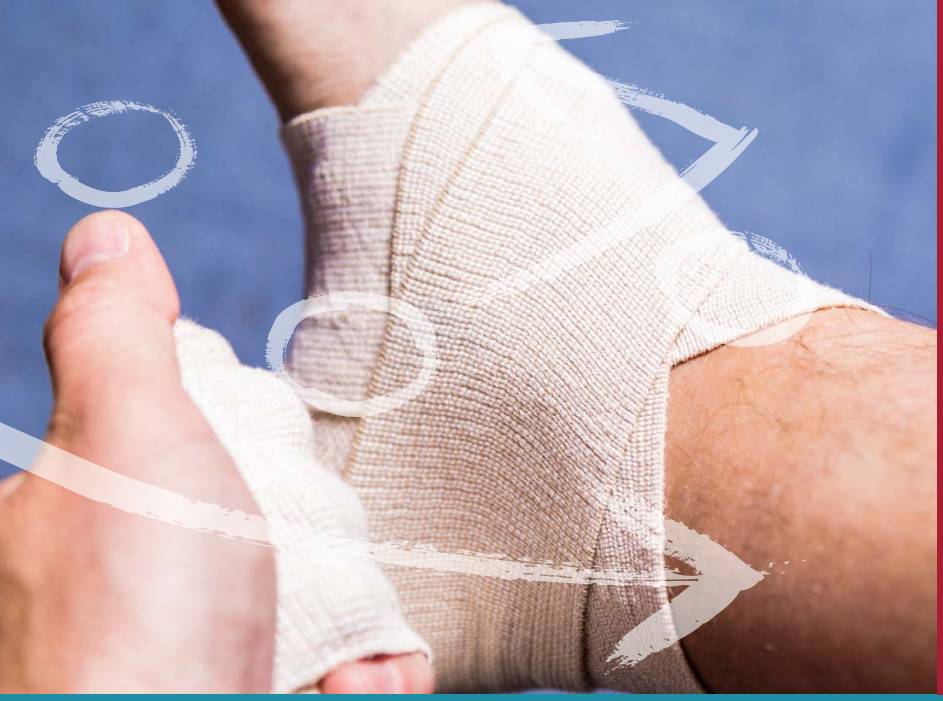

Protecting and Promoting the
Health of NFL Players:
Legal and Ethical Analysis and Recommendations

Chapter 3

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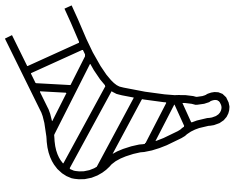
Athletic Trainers



Athletic trainers are generally NFL players' first line of healthcare and are thus important stakeholders in player health. While athletic trainers may very well provide the best care possible to players, the structure in which athletic trainers — who are employees of the club and part of the club's medical staff — provide care to players has the potential to conflict with players' best interests, and raises concerns, as will be explained below. As discussed in Chapter 2: Club Doctors, on the one hand, the club's medical staff has an obligation to provide the player care and advice that is in the player's best interests. On the other hand, clubs engage athletic trainers and doctors because medical information about and assessment of players is necessary for clubs' decisions about a player's ability to perform at a sufficiently high level in the short and long-term. These dual roles for club medical staff, including athletic trainers, conflict because players and clubs often have conflicting interests, but the medical staff is called to serve both parties.

Before we begin our analysis, it is important to point out that throughout this chapter we emphasize that the practice of athletic trainers is likely heterogeneous from club to club at least to some extent. Nevertheless, we were unable to interview athletic trainers 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 (the joint association for NFL clubs, *i.e.,* club athletic trainers' employers), 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 our 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.

Specifically, the NFL facilitated review of Part 2: The Medical Team by four NFL club athletic trainers, all of whom were members of the Professional Football Athletic Trainers Society (PFATS), and PFATS' outside counsel, prior to publication. We did not communicate with PFATS directly. PFATS provided comments through the NFL, which were incorporated into this Report.

