Jacques Tamin, Models of occupational medicine practice: an approach to understanding moral conflict in "dual obligation" doctors, 16 Med. Health Care Philos. 499 (2013); Elaine Draper, The Company Doctor: Risk, Responsibility and Corporate Professionalism (2003); and, Elaine Draper, Preventive law by corporate professional team players: liability and responsibility in the work of company doctors, 15 J. Contemp. Health Law Policy 525 (1999).
- 38 Barry R. Furrow et al., *Health Law* 61 (2d ed. 2000).
- 39 See, e.g., New York State Education § 6530 (defining "professional misconduct" applicable to physicians as, among other things, "practicing the profession with negligence on more than one occasion," "practicing the profession with gross negligence on a particular occasion," "[r]evealing of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law," and "[d]elegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them.")
- 40 Furrow, *supra* note 38, at 59. However, "[m]ost boards do not have adequate staff to respond to the volume of complaints and to conduct extensive investigations of unprofessional conduct," leading consumer groups to complain about the industry's failure to self-regulate. Mark A. Hall et al., *Med. Liability and Treatment Relationships* 137 (2008).
- 41 *Id.*
- 42 *Id.*
- 43 AMA Code of Medical Ethics, Am. Med Ass'n, <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 22, 2016), archived at <http://perma.cc/8JJ4-MYJX>.
- 44 AMA Mission & Guiding Principles, Am. Med Ass'n, <http://www.ama-assn.org/ama/pub/about-ama.page?> (last visited Jan. 8, 2016), archived at <https://perma.cc/2QCB-EADZ>.
- 45 See 2011 CBA, Art. 39 § 1(a)-(b) (listing the various types of doctors contemplated or required to be hired by NFL Clubs).
- 46 See Update: Evaluation and Management of Concussion in Sports, Am. Acad. of Neurology, https://www.aan.com/uploadedFiles/Website_Library_Assets/Documents/3Practice_Management/5Patient_Resources/1For_Your_Patient/6_Sports_Concussion_Toolkit/evaluation.pdf (last visited Aug. 7, 2015), archived at <https://perma.cc/4UEF-SM88?type=pdf>.
- 47 ACOEM Code of Ethics, Am. Coll. of Occupational & Envtl. Med., <http://www.acoem.org/codeofconduct.aspx> (last visited Aug. 7, 2015), archived at <http://perma.cc/6R8A-XN6V> [hereinafter ACOEM Code of Ethics].
- 48 International Code of Ethics for Occupational Health Professionals, Int'l Comm'n on Occupational Health, http://www.icohweb.org/site_new/multimedia/core_documents/pdf/code_ethics_eng_2012.pdf (last visited Aug. 7, 2015), archived at <https://perma.cc/2URK-LT9V?type=pdf>.
- 49 About Us, Int'l Fed'n of Sports Med., www.fims.org/about (last visited Aug. 7, 2015), archived at <http://perma.cc/458J-R3KF>.
- 50 Our History, Int'l Fed'n of Sports Med., <http://www.fims.org/about/our-history/> (last visited Aug. 7, 2015), archived at <http://perma.cc/UQ33-93XZ>.
- 51 See Member Associations, Int'l Fed'n of Sports Med., <http://www.fims.org/en/associations/national/#United%20States> (last visited August 6, 2015), archived at <http://perma.cc/2Y7G-63Z4>.
- 52 FIMS Code of Ethics, Int'l Fed'n of Sports Med., <http://www.fims.org/files/8214/1933/5848/FIMSCodeOfEthics.pdf> (last visited Aug. 7, 2015), archived at <https://perma.cc/NCZ7-X3KV?type=pdf> [hereinafter FIMS Code of Ethics]. FIMS also published a Team Physician Manual which is one of the preeminent manuals for sports injuries and also covers the same ethical considerations espoused in its Code of Ethics.
- 53 Team Physician Consensus Statement: 2013 Update, Am. Coll. of Sports Med., http://www.acsm.org/docs/other-documents/team_physician_consensus_statement_2013_update-24.pdf (last visited Aug. 7, 2015), archived at <https://perma.cc/A5G5-68HJ?type=pdf>.
- 54 See *Thierfelder v. Wolfert*, 52 A.3d 1251, 1264 (Pa. 2012) (discussing elements of a medical malpractice claim); *Hamilton v. Wilson*, 249 S.W.3d

- 425, 426 (Tex. 2008) (same); *Sullivan v. Edward Hosp.*, 806 N.E.2d 645, 653 (Ill. 2004) (same).
- 55 *Id.*
- 56 See *Greenberg v. Perkins*, 845 P.2d 530, 535 (Colo. 1993) (discussing various states' positions on whether a physician-patient relationship is required for a medical malpractice action).
- 57 See Benjamin Grossberg, *Uniformity, Federalism, and Tort Reform: The Erie Implications of Medical Malpractice Certificate of Merit Statutes*, 159 U. Pa. L. Rev. 217 (2010) (identifying 25 states with statutes that require certificates of merit by another doctor for a medical malpractice claim).
- 58 CBA, Art. 39, § 1(c).
- 59 This information was provided by the NFLPA.
- 60 NFL Comments and Corrections (June 24, 2016).
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- 63 AMA Code of Medical Ethics, Am. Med. Ass'n, [http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page?](http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page) (last visited Feb. 24, 2016), archived at <https://perma.cc/6YPW-G5BD>.
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- 65 Opinion 1.1.6—Quality, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/4QS7-F5FT>.
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- 68 *Id.*
- 69 *Id.*
- 70 *Id.* at ¶ 4.
- 71 See, e.g., John Lantos, Ann Marie Matlock & David Wendler, *Clinician Integrity and Limits to Patient Autonomy*, 305 J. Am. Med. Ass'n, 495–99 (2011) (“Respect for patient autonomy plays a central role in modern clinical ethics”); Simon N. Whitney, Amy L. McGuire & Laurence B. McCullough, *A Typology of Shared Decision Making, Informed Consent, and Simple Consent*, 140 Ann. Intern. Med., 54–59 (2003) (“Enhancing patient choice is a central theme of medical ethics and law.”); Cathy Charles, Amiram Gafni & Tim Whelan, *Decision-making in the Physician-Patient Encounter: Revisiting the Shared Treatment Decision-Making Model*, 49 Social Sci. & Med., 651–61 (1999) (emphasizing the need to respect differences in patient preferences). See also *Stedman's Medical Dictionary* (28th ed. 2006) (defining “autonomy” as “[t]he condition or state of being autonomous, able to make decisions unaided by others”); *Black's Law Dictionary* (9th ed. 2009) (defining “autonomy” as: “the right of self-government”; “an individual's capacity for self-determination”).
- 72 Jamie Staples King & Benjamin Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decisionmaking*, 32 Am. J. Law & Med. 429, 493–501 (2006). (explaining that 25 states have adopted the physician-based standard, 23 have adopted a patient-based standard and two have adopted a hybrid standard).
- 73 Furrow, Barry R. Furrow et al., *Health Law* 217 (2d ed. 2000).
- 74 *Fuller v. Starnes*, 597 S.W. 2d 88 (Ark. 1980).
- 75 *Canterbury v. Spence*, 464 F.2d 772, 787 (D.C. Cir. 1972).
- 76 *Pedersen v. Vahidy*, 552 A.2d 419 (Conn. 1989).
- 77 King & Moulton, *supra* note 72.
- 78 *Id.*
- 79 CBA, Art. 39, § 1(c).
- 80 CBA, Art. 40, § 2(a).
- 81 Opinion 8.6—Promoting Patient Safety, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/3APG-V3WR>. See also ACOEM Code of Ethics, Ethical Principle VI: An Obligation to Advise and Report: “Occupational and environmental health professionals should communicate effectively and in a timely manner to an individual all significant observations about the health and health risk of that person and provide advice about interventions available to restore, sustain, and improve health or prevent illness.”
- 82 FIMS Code of Ethics at ¶ 4.
- 83 *Id.* at ¶ 3.
- 84 *Id.* at ¶ 1.
- 85 ACOEM Code of Ethics.
- 86 Mark A. Hall et al., *Health Care Law and Ethics* 168–69 (2003) (collecting cases and statutes).
- 87 *Id.*
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- 90 See Mark A. Rothstein, Jessica Roberts, Tee L. Guidotti, *Limiting Occupational Medical Evaluations Under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act*, 41 Am. J. L. & Med. 523, 542 (2015) (“the health care providers from whom employers obtain medical records (e.g., physicians, hospitals) are very likely to be covered entities.”)
- 91 “Protected health information means individually identifiable health information . . . that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.” 45 C.F.R. § 160.103. “Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.” *Id.*
- 92 C.F.R. § 160.103.
- 93 C.F.R. § 160.103.
- 94 *Id.*
- 95 C.F.R. § 164.512(b)(v).
- 96 C.F.R. § 1904.4.
- 97 C.F.R. § 164.512(l).
- 98 Hall, *supra* note 86, at 171.
- 99 See Joy Pritts et al., *The State of Health Privacy: A Survey of State Health Privacy Statutes* (2d ed. 2003), available at <http://sharps.org/wp-content/uploads/PRITTS-REPORT1.pdf>, archived at <https://perma.cc/C72H-R3LK?type=pdf> (describing 21 states with laws restricting doctors from disclosing healthcare information, subject to various exceptions).
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- 101 See, e.g., Arizona: A.R.S. § 12-2294(C)(9); A.R.S. § 36-509(A)(14); California: Ann. Cal. Civ. Code § 56.10(c)(2) (West 2014); Ann. Cal. Civ. Code § 56.10(c)(8)(A) (West 2014); Ann. Cal. Civ. Code § 56.10(c)(8)(B) (West 2014); Colorado: Colo. Rev. Stat. Ann. § 8-43-404(2); Colo. Rev. Stat. Ann. § 8-47-203(1)(a); 7 Colo. Code Regs. 1101-3-8; 7 Colo. Code Regs. 1101-3-8; Florida: Fla. Stat. Ann. § 440.13(4)(c); Fla. Stat. Ann. § 397.501(7)(a)(4); Georgia: Ga. Code Ann. § 34-9-207(a); Ga. Code Ann. § 34-9-207(b); Illinois: Ill. Comp. Stat. Ann 305/8(a); Indiana: Ind. Code

- Ann. § 16-39-5-3; Louisiana: LSA-R.S. 23:1125; LSA-R.S. 23:1127; Maryland: MD. Code Ann. § 4-305(b)(5); Md. Code Regs. 14.09.03.07; Massachusetts: M.G.L.A. 152 § 20; Michigan: Opinion No. 6593 of the Michigan Attorney General, 1989; Minnesota: Minn. Stat. Ann. § 176.138(a); Missouri: Mo. Rev. Stat. § 287.140(7); New Jersey: N.J. Stat. Ann. § 45:14B-32; N.J. Stat. Ann. § 34:15-128(a)(2); New York: N.Y. Workers' Compensation Law § 13-(g) (McKinney); North Carolina: N.C. Gen. Stat. Ann. § 97-25.6(c)(1); N.C. Gen. Stat. Ann. § 97-25.6(c)(2); Ohio: Ohio Rev. Code Ann. § 4123.651(B); Pennsylvania: 77 Pa. Stat. Ann. § 835; 77 Pa. Stat. Ann. § 531; 50 Pa. Stat. Ann. § 711; Tennessee: Tenn. Code Ann. § 50-6-204(a)(2)(A); Texas: Tex. Labor Code Code. Ann. § 408.025(d); Virginia: Va. Code Ann. § 65.2-604(A); Va. Code Ann. § 65.2-607(A); and, Washington: Wash. Rev. Code Ann. §51.36.060; Wash. Rev. Code Ann. § 70.02.050(1)(d).
- 102 CBA, Art. 39, § 1(c).
- 103 Opinion 3.1.5—Professionalism in Relationships with Media, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/ZR8K-FC93>.
- 104 Opinion 3.2.1—Confidentiality, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/ZR8K-FC93>.
- 105 FIMS Code of Ethics at ¶ 4.
- 106 Id. at ¶ 11.
- 107 Id. at ¶ 4.
- 108 *Kloster v. Hormel Foods Corp.*, 612 N.W.2d 772, 775 (Iowa 2000) (“When a physician acts contrary to the best interests of a patient, these acts or omissions undermine the public trust, and may rise to the level of malpractice.”); *Pearce v. Ollie*, 826 P.2d 888, 907 (Idaho 1992) (“The physician’s fiduciary duty requires that he act in the best interests of his patient so as to protect the sanctity of the physician-patient relationship”) (citing *Petrillo v. Syntex Labs., Inc.*, 148 Ill. App.3d 581, 594 (Ill. App. 1986) “There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the ‘good faith’ required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.”).
- 109 CBA, Art. 39, § 1(c).
- 110 Opinion 11.2.2—Conflicts of Interest in Patient Care, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/73DF-THU4>.
- 111 Opinion 1.1.1—Patient-Physician Relationships, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last Aug. 1, 2016), archived at <https://perma.cc/4QS7-F5FT>.
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- 115 Id. at ¶ 3.
- 116 Id.
- 117 Id. at ¶ 4.
- 118 Id. at ¶ 11.
- 119 See Code of Ethics, Am. Bd. of Physician Specialties, <http://www.abpsp.org/code-of-ethics> (last visited Aug. 7, 2015), archived at <http://perma.cc/S5YG-XSTR>.
- 120 Standards of Professionalism: Providing Musculoskeletal Services to Patients ¶¶ 14–16, Am. Acad. of Orthopaedic Surgeons (2008), <http://www3.aaos.org/member/profcomp/provmuscscserv.pdf>, archived at <https://perma.cc/A4X6-V9GD?type=pdf>.
- 121 See id.
- 122 See *Dyer v. Trachtman*, 679 N.W. 2d 311, 314–15 (Mich. 2004) (collecting cases); See also Mark A. Rothstein, Jessica Roberts, Tee L. Guidotti, Limiting Occupational Medical Evaluations Under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, 41 Am. J. L. & Med. 523, 534–35 (2015) (discussing limits of physician-patient relationship in occupational medicine).
- 123 *Dyer*, supra n. 122; *Greenberg v. Perkins*, 845 P.2d 530, 535 (Colo. 1993) (“physician owes a duty of care to a nonpatient examinee to conduct the examination in a manner not to cause harm to the person being examined.”) (internal quotations and citations removed).