Also, in April 2016, we engaged the National Athletic Trainers Association (NATA), a professional organization for athletic trainers in all sports and at all levels of play, about reviewing relevant portions of a draft of this Report. Among comments provided to us, NATA asked whether we had sought to interview NFL club athletic trainers through either PFATS or NATA, apparently unaware of the NFL's prior response to our planned interviews. When we explained that we had not pursued such interviews for the reasons indicated above, NATA indicated that it would have preferred a different approach. At that time, we invited NATA to have individual club athletic trainers interviewed. Ultimately, however, NATA informed us that it discussed our invitation with PFATS and it declined.[1] Indeed, when it provided comments for this chapter, PFATS, the organization with the highest level of interest in protecting club athletic trainers, did not raise any concern that we had not interviewed athletic trainers as part of this Report.

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

(A) Background

The CBA dictates the required presence, education and certification of athletic trainers:

> All athletic trainers employed or retained by Clubs to provide services to players, including any part time athletic trainers, must be certified by the National Athletic Trainers Association and must have a degree from an accredited four-year college or university. Each Club must have at least two full-time athletic trainers. All part-time athletic trainers must work under the direct supervision of a certified athletic trainer.[2]

The required education for athletic trainers has actually increased since the execution of the CBA. Athletic trainers now must have a master's degree.[3]

Each NFL club employs approximately four athletic trainers, including a head athletic trainer and three assistants. Head athletic trainers have an average of 21.9 years of experience in the NFL, while assistants average approximately 8.4 years of experience in the NFL.[4] In the 2014 season, 26 athletic trainers had at least 20 years of experience and 8 had more than 30 years of experience.[5] Athletic trainers, unlike most club doctors, are full-time employees of the club and not independent contractors.

To become a certified athletic trainer, an individual must graduate with a bachelor's or master's degree from an athletic training degree program accredited by the Commission on Accreditation of Athletic Training Education[a] and pass a test administered by the Board of Certification for the Athletic Trainer (BOC).[6] In addition, 42 states require licensure by the state, 3 states require certification (Louisiana, South Carolina, and New York) and 4 states only require registration (Oregon, Colorado, West Virginia, and Minnesota).[7] However, only three states (Illinois, Nebraska, and Vermont) require an athletic trainer to be certified by the BOC to be licensed.[8] Finally, only California has no licensure, certification, or registration requirements of any kind.[9]

States generally define athletic trainers as individuals responsible for the recognition, prevention, and treatment of athletic injuries.[10] The states that do describe athletic

a According to NATA, 85 percent of PFATS' members have at least a master's degree.

trainers' duties in more detail, define such duties in broad terms. Illinois' Athletic Trainers Practice Act is instructive:[b]

> Specific duties of the athletic trainer include but are not limited to:
>
> (a) Supervision of the selection, fitting, and maintenance of protective equipment;
>
> (b) Provision of assistance to the coaching staff in the development and implementation of conditioning programs;
>
> (c) Counseling of athletes on nutrition and hygiene;
>
> (d) Supervision of athletic training facility and inspection of playing facilities;
>
> (e) Selection and maintenance of athletic training equipment and supplies;
>
> (f) Instruction and supervision of student trainer staff;
>
> (g) Coordination with a team physician to provide:
>
> i pre-competition physical exam and health history updates,
>
> ii. game coverage or phone access to a physician or paramedic,
>
> iii. follow-up injury care,
>
> iv. reconditioning programs, and
>
> v assistance on all matters pertaining to the health and well-being of athletes.
>
> (h) Provision of on-site injury care and evaluation as well as appropriate transportation, follow-up treatment and rehabilitation as necessary for all injuries sustained by athletes in the program;
>
> (i) With a physician, determination of when an athlete may safely return to full participation post-injury; and
>
> (j) Maintenance of complete and accurate records of all athletic injuries and treatments rendered.[11]

Generally, state licensing statutes and regulations require athletic trainers to work under the direction of a licensed physician.[12] Indeed, all club athletic trainers work under the supervision of a club doctor and it is important that athletic trainers act within the scope of their practice. Nevertheless, athletic trainers are often the first and most consistent source of medical care provided to players. Club doctors generally only visit practice for a few hours a few times per week (*see* Chapter 2: Club Doctors, Section F: Current Practices), as players' conditions are unlikely to change much on a day-to-day basis. Thus, during the week, athletic trainers are responsible for treating ongoing injuries by all available methods, including, for example, ice, heat, ultrasound, massage, and stretching. The athletic trainer and club doctor remain in contact about players' conditions during the week and the club doctor directs the athletic trainer as to how treatment should proceed.[c]