- 124 *Bazakas v. Lewis*, 911 N.E.2d 847, 849 (N.Y. 2009) (“an [independent medical examination] is essentially adversarial”); *Dyer*, 679 N.W. 2d at 315 (independent medical examination “physician often examines the patient under circumstances that are adversarial”); *Greenberg*, 845 P.2d at 539 (discussing that doctor was acting “in an adversary setting”).
- 125 See *Dyer*, 679 N.W. 2d at 315 (collecting cases). See also *Murphy v. Blum*, 554 N.Y.S.2d 640 (App.Div. 1990) (holding that no physician-patient relationship arose out of pre-season physical exam of NBA referee conducted solely to advise league regarding referee’s physical capabilities); Matthew J. Mitten, Emerging Legal Issues in Sports Medicine: A Synthesis, Summary, and Analysis, 76 St. John’s L. Rev. 5, 13–14 (2002) (discussing the legal duty of care where doctor is only performing a medical examination on behalf of an employer).
- 126 See *Reed v. Bojarski*, 764 A.2d 433 (N.J. 2001) (physician retained to perform a pre-employment physical has a duty to inform the patient of a potentially serious medical condition); *Green v. Walker*, 910 F.2d 291 (5th Cir. 1990) (holding that, under Louisiana law, a doctor performing an examination on behalf of an employer, had “a duty to conduct the requested tests and diagnose the results thereof, exercising the level of care consistent with the doctor’s professional training and expertise, and to take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee’s physical or mental well-being”).
- 127 CBA, Art. 39 § 1(c).
- 128 Opinion 1.2.6—Work-Related & Independent Medical Examinations, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited July 26, 2016), archived at <https://perma.cc/4QS7-F5FT>.
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- 131 Tee L. Guidotti et al., Occupational Health Services: A Practical Approach 37 (2d ed. 2013), citing the ACOEM Code of Ethics.
- 132 NFL Comments and Corrections (June 25, 2016).
- 133 NFL CBA, Art. 39, § 1(c).
- 134 NFL Comments and Corrections (June 24, 2016).
- 135 Id.
- 136 *Dyer*, 679 N.W. 2d at 315–17 (collecting cases); *Greenberg*, 845 P.2d at 535 (Colo. 1993) (“physician owes a duty of care to a nonpatient examinee to conduct the examination in a manner not to cause harm to the person being examined.”) (internal quotations and citations removed).
- 137 See, e.g., *Yoder v. Cotton*, 758 N.W.2d 630 (Neb. 2008); *Jacobsen-Wayne v. Calvin C.M. Kam*, 198 F.3d 254 (9th Cir. 1999) (both affirming granting of defendant physician who had performed independent medical examination summary judgment on informed consent claim by finding that plaintiff had consented to the examination).
- 138 Opinion 1.2.6—Work-Related & Independent Medical Examinations, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited July 26, 2016), archived at <https://perma.cc/4QS7-F5FT>.

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- 139 Mark A. Hall et al., *Health Care Law and Ethics* 169 (2003).
- 140 Opinion 3.2.3—Industry-Employed Physicians and Independent Medical Examiners, Am. Med. Ass’n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/ZR8K-FC93>.
- 141 FIMS Code of Ethics at ¶ 10.
- 142 *Id.* at ¶ 4.
- 143 ACOEM Code of Ethics, Ethical Principle V.
- 144 Dyer, 679 N.W.2d at 315–17 (collecting cases); Greenberg, 845 P.2d at 535 (“physician owes a duty of care to a nonpatient examinee to conduct the examination in a manner not to cause harm to the person being examined.”) (internal quotations and citations removed).
- 145 Opinion 1.2.6—Work-Related & Independent Medical Examinations, Am. Med. Ass’n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited July 26, 2016), archived at <https://perma.cc/4QS7-F5FT>.
- 146 FIMS Code of Ethics at ¶ 8.
- 147 *Id.* at ¶ 11.
- 148 *Id.* at ¶ 2.
- 149 See 2011 CBA, Art. 39, § 4. Second opinions are discussed in further detail below in Chapter 4: Second Opinion Doctors.
- 150 FIMS Code of Ethics at ¶ 4.
- 151 Opinion 1.2.3—Consultation, Referral & Second Opinions, Am. Med. Ass’n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/4QS7-F5FT>.
- 152 Code of Ethics, Am. Bd. of Physician Specialties, <http://www.abpsus.org/code-of-ethics> (last visited Aug. 7, 2015), archived at <http://perma.cc/BU3D-VAQZ>.
- 153 Opinion 10.2—Physician Employment by a Nonphysician Supervisor, Am. Med. Ass’n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/73QV-B54W>.
- 154 Rob Huizenga, *You’re Okay, It’s Just a Bruise* 259 (1994).
- 155 *Id.* at 19 (Rosenfeld telling player “It’s just a stinger—you’ll be fine.”); *id.* at 21 (Rosenfeld telling player “You’re okay—it’s nothing serious.”); *id.* at 58 (Rosenfeld telling Huizenga “You’ve got to treat [players] differently from your office patients.”); *id.* at 147 (Rosenfeld telling player “So you really can’t hurt the joint any more. We may as well just shoot it up and let you go back out there and play.”). Huizenga also questioned Rosenfeld’s acumen. *Id.* at 123 (criticizing Rosenfeld for moving the neck of a player with neck pain); *id.* at 149 (Rosenfeld signing a prescription for anabolic steroids); *id.* at 256–67 (describing disagreement with Rosenfeld about a player’s condition which led to Huizenga’s resignation); *id.* at 270–71 (alleging that Rosenfeld and his medical practice had been sued over sixty times, mostly for medical malpractice).
- 156 *Id.* at 227.
- 157 *Id.* at 57 (“There was a fuzzy boundary between good medicine and good team doctoring.”); *id.* at 58 (“I was supposed to keep players informed of their health status, not to hide feelings from them. And every doctor knows that his legal and ethical responsibility is to the patient, regardless of who pays the bill.”); *id.* at 103–04 (describing having player sign waiver that he understood certain risks “to protect the Raiders”); *id.* at 106 (describing process for having players sign a waiver stating that were healthy following pre-season physical); *id.* at 115 (stalling to get player off the field for competitive purposes); *id.* at 125 (declaring “It’s not ethical for me to stay here. I can’t be associated with this kind of medicine.”); *id.* at 240 (debating the ethics of disclosing players’ medical records).
- 158 *Id.* at 266–67.
- 159 Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL* x (2001).
- 160 *Id.* at xi.
- 161 *Id.* at 32.
- 162 *Id.* at 170.
- 163 How does a physician become an NFL team physician? Nat’l Football League Physicians Soc’y, <http://nflps.org/faqs/how-does-a-physician-become-an-nfl-team-physician/> (last visited Aug. 7, 2015), archived at <http://perma.cc/AD7J-LD8A>.
- 164 see Synernet Staff Visits NFL Headquarters, Synernet (Feb. 11, 2015), <http://www.synernet.net/news/news.aspx>, archived at <https://perma.cc/E4UC-WNWP>.
- 165 NFL Comments and Corrections (June 24, 2016).
- 166 Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).
- 167 NFL Comments and Corrections (June 24, 2016).
- 168 Home, NFL Scouting Combine, <http://www.nflcombine.net/> (last visited Aug. 7, 2015), archived at <http://perma.cc/BQW4-E66Q>.
- 169 *Id.*
- 170 History, NFL Scouting Combine, <http://www.nflcombine.net/history/> (last visited Aug. 7, 2015), archived at <http://perma.cc/7V7T-HGDV>.
- 171 See Jeff Foster Talks About Challenges of Hosting NFL Scouting Combine, NFL.com (Feb. 19, 2014), <http://www.nfl.com/news/story/0ap200000326405/article/jeff-foster-talks-about-challenges-of-hosting-nfl-scouting-combine>, archived at <http://perma.cc/5D2C-6G8L> (discussing National Football Scouting, Inc.’s operation of the NFL Combine).
- 172 Albert Breer, NFL Scouting Combine’s Evolution Raises Questions About Future NFL.com (Feb. 18, 2013), <http://www.nfl.com/combine/story/0ap100000139993/article/nfl-scouting-combines-evolution-raises-questions-about-future>, archived at <http://perma.cc/YK3Y-U6J9>.
- 173 NFL Comments and Corrections (June 24, 2016).
- 174 Jessica L. Roberts et al., *Evaluating NFL Player Health and Performance: Legal and Ethical Issues*, Univ. Penn. L. Rev. (forthcoming 2017).
- 175 Breer, *supra* n. 172.
- 176 Dana Hunsinger Benbow, *The real reason for the NFL Scouting Combine*, Ind. Star, Feb. 25, 2016, <http://www.indystar.com/story/sports/nfl/2016/02/20/real-reason-nfl-scouting-combine/80251866/>, archived at <https://perma.cc/7ZPW-A35X>.
- 177 Jeff Foster Talks About Challenges of Hosting NFL Scouting Combine, *supra* note 171.
- 178 About IU Health, Ind.Univ. Health, <http://iuhealth.org/about-iu-health/> (last visited Aug. 7, 2015), archived at <http://perma.cc/6Z43-JKHD>; see also Hunsinger Benbow, *supra* n. 176.
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- 180 See *id.* (“350 MRIs were conducted on 330 players in a four-day period, with IU Health”).
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- 183 What role do team physicians play at the NFL Combines?, Nat’l Football League Physicians Soc’y, <http://nflps.org/faqs/what-role-do-team-physicians-play-at-the-nfl-combines/> (last visited Aug. 7, 2015), archived at <http://perma.cc/57K9-W8Y5>.
- 184 *Id.*
- 185 *Id.* at 26.
- 186 Rob Huizenga, *You’re Okay, It’s Just a Bruise* 76–77 (1994)..
- 187 Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL* 1 (2001).
- 188 *Id.* at 12.
- 189 *Id.* at 19.
- 190 *Id.* at 37.

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- 194 *Id.*; see also Transcript – 2016 Injury Data Results Conference Call, NFL Communications, Jan. 29, 2016, <https://nflcommunications.com/Pages/Transcript---2016-Injury-Data-Results-Conference-Call.aspx>, archived at <https://perma.cc/RKC6-352G>.
- 195 NFL Comments and Corrections (June 24, 2016).
- 196 See *Do team physicians have their own practices, or do they work for the clubs full-time?*, Nat'l Football League Physicians Soc'y, <http://nflps.org/faqs/do-team-physicians-have-their-own-practices-or-do-they-work-for-the-clubs-full-time>, archived at <http://perma.cc/Y535-ZMBM> (last visited Aug. 7, 2015) (stating that Club doctors “have [their] own private or university practices, in addition to [their] work as team physicians.”)
- 197 Townley, Arb. Oct. 29, 2008, available as Exhibit 16 to the Declaration of Dennis L. Curran in Support of Defendant National Football League's Motion to Dismiss Second Amended Complaint (Section 301 Preemption), *Dent v. Nat'l Football League*, 14-cv-2324 (N.D. Cal. Sep. 24, 2014), ECF No. 73.
- 198 *How do NFLPS physicians collaborate with team trainers to ensure optimum health for players?*, Nat'l Football League Physicians Soc'y, <http://nflps.org/faqs/how-do-nflps-physicians-collaborate-with-team-trainers-to-ensure-optimum-health-for-players/> (last visited Aug. 7, 2015), archived at <http://perma.cc/HVD3-BJJ5>.
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- 201 Dave Siebert, *What Is Medical Care Like on an NFL Sideline?*, Bleacher Report (Nov. 15, 2013), <http://bleacherreport.com/articles/1850732-what-is-medical-care-like-on-an-nfl-sideline>, archived at <http://perma.cc/7JR4-HR3G>.
- 202 *Id.*
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- 204 Siebert, *supra* note 201.
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- 208 *Id.*
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- 212 *Id.*
- 213 H.R. 921/S. 689, 114th Cong. (2015).
- 214 Siebert, *supra* note 201.
- 215 See, e.g., Kirsten E. Austad, et al., *Changing Interactions Between Physician Trainees and the Pharmaceutical Industry: A National Survey*, 28 J. Gen. Intern. Med. 164–71 (2013) (analyzing how pharmaceutical companies' access to medical students might affect student attitudes toward the industry); Christopher T. Robertson et al., *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 J. L., Med., & Ethics 452 (2012) (discussing ways in which financial relationships can influence physician decisions); Kate Greenwood, Carl H. Coleman, Kathleen M. Boozang, *Toward Evidence-Based Conflicts of Interest Training for Physician-Investigators*, 40 J.L. Med. & Ethics 500, 505–06 (2012).
- 216 Howard Fendrich and Eddie Pells, *AP Survey: NFL players question teams' attitudes on health*, Associated Press (Jan. 30, 2016, 7:39 PM), <http://pro32.ap.org/article/ap-survey-nfl-players-question-teams%E2%80%99-attitudes-health>, archived at <https://perma.cc/V5RR-XGY3>.
- 217 *Id.*
- 218 Des Bieler, *Calvin Johnson says painkillers were handed out 'like candy' to NFL players*, Wash. Post, July 6, 2016, <https://www.washingtonpost.com/news/early-lead/wp/2016/07/06/calvin-johnson-says-painkillers-were-handed-out-like-candy-to-nfl-players/>, archived at <https://perma.cc/H6HS-YVTM>.
- 219 See 2011 CBA, Art. 39, § 1(c) (“All Club physicians are required to disclose to a player any and all information about the player's physical condition that the physician may from time to time provide to a coach or other Club representative, whether or not such information affects the player's performance or health. If a Club physician advises a coach or other Club representative of a player's serious injury or career threatening physical condition which significantly affects the player's performance or health, the physician will also advise the player in writing. The player, after being advised of such serious injury or career-threatening physical condition, may request a copy of the Club physician's record from the examination in which such physical condition was diagnosed and/or a written explanation from the Club physician of the physical condition.”)
- 220 Andrew Brandt, *Peer Review Response* (Oct. 30, 2015).
- 221 CBA, Art. 39, § 3(a).
- 222 NFL Comments and Corrections (June 24, 2016).