Additionally, athletic trainers prepare players for each practice by taping, bracing, and padding various joints and body parts. Athletic trainers must also be prepared to respond to any new injuries that occur. Each day, athletic trainers, in consultation with the club's coaches and management, complete the daily Injury Report (discussed at length in Chapter 17: The Media), describing a player's practice participation level.[13]

Game days proceed similarly, only with the likelihood of injury significantly increased.[14] Athletic trainers assist in the evaluation of injuries, including the performance of relevant diagnostic testing. In so doing, athletic trainers work closely with the various club doctors present on game days.[15]

> Athletic trainers are often the first and most consistent source of medical care provided to players.

Athletic trainers are also largely responsible for maintaining the player's medical records. Beginning in 2014, all clubs utilize a customized electronic medical record (EMR) system created by eClinicalWorks.[16] A player's EMR consists of all of the athletic trainers' and doctors' diagnosis and treatment notations, including any sideline examination performed on the player.[17] Athletic trainers are generally the persons responsible for entering the notes into the EMR. Additionally, to the extent a player has obtained a second medical opinion paid for by the club, the athletic trainer will incorporate the second opinion doctor's report into the player's EMR.[18] The player's EMR also provides

b Nevertheless, in reviewing a draft of this chapter, NATA indicated that "many" statutes governing athletic trainers are currently under legislative review.

c According to the NFLPS, "[t]he 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 communication (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." *Frequently Asked Questions*, NFLPS, 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/8FL2-F54H.

de-identified data to the NFL Injury Surveillance System (NFLISS), which tracks player injuries and is discussed in greater detail in Chapter 1: Players.[19]

The EMR system also includes a player portal that permits players to access their medical records at any time, including after their career is over.[20] The player's EMR is otherwise restricted to the club medical staff and those for whom the player has authorized access.[21] However, as explained below, players routinely execute collectively bargained waivers permitting club employees to access their medical information. Additionally, clubs interested in acquiring a player can request access to a player's medical file.[22]

Given the breadth and depth of athletic trainers' work and experience, it is not surprising that some athletic trainers are responsible for the club's entire medical operations and staff. In the 2015 season, five clubs had head athletic trainers who were also Directors of Sports Medicine or some similar title for the club (Houston Texans, Atlanta Falcons, New York Giants, San Francisco 49ers, Seattle Seahawks), even though none of the athletic trainers are doctors. In this capacity, the head athletic trainers are responsible for overseeing the entire medical staff, including doctors, and serve as an important liaison among players, coaches, and management.[23] In addition, they might be principally responsible for determining and communicating with the club's outside medical providers.[24] As a matter of law and ethics, club athletic trainers' must practice under the direction of a doctor.[25] Thus, an athletic trainer's oversight of a club doctor must be merely administrative and should not extend to medical issues. However, if the athletic trainer has the authority to terminate the club's relationship with the club doctor, there is the possibility that the club doctor will feel pressure from the athletic trainer concerning certain medical issues.

As noted above, PFATS is an organization that represents the athletic trainers of NFL clubs.[26] "[M]embership in PFATS is limited to those professionally certified in accordance with the most current NFL Collective Bargaining Agreement and who are employed full-time as head or assistant athletic trainers by any of the 32 NFL franchises."[27] PFATS' mission statement is as follows:

> The Professional Football Athletic Trainers Society (PFATS) is a Professional Association representing the athletic trainers of the National Football League. We serve the players of the NFL, the member Clubs, and other members of the community. Our purpose is to ensure the highest quality of health care is provided to the National Football League. We are dedicated to the welfare of our members and committed to the promotion and advancement of athletic training through education and research. The Society is founded on the professional integrity and the ethical standards of our members and the fellowship that exists among us.[28]

In addition to PFATS, it is likely that many club athletic trainers are also members of NATA, mentioned above in the CBA provision. NATA is a voluntary professional membership association for certified athletic trainers across all levels of competition.[29] NATA's stated mission "is to enhance the quality of health care provided by certified athletic trainers and to advance the athletic training profession."[30] NATA informed us that 0.38 percent of its 32,651 members (equal to 124) work in the NFL.[31] At a mean of 3.875 per club, it appears almost every NFL athletic trainer is a member of NATA.

The CBA's requirement that athletic trainers be certified by NATA is actually in error and a requirement with which athletic trainers cannot comply. NATA is a voluntary professional association but does not *certify* athletic trainers. Athletic trainers are certified by the BOC.[32] The BOC used to be part of NATA, but split from the voluntary association in 1989.[33] Fortunately, the error has no impact, as all NFL athletic trainers are BOC-certified.[34] Nevertheless, to ensure players are being treated by the highest quality athletic trainers, the CBA should be amended to require the correct certification, the **Board of Certification for the Athletic Trainer.**

Lastly, the BOC promulgates Standards of Professional Practice.[35] The BOC is accredited by the National Commission for Certifying Agencies and is the only accredited certification program for athletic trainers in the United States.[36]

(B) Current Legal Obligations[d]

Athletic trainers generally have a duty to conduct themselves in accordance with "the standard of care required of an ordinary careful trainer" when providing care and treatment to athletes.[37] A breach of an athletic trainer's duty could lead to a negligence or medical malpractice claim. Whether the claim is considered medical malpractice depends on each state's medical malpractice and professional negligence laws and whether the athletic trainer is considered a healthcare professional within the scope of the law.[38]

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

Athletic trainers also have legal obligations consistent with their licensure. As discussed above, the vast majority of states require athletic trainers to be licensed. Generally, each state's governing act and/or related regulations also includes standards of professional conduct with which athletic trainers must comply.[39] Many of the standards are similar to those of other licensed or certified professionals, such as prohibitions against false statements and discrimination against protected classes.[40]

State statutes and regulations governing athletic trainers are inconsistent concerning the practice of out-of-state athletic trainers. As a general rule, each state's statute or regulations require a person performing the duties of an athletic trainer to be licensed by that state. Some states (such as Pennsylvania[41]) explicitly authorize athletic trainers from out-of-state teams to work within the state. However, other states (such as Florida[42]) do not provide any exemption for out-of-state athletic trainers. Thus, theoretically, athletic trainers of clubs from outside Florida whose clubs are playing in Florida may be violating Florida's statutes governing athletic trainers by performing services in Florida. Nevertheless, we are unaware of any enforcement proceedings brought against out-of-state athletic trainers performing services with a visiting club. We do not mean to suggest athletic trainers practicing out-of-state are acting inappropriately and, in fact, believe it may be preferable if all states had statutes explicitly permitting out-of-state athletic trainers to perform their duties within the state while with a visiting club. Because this does not appear to be a problem in practice, we have not made this a formal recommendation.

Although the CBA has many provisions governing player health and safety, only two are directed at athletic trainers.

First, as discussed above, the CBA dictates the required presence, education and certification of athletic trainers.

Second, athletic trainers have an obligation to permit a player to examine his medical records once during the preseason and once after the regular season. Athletic trainers are also obligated to provide a copy of a player's medical records to the player upon request in the offseason.[43] However, these CBA provisions, agreed to in 2011, are now outdated. As discussed above, players can now obtain their medical records any time they would like via the EMR system.

Below we discuss statutory requirements concerning the confidentiality of medical information. As briefly discussed in the introduction to this chapter, an athletic trainer's conflicting interests can create complications concerning the treatment of player medical information. Indeed, in Section D: Current Practices, we provide the thoughts of some current players about these conflicts. However, before discussing the statutory requirements, it is important to first state that 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. 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, even though these waivers have been collectively bargained between the NFL and NFLPA.[44]

Nevertheless, the federal Health Insurance Portability and Accountability Act (HIPAA) likely governs athletic trainer's requirements concerning the confidentiality of player medical information. HIPAA requires healthcare providers covered by the law to obtain a patient's authorization before disclosing health information protected by HIPAA.[45] 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."[46]

Athletic trainers likely meet the third criteria to be considered a covered entity under HIPAA.[e] A "[h]ealth care provider" is defined by HIPAA as anyone who "furnishes . . . health care in the normal course of business."[47] 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 individual or that affects the structure or function of the body."[48] Moreover, athletic trainers enter players' health information into EMRs that are accessed by doctors. Athletic trainers thus appear to provide healthcare within the meaning of HIPAA and thus must comply with its requirements.