- 223 CBA, Art. 39, § 3(d).
- 224 CBA, Art. 50, § 1(a).
- 225 CBA, Art. 50, § 1(d).
- 226 This information was provided by the NFLPA.
- 227 *Id.*
- 228 See 2011 CBA, Art. 43, § 1.
- 229 See 2011 CBA, Art. 43, § 6 (discussing constitution of Arbitration Panel); 2011 CBA, Art. 43 § 8 (discussing Arbitrator's authority, including to grant a “money award”).
- 230 For articles discussing generally medical malpractice in the sports context and the preclusion of claims by workers' compensation statutes, see, e.g., Matthew J. Mitten, *Team Physicians as Co-Employees: A Prescription that Deprives Professional Athletes of an Adequate Remedy for Sports Medicine Malpractice*, 50 St. Louis U. L.J. 211 (2005); John Redlingshafer, *Tonight's Matchup – Workers' Compensation v. Medical Malpractice: What Should Lower-Paid, Inexperienced Athletes Received When a Team Doctor Allegedly Aids in Ending Their Careers?*, 2 DePaul J. Sports L. & Contemp. Probs. 100 (2004) (same).
- 231 See *Lotysz v. Montgomery*, 766 N.Y.S.2d 28 (N.Y. App. Div. 2003) (NFL player's medical malpractice claim against club doctor barred by state workers' compensation statute); *Daniels v. Seattle Seahawks*, 968 P.2d 883 (Wash. Ct. App. 1998) (same); *Hendy v. Losse*, 819 P.2d 1 (Cal. 1991) (same). See also Pam Louwagie & Kevin Seifert, *Stringer Claims Against Vikings Dismissed*, Newspaper of the Twin Cities (Minneapolis, MN), Apr. 26, 2003, available at 2003 WLNR 14250471 (medical malpractice claims against Club doctors barred by workers' compensation statute). See *Rivers v. New York Jets*, 460 F.Supp. 1233 (E.D. Mo. 1978) (player's claim that Club wrongfully concealed the true nature of player's condition barred by workers' compensation statute); *Brinkman v. Buffalo Bills Football Club Division of Highwood Service, Inc.*, 433 F.Supp. 699 (W.D.N.Y. 1977) (player's claim that Club failed to provide adequate medical care barred by workers' compensation law). But see *Bryant v. Fox*, 515 N.E.2d 775 (Ill. App. Ct. 1987) (NFL player's medical malpractice claim against Club doctor not barred by workers' compensation statute where evidence established that doctor was an independent contractor). Case law from other sports leagues suggests the same outcome. See, e.g., *Martin v. Casagrande*, 559 N.Y.S.2d 68 (N.Y. App. Div. 1990) (NHL player's claim that Club doctor and general manager conspired to withhold information about player's medical condition barred by workers' compensation statute); *Bayless v. Philadelphia National League Club*, 472 F.Supp. 625 (E.D. Pa. 1979) (former MLB player's claim that Club negligently administered pain-killing drugs barred by workers' compensation statute).

- 232 See William J. Appel, “Dual capacity doctrine” as basis for employee’s recovery for medical malpractice from company medical personnel, 73 A.L.R.4th 115 (1999); Nick DiCello, No Pain, No Gain, No Compensation: Exploiting Professional Athletes through Substandard Medical Care Administered by Team Physicians, 49 Clev. St. L. Rev. 507, 532–33 (2001).
- 233 See *Jackson v. Kimel*, 992 F.2d 1318, 1325 n.4 (4th Cir. 1993) (collecting cases holding that employees that are not signatories to the CBA cannot be sued for violations of the CBA).
- 234 See 2011 CBA, Art. 2, § 2 (generally discussing CBA’s binding effect on NFL, NFLPA, players and Clubs but no other party).
- 235 CBA, Art. 43, § 2.
- 236 This information was provided by the NFLPA.
- 237 The Non-Injury Grievance arbitrator has the authority to determine whether a complaint against a doctor fit within his or her jurisdiction under Article 43. See 2011 CBA, Art. 43, § 1 (discussing scope of Non-Injury Grievance arbitrator’s jurisdiction).
- 238 U.S.C. § 185.
- 239 *Allis-Chambers Corp. v. Lueck*, 471 U.S. 202, 213, 200 (1985).
- 240 See, e.g., *Givens v. Tennessee Football, Inc.*, 684 F. Supp. 2d 985 (M.D. Tenn. 2010) (player’s tort claims against Club arising out of medical treatment preempted); *Williams v. Nat’l Football League*, 582 F.3d 863 (8th Cir. 2009) (players’ tort claims arising out of drug test preempted).
- 241 See, e.g., *Givens*, 684 F. Supp. 2d 985 (claims against Club preempted); *Jeffers v. D’Alessandro*, 199 N.C. App. 86 (N.C. App. 2009) (same); *Sherwin v. Indianapolis Colts, Inc.*, 752 F.Supp. 1172 (N.D.N.Y. 1990) (claims against Club preempted; claims against doctors dismissed on jurisdictional grounds); see also *Brocaill v. Detroit Tigers, Inc.*, 268 S.W.3d 90 (Tex. App. 2008) (MLB player’s claim that Club failed to provide a proper second opinion preempted).
- 242 (*Das, Arb. Mar. 25, 2008*). For a more complete discussion of *Jeffers*, see Chapter 8: NFL Clubs.
- 243 See *Hendy*, 819 P.2d 1; Pam Louwagie & Kevin Seifert, *Stringer Claims Against Vikings Dismissed*, Newspaper of the Twin Cities (Minneapolis, MN), Apr. 26, 2003, available at 2003 WLNR 14250471.
- 244 Felisa Cardona, *Jury Finds Doctor Not Negligent in Advice to Former Bronco Al Wilson*, Denver Post, Jun. 17, 2011, http://www.denverpost.com/ci_18296823, archived at <http://perma.cc/QUJL8-4WTU>.
- 245 NFL Comments and Corrections (June 24, 2016).
- 246 U.S.C. §§ 11101–52.
- 247 See Michael D. Benson, Jordan B. Benson, Mark S. Stein, *Hospital Quality Improvement: Are Peer Review Immunity, Privilege, and Confidentiality in the Public Interest?* 11 NW J. L. & Soc. Pol’y 1 (2016).
- 248 U.S.C. § 11137(b)(1).
- 249 *Id.*
- 250 NFL Comments and Corrections (June 24, 2016).
- 251 *Id.*
- 252 This information was provided by the NFLPA.
- 253 U.S. Medical Regulatory Trends and Actions, Fed’n of State Med. Bds. 19 (2014), http://www.fsmb.org/Media/Default/PDF/FSMB/Publications/us_medical_regulatory_trends_actions.pdf.
- 254 See Am. Med. Ass’n, *State Med. Licensure Requirements and Statistics 2014*, 91–93 (2014) (discussing states which have adopted or reference the AMA Code); Ty Alper, *The Role of State Medical Boards in Regulating Physician Participation in Executions*, 95 *Journal of Med. Licensure and Discipline* 7 (2009) (“The ethical guidelines of the state-based medical associations, many of which mirror those of the AMA . . .”); W. Noel Keyes, *The Choice of Participation by Physicians in Capital Punishment*, 22 *Whittier L. Rev.* 809 (2001) (discussing adopting of the AMA Code by many states).
- 255 Mark A. Hall et al., *Health Care Law and Ethics* 137 (2003).
- 256 *Rules in Cases of Original Jurisdiction*, Am. Med. Ass’n, <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs/governing-rules/rules-cases-original-jurisdiction.page?> (last visited Aug. 7, 2015), archived at <http://perma.cc/P82E-TFV7>.
- 257 Bylaw 6.50 of the Council on Ethical and Judicial Affairs, Am. Med. Ass’n, <http://www.ama-assn.org/ama/pub/about-ama/our-people/ama-councils/council-ethical-judicial-affairs/ceja-bylaws.page?> (last visited Aug. 7, 2015), archived at <http://perma.cc/F9QQ-K57A>.
- 258 *Id.*
- 259 *Id.*
- 260 See Art. 11 of the FIMS Statutes, Int’l Fed. of Sports Med., <http://www.fims.org/en/general/statutes> (last visited Aug. 7, 2015), archived at <http://perma.cc/SL4Q-NHAU>.
- 261 CBA, Art. 39, § 1(c).
- 262 See Christopher T. Robertson et al., *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 *J. of L., Med. & Ethics* 452 (2012) (discussing ways in which financial relationships can influence physician decisions); Aaron S. Kesselheim & David Orentlicher, *Introduction: Insights from a National Conference: “Conflicts of Interest in the Practice of Medicine,”* 40 *J. of L., Med. & Ethics* 436–40 (2012) (same).
- 263 Opinion 1.2.5–Sports Medicine, Am. Med. Ass’n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/4QS7-F5FT>.
- 264 FIMS Code of Ethics at ¶ 1, ¶ 4.
- 265 See e.g., Brad Partridge, *Dazed and Confused: Sports Medicine, Conflicts of Interest, and Concussion Management*, 11 *J. of Bioethical Inquiry* 65–74 (2014); Testoni et al., *Sports Medicine and Ethics*, 13 *Am. J. of Bioethics* 10 (2013); Warren R. Dunn et al., *Ethics in Sports Medicine*, 35 *Am. J. of Sports Med.* 840–44 (2007); Ivan Waddington, *Sport Health and Drugs* (2000).
- 266 Thomas H. Murray, *Divided Loyalties in Sports Medicine*, 12:8 *The Physician & sportsmedicine* 134, 140 (1984).
- 267 CBA, Art. 39, § 1(c).
- 268 Jessica L. Roberts, et al., *Evaluating NFL Player Health and Performance: Legal and Ethical Issues*, U. Penn. L. Rev. (forthcoming 2016).
- 269 See 2011 CBA, Art. 15, § 6; Art. 16, § 7; Art. 66, § 1.
- 270 See, Robertson et al., *supra* n 263; Kesselheim and Orentlicher, *supra* n. 263.
- 271 NFL Comments and Corrections (June 24, 2016).
- 272 Kate Greenwood, Carl H. Coleman, Kathleen M. Boozang, *Toward Evidence-Based Conflicts of Interest Training for Physician-Investigators*, 40 *J.L. Med. & Ethics* 500, 505–06 (2012); Christopher Robertson, Susannah Rose, Aaron S. Kesselheim, *Effect of Financial Relationships on the Behaviors of Health Care Professionals: A Review of the Evidence*, 40 *J.L. Med. & Ethics* 452, 453 (2012).
- 273 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 Partridge, *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).
- 274 See, e.g., *Uniform Anatomical Gift Act* (2006), § 14(i) (“Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent’s death may participate in the procedures for removing or transplanting a part from the decedent.”); *Ethical Controversies in Organ Donation After Circulatory Death*, *Am. Acad. of Pediatrics* (2013), <http://pediatrics.aappublications.org/content/131/5/1021>, archived at <https://perma.cc/NN9V-7RKK>.

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- 278 See Christopher Tarver Robertson, *Biased Advice*, 60 Emory L.J. 653, 666–68 (2011) (explaining study showing that disclosing parties “apparently felt that the disclosure gave them a ‘moral license’ to be even more biased” and that the people to the whom biases are disclosed “failed to effectively use the disclosure to adjust for the inaccuracy of the given advice[.]”); Omri Ben-Shahar & Carl E. Schneider, *The Failure of Mandated Disclosure*, 159 U. Penn. L. Rev. 647 (2011); I Robert Gatter, *Communicating Loyalty: Advocacy and Disclosure of Conflicts in Treatment and Research Relationships*, in *The Oxford Handbook of U.S. Health Law* (I. Glenn Cohen, Allison K. Hoffman, William M. Sage eds. 2015–2016).
- 279 See Defendant National Football League’s Response to the Players Association’s December 2, 2014 Letter Brief, *Dent v. Nat’l Football League*, 14-cv-2324, 2–3 (N.D. Cal. Dec. 4, 2014) (NFL explaining that the NFLPA’s position “that lawsuits by players against club doctors are [not] prohibited by applicable CBAs . . . is consistent with what the NFL told [the] Court”; also explaining that “there ‘very well could be’ a non-preempted malpractice lawsuit against a Club doctor”; and, acknowledging that malpractice suits against club doctors “regularly are brought to verdict against Club physicians.”)
- 280 See Practice: Personal Injury and Tort, JAMS, <http://www.jamsadr.com/personal-injury/> (last visited Aug. 7, 2015), archived at <http://perma.cc/5Z2V-MHXR>.
- 281 U.S.C. § 321(g)(1).
- 282 U.S.C. § 801, et seq.
- 283 This information was provided by the NFL and NFLPS.
- 284 This information was provided by the NFL.
- 285 See Complaint, *Dent v. Nat’l Football League*, 14-cv-2324 (N.D. Cal. May 20, 2014), ECF No. 1, ¶ 203 (“amphetamines in the form of yellow and purple pills were available in jars in the locker room for any and all to take as they saw fit”); Sally Jenkins & Rick Maese, *Pain and Pain Management in NFL Spawn a Culture of Prescription Drug Use and Abuse*, Wash. Post, April 14, 2013, available at 2013 WLNR 9074933 (William Barr, the director of New York University’s Langone Medical Center, and a concussion consultant for the New York Jets from 1995 to 2004 describing a “huge candy jar of Toradol”); see Rob Huizenga, *You’re Okay, It’s Just a Bruise 13* (1994) (former Raiders Club doctor describing the safe door where prescription medications were kept as “wide open”); id. at 40 (players complaining that Huizenga had removed the “candy jar”); Scranton, Pierce E. Scranton, Jr., *Playing Hurt: Treating and Evaluating the Warriors of the NFL 27* (2001) (discussing providing the anesthetic Marcaine so that players could make it through the game; and providing Vicodin or Percocet after the game for pain management).
- 286 See Complaint, *Dent v. Nat’l Football League*, 14-cv-2324 (N.D. Cal. May 20, 2014), ECF No. 1, ¶ 204 (alleging that jars of amphetamines were removed after the death of NFL safety Don Rogers and NBA prospect Len Bias in 1986); *Whatever It Takes: To Stay In The Game*, Tampa Tribune (FL), Dec. 30, 2007, available at 2007 WLNR 25835392 (NFL player Brad Culpepper: “It’s not like there’s a giant candy jar out in the open that you just go stick your hand into and pull out the meds . . . [i]t’s just keep it under lock and key.”); See Rob Huizenga, *You’re Okay, It’s Just a Bruise* (1994) (discussing the end to the “candy jar” practice).