In reviewing a draft of this Report, the NFL stated that "NFL Club medical teams, when providing medical care to players for football related injuries and illnesses, are not 'HIPAA-covered entities.'"[49] However, the NFL provided no explanation for this legal conclusion and did not respond specifically to our analysis in the prior paragraph.

e On a related point, it is not clear whether clubs would be considered covered entities under HIPAA. *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).

We acknowledge this is not a clear issue, but, based on our interpretation of HIPAA, it seems likely that athletic trainers are covered entities within the meaning of HIPAA and do have to comply with the law.

If athletic trainers are required to comply with HIPAA as we believe, the law nevertheless permits healthcare providers to provide health information about an employee to an employer without the employee's authorization where: (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.[50]

NFL club athletic trainers might meet the requirements of HIPAA, permitting them to provide health information about players to the clubs under the following conditions: (1) athletic trainers provide healthcare to players at the request of the employer; (2) nearly every time athletic trainers disclose medical information to the club, it concerns a work-related illness or injury; and, (3) NFL clubs are required by law to keep records of employee injuries, for example, the Occupational Health and Safety Act requires employers with more than 10 employees to maintain records of work-related injuries and illnesses.[51] 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.

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.

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.[52]

In addition to the federal HIPAA, some states have passed laws restricting the disclosure of medical information by healthcare providers.[53] 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.[54] Specifically, it likely varies from state to state whether athletic trainers are governed by the state confidentiality laws, *e.g.*, whether they are considered healthcare providers within the meaning of the law.

Similar to HIPAA, 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.[55,f] 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.

(C) Current Ethical Codes

Our initial research did not reveal any ethics code promulgated by PFATS. During its review of a draft of this chapter, PFATS did provide a non-public Code of Ethics that has existed as part of its Constitution since its formal organization in 1982. The sections of the Code most relevant to our analysis include:[56]

1. **General Principles:**

a. The Society is unique in its scope of caring for only athletes engaged under contract to an NFL Club. The membership is charged with the responsibility of providing unique and important health care for highly visible, talented and experienced athletes that are well paid to execute their talents as professional football players.

b. Although the primary role of the certified athletic trainer is to diligently work to make available the best possible health care for the players, the certified athletic trainer also serves as liaison between player, physician, coaching staff, management, and media and must always act in a professional manner in dealing with each of these groups.

* * *

f 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.

3. **National Athletic Trainers Association Code of Ethics:**
   The most current version of the Code of Ethics on the National Athletic Trainers Association (NATA) shall be deemed to be incorporated by reference as part of this Code of Ethics as if fully set forth herein.

4. **Responsibility of the Certified Athletic Trainer to the Player:**
   Player information given to the certified athletic trainer of a confidential nature with the context of the physician/patient relationship is privileged communication and must be held in trust by the certified athletic trainer.

5. **Responsibility of the Certified Athletic Trainer to the Medical Staff:**

a. It should be remembered that the role of the certified athletic trainer is that of a paramedical person, and that diagnosing of injuries/illnesses and prescribing remedial exercise and medication is the job of the physicians employed.

b. The certified athletic trainer shall honor the standing operating procedures established by the team physicians in the physicians' absence, and shall care for the athletes in compliance with standing orders until such time that the athletes can be seen by physicians.

6. **Responsibility of the Certified Athletic Trainer to the Club:**

a. The certified athletic trainer is a professional member of the NFL Club that is his employer and should be completely loyal to the Club.

b. Different Clubs and Coaches have different methods and philosophies. The certified athletic trainers are expected to provide their best professional services within the framework of the existing Club and coaching policy but should never violate professional ethics based on purported "Club Policy."

PFATS' Code of Ethics recapitulates the structural conflicts of interest in NFL player healthcare that we believe are problematic. The Code of Ethics includes multiple contradictions and troubling provisions that lay bare the inherent problem of having a medical provider provide services to both the club and players, as is discussed further in the recommendations below.

First, the Code of Ethics declares that athletic trainers must provide "the best possible health care for the players" but also declares that the athletic trainer "should be completely loyal to the Club." Providing the best possible healthcare might not always be in the club's interest. For example, recommending that a player miss games due to injury might be best for the player, but deprives the club of the player's services. The Code of Ethics does not address how athletic trainers are supposed to resolve these competing interests.