- 287 Indeed, even if a “jar” was no longer available, Former Player 1, who retired in 2010, said Club doctors would provide “painkillers and anti-inflammatories . . . like candy.” Additionally, Former Player 1 said that the Club doctors never discussed any of the risks or benefits of the painkillers with the players.
- 288 John Tokish, Elisha Powell, Theodore Schlegel & Richard Hawkins, *Ketorolac Use in the National Football League*, 30 *The Physician and Sports Medicine* 9 (2002).
- 289 of the then 31 NFL Clubs responded to the survey.
- 290 Id. at 21.
- 291 Ketorolac, Nat’l Inst. Health: U.S. Nat’l Library of Med., <http://www.nlm.nih.gov/medlineplus/druginfo/meds/a693001.html> (last visited Aug. 7, 2015), archived at <http://perma.cc/TU2P-6FDX>.
- 292 John Barr, *Painkiller Misuse Dulls the NFL Pain*, ESPN, <http://sports.espn.com/espn/eticket/story?page=110128/painkillersnews> (last visited Aug. 7, 2015), archived at <http://perma.cc/FSP7-AAES>, citing Centers for Disease Control and Prevention, *Unintentional Drug Poisoning in the United States* (July 2010).
- 293 Linda Cottler, Arbi Ben Abdallah, Simone Cummings, John Barr, Rayna Banks & Ronnie Forchheimer, *Injury, Pain, and Prescription Opioid Use Among Former National Football League (NFL) Players*, 116 *Drug Alcohol Depend.* 188,194 (2011).
- 294 It is unclear what group the Washington/ESPN study references. There are various unofficial groups of former NFL players with a variety of monikers, but research has not revealed any group using the name “Retired NFL Football Players Association.”
- 295 The Washington/ESPN study adopted the definition of “misuse” from the U.S. National Survey on Drug Use and Health, meaning “use without a prescription or use simply for the experience or feeling the drug causes.”
- 296 See Jim Baumbach, *Life After Football*, Newsday, Jan. 22, 2015, <http://data.newsday.com/projects/sports/football/life-football/>, archived at <http://perma.cc/77DP-LUUE>.
- 297 What are over-the-counter (OTC) drugs and how are they approved? F.D.A., <http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194951.htm> (last visited June 17, 2016), archived at <https://perma.cc/C6U2-3Q2X>.
- 298 U.S.C. § 353(b)(1).
- 299 Peter Barton Hutt, Richard A. Merrill, Lewis A. Grossman, *Food and Drug Law 815* (2007).
- 300 The list of controlled substances can be viewed from the DEA’s website at http://www.deadiversion.usdoj.gov/schedules/orangebook/c_cs_alpha.pdf, archived at <https://perma.cc/3WUT-FDRP?type=pdf>.
- 301 U.S.C. § 801, et seq.
- 302 Brian T. Yeh, *The Controlled Substances Act: Regulatory Requirements*, Congressional Research Service, 1 (2012), <https://www.fas.org/sgp/crs/misc/RL34635.pdf>, archived at <https://perma.cc/P79Q-BPXC?type=pdf>.
- 303 Peter Barton Hutt, Richard A. Merrill, Lewis A. Grossman, *Food and Drug Law 60* (2007).
- 304 U.S.C. §§ 811–12.
- 305 See 21 U.S.C. § 812(c) (listing Schedules of controlled substances); U.S. Dep’t of Justice– Drug Enforcement Administration, *Practitioner’s Manual: An Informational Outline of the Controlled Substances Act*, 5 (2006), http://www.deadiversion.usdoj.gov/pubs/manuals/pract/pract_manual012508.pdf [hereinafter *DEA Practitioner’s Manual*] (describing Schedules of controlled substances). Schedule I substances are those that: (a) have a high potential for abuse; (b) has no currently accepted medical use in the United States; and (c) there is a lack of accepted safety for use of the drug or other substance under medical supervision. 21 U.S.C. § 812(b)(1). Cocaine is a Schedule II controlled substance. 21 U.S.C. § 812(c). Anabolic steroids are a Schedule III controlled substance. Id.
- 306 *DEA Practitioner’s Manual* at 6 (describing Schedules of controlled substances).
- 307 Id. at 4.
- 308 See 21 U.S.C. § 844 (prescribing criminal penalties for possession of a controlled substance without a prescription); 21 U.S.C. § 829 (prohibiting the dispensing of Schedule II, III or IV controlled substances without a prescription).

- 309 Vicodin, Percocet, and OxyContin are brand names for certain types of opioid pain medications. Opioids are Schedule II controlled substances. 21 U.S.C. § 812(c).
- 310 See Agents Visit Cincy, Lions About Meds, ESPN (Nov. 17, 2014), http://espn.go.com/nfl/story/_id/11895109/lions-bengals-teams-question, archived at <http://perma.cc/4MHW-G7SB>.
- 311 “The term ‘distribute’ means to deliver (other than by administering or dispensing) a controlled substance or a listed chemical. The term ‘distributor’ means a person who so delivers a controlled substance or a listed chemical.” 21 U.S.C. § 802(11).
- 312 “The term ‘dispense’ means to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. The term ‘dispenser’ means a practitioner who so delivers a controlled substance to an ultimate user or research subject.” 21 U.S.C. § 802(10).
- 313 C.F.R. § 1301.11.
- 314 U.S.C. § 823(b).
- 315 In considering whether someone is qualified to be registered to distribute Schedule I or II controlled substances, the DEA considers: “(1) maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels; (2) compliance with applicable State and local law; (3) prior conviction records of application under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances; (4) past experience in the distribution of controlled substances; and (5) such other factors as may be relevant to and consistent with the public health and safety.” 21 U.S.C. § 823(b).
- 316 See Cal. Health & Safety Code § 11150 (West 2014) (“[n]o person other than a physician, dentist, podiatrist, or veterinarian, or naturopathic doctor . . . or pharmacist . . . shall write or issue a prescription”); see Cal. Health & Safety Code § 11153 (West 2014) (“[a] prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice”); N.Y. Public Health Law § 3331 (“[a] practitioner [or veterinarian], in good faith, and in the course of his or her professional practice only [in the course of the practice of veterinary medicine only], may prescribe, administer and dispense [scheduled substances] or he may cause them to be administered by a designated agent under his direction and supervision”); Tex. Health & Safety Code Ann. § 481.061 (“[e]xcept as otherwise provided by this chapter, a person who is not a registrant may not manufacture, distribute, prescribe, possess, analyze, or dispense a controlled substance in this state”); Tex. Health & Safety Code Ann. § 481.002 (“[p]ractitioner’ means: (A) a physician, dentist, veterinarian, podiatrist, scientific investigator, or other person licensed, registered, or otherwise permitted to distribute, dispense, analyze, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state. . . . ‘Prescribe’ means the act of a practitioner to authorize a controlled substance to be dispensed to an ultimate user”).
- 317 See also DEA Practitioner’s Manual at 47–51 (attaching DEA Form 224, Application for Registration, which requires the applicant to identify his or her “business activity” from a finite list of medical professions, and requires the applicant to provide his or her state license number).
- 318 C.F.R. § 1301.12; see also *U.S. v. Clinical Leasing Service, Inc.*, 925 F.2d 120 (5th Cir. 1991) (statute requiring registration of physicians who distribute controlled substances at “each principal place of business” was not unconstitutionally vague).
- 319 C.F.R. § 1301.71(a).
- 320 Opinion 9.6.6—Prescribing & Dispensing Drugs & Devices, Am. Med. Ass’n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/D4J6-JH8K>.
- 321 This information was provided by the NFL and NFLPS.
- 322 This information was provided by the NFL.
- 323 Letter from Larry Ferazani, NFL, to authors (July 18, 2016).
- 324 This information was provided by the NFL.
- 325 Letter from Larry Ferazani, NFL, to authors (July 18, 2016).
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- 329 Nat’l Football League, 2015 Player Health & Safety Report 26 (2015), <http://static.nfl.com/static/content/public/photo/2015/08/05/0ap3000000506671.pdf>, archived at <https://perma.cc/Y4BN-TUP7?type=pdf>.
- 330 *Id.*
- 331 Matthew Matava et al., Recommendations of the National Football League Physicians Society Task Force on the Use of Toradol Ketorolac in the National Football League, 4 Sports Health 377 (2012). At the time, Matava was the St. Louis Rams Club doctor, and co-authors Gritter and Heyer were Carolina Panthers Club doctors, Schlegel was a Denver Broncos Club doctor, and Yates was a Pittsburgh Steelers Club doctor.
- 332 *Id.* at 378.
- 333 *Id.* at 382.
- 334 Letter from Tim English, Staff Counsel, NFLPA, to Dennis Curran, Senior VP of Labor Litigation & Policy, NFL (Dec. 11, 2012), available as Exhibit 18 to the Declaration of Dennis L. Curran in Support of Defendant National Football League’s Motion to Dismiss Second Amended Complaint (Section 301 Preemption), *Dent v. Nat’l Football League*, 14-cv-2324 (N.D. Cal. Sep. 24, 2014), ECF No. 73.
- 335 Dave Siebert, What Is Medical Care Like on an NFL Sideline?, Bleacher Report (Nov. 15, 2013), <http://bleacherreport.com/articles/1850732-what-is-medical-care-like-on-an-nfl-sideline>, archived at <http://perma.cc/7JR4-HR3G>.
- 336 Outside the Lines Discussion: Prescription Medication in the NFL, (ESPN television broadcast Nov. 17, 2014), http://espn.go.com/nfl/story/_id/11895109/lions-bengals-teams-questioned-dea-agents, archived at <http://perma.cc/4MHW-G7SB>.
- 337 Agents Visit Cincy, Lions About Meds, ESPN (Nov. 17, 2014), http://espn.go.com/nfl/story/_id/11895109/lions-bengals-teams-question, archived at <http://perma.cc/4MHW-G7SB>; Ken Belson, Federal Investigation Into Painkillers Targets N.F.L. Teams’ Medical Staffs, N.Y. Times, Nov. 17, 2014, http://www.nytimes.com/2014/11/17/sports/football/dea-investigation-of-painkillers-targets-nfl-teams-medical-staffs.html?_r=0, archived at <http://perma.cc/MTU2-MLC5>.
- 338 *Id.*
- 339 *Id.*
- 340 Outside the Lines Discussion: Prescription Medication in the NFL, *supra* note 337.
- 341 NFL Substance Abuse Policy, General Policy, n. 1.
- 342 NFL Substance Abuse Policy at p. 1.
- 343 *Id.*
- 344 NFL Substance Abuse Policy, § 1.4.1.
- 345 NFL Substance Abuse Policy, § 1.5.1(a).
- 346 *Id.*
- 347 *Id.*
- 348 NFL Substance Abuse Policy, § 1.5.1(b).
- 349 *Id.*
- 350 NFL Substance Abuse Policy, § 1.5.2(a).
- 351 NFL Substance Abuse Policy, § 1.5.2(d).
- 352 *Id.*

- 353 Letter from Tim English, Staff Counsel, NFLPA, to Dennis Curran, Senior VP of Labor Litigation & Policy, NFL (Dec. 11, 2012), available as Exhibit 18 to the Declaration of Dennis L. Curran in Support of Defendant National Football League's Motion to Dismiss Second Amended Complaint (Section 301 Preemption), *Dent v. Nat'l Football League*, 14-cv-2324 (N.D. Cal. Sep. 24, 2014), ECF No. 73.
- 354 This information was provided by the NFLPA.
- 355 E-mail with Larry Ferazani NFL, Vice President, Labor Litigation & Policy (June 1, 2016). As discussed earlier, in 2012, one club doctor did require players to sign a waiver before administering Toradol.
- 356 See Complaint, *Dent v. Nat'l Football League*, 14-cv-2324 (N.D. Cal. May 20, 2014), ECF No. 1.
- 357 *Id.* at ¶ 15. In addition to state law claims sounding in fraud and negligence, the plaintiffs alleged the NFL violated several statutes. For example, the plaintiffs allege that the NFL violated: "the Controlled Substances Act's requirements governing the acquisition, storage, provision and administration of, and recordkeeping concerning, Schedule II, III and IV controlled substances"; the Food, Drug, and Cosmetic Act's "requirements for prescriptions, warnings about known and possible side effects, and proper labeling, among other violations"; and, "state laws governing the acquisition, storage and dispensation of prescription medications." *Id.* at ¶¶ 354–57.
- 358 *Id.*
- 359 *Dent v. Nat'l Football League*, 14-cv-2324, 2014 WL 7205048 (N.D. Cal. Dec. 17, 2014). See also *Nelson v. Nat'l Hockey League*, 13-cv-4846, 2014 WL 656793 (N.D.Ill. Feb. 20, 2014) (claims by estate of deceased NHL player that NHL negligently failed to monitor the player's use of addictive medications and head trauma preempted by CBA).
- 360 *Dent v. Nat'l Football League*, 14-cv-2324, 2014 WL 7205048 at *12 (N.D. Cal. Dec. 17, 2014).
- 361 *Id.*
- 362 *Dent v. NFL*, 15-15143 (9th Cir.).
- 363 See Complaint, *Evans v. Arizona Football Clubs, LLC*, 15-cv-1457 (D.Md. May 21, 2015), ECF No. 1.
- 364 See *id.*; Josh Alper, Former players file 2nd lawsuit claiming teams pushed painkillers to mask pain, ProFootballTalk (May 21, 2015, 4:21 PM), <http://profootballtalk.nbcsports.com/2015/05/21/former-players-file-2nd-lawsuit-claiming-teams-pushed-painkillers-to-mask-pain/>, archived at <http://perma.cc/53R8-T8UK>.
- 365 *Evans v. Arizona Cardinals Football Club*, 16-cv-1030, 2016 WL 3566945, *1 (N.D.Ca. July 1, 2016).
- 366 *Id.*
- 367 *Id.* at *4.
- 368 *Id.*