Second, the Code of Ethics declares that communications between the player and athletic trainer are confidential and "must be held in trust." However, the Code of Ethics also declares that an athletic trainer "serves as liaison between player, physician, coaching staff, management, and media," effectively acknowledging what we know to be actual practice—that athletic trainers communicate regularly with coaches and club executives about player health. Although these communications are permitted by the collectively bargained waivers executed by players as discussed above, PFATS' Code of Ethics on this point is self-contradictory.

Third, the Code of Ethics declares that "athletic trainers are expected to provide their best professional services within the framework of the existing Club and coaching policy[.]" It is unclear why athletic trainers' purported obligations to provide "the best possible health care for the players" is subject to "Club and coaching policy."

Fourth, the Code of Ethics references that NFL players are "highly visible, talented and experienced athletes that are well paid to execute their talents as professional football players." The players' visibility and compensation should be irrelevant to the healthcare that athletic trainers provide to the players and has no place in a Code of Ethics.

Moving on, as referenced in PFATS' Code of Ethics, NATA also has a Code of Ethics.[57] The principles most relevant to our analysis include:

> 1: Members shall respect the rights, welfare and dignity of all.
>
> 1.3: Members shall preserve the confidentiality of privileged information and shall not release such information to a third party not involved in the patient's care without a release unless required by law.
>
> 2.1: Members shall comply with applicable local, state, and federal laws and institutional guidelines.
>
> 3.2: Members shall provide only those services for which they are qualified through education or experience and which are allowed by their practice acts and other pertinent regulation.
>
> 4: Members shall not engage in conduct that could be construed as a conflict of interest or that reflects negatively on the profession.

> 4.3: Members shall not place financial gain above the patient's welfare and shall not participate in any arrangement that exploits the patient.[g]

The above-stated principles leave significant room for interpretation and debate and NATA does not make any enforcement decisions public. Consequently, it is difficult to know how these principles are applied in practice.

In addition, NATA issues a variety of "Position Statements," "Official Statements," "Consensus Statements" and "Support Statements" on a variety of topics related to the health of athletes generally, including treatment of various medical conditions and issues including but not limited to concussions, psychological issues, cardiac arrest, ankle sprains, performance-enhancing drugs, nutritional supplements, and weight loss and eating disorders.[58]

NATA also has issued a Position Statement on pre-participation physical examinations (PPE) and disqualifying conditions.[59] NATA's Position Statement directs that a "licensed physician (doctor of medicine or doctor of osteopathy) is the most appropriate person to direct and conduct the PPE."[60] Additionally, the Position Statement declares that "[p]rivacy must be respected at all times when the findings of the PPE are communicated. Written authorization must be provided by the athlete . . . before any private health information is released."[61] NATA's requirement of a written authorization is generally inconsistent with the law and ethical codes of doctors in cases of fitness-for-play examinations, which generally permit doctors performing PPEs to disclose medical information about the examination and the examinee to the employer, as discussed in Chapter 2: Club Doctors.

The BOC's Standards of Professional Practice also include several relevant directives, with which all certified athletic trainers must "agree to comply,"[62] including:

- **Standard 1:** The Athletic Trainer renders service or treatment under the direction of a physician.
- **Standard 2:** Prevention: The Athletic Trainer understands and uses preventive measures to ensure the highest quality of care for every patient.
- **Standard 3:** Immediate Care: The Athletic Trainer provides standard immediate care procedures used in emergency situations, independent of setting.
- **Standard 4:** Clinical Evaluation and Diagnosis: Prior to treatment, the Athletic Trainer assesses the patient's level of function. The patient's input is considered an integral part of the initial assessment. The Athletic Trainer follows standardized clinical practice in the area of diagnostic reasoning and medical decision making.
- **Standard 5:** Treatment, Rehabilitation and Reconditioning: In development of a treatment program, the Athletic Trainer determines appropriate treatment, rehabilitation and/ or reconditioning strategies. Treatment program objectives include long- and short-term goals and an appraisal of those which the patient can realistically be expected to achieve from the program. Assessment measures to determine effectiveness of the program are incorporated into the program.
- **Standard 6:** Program Discontinuation: The Athletic Trainer, with collaboration of the physician, recommends discontinuation of the athletic training service when the patient has received optimal benefit of the program. The Athletic Trainer, at the time of discontinuation, notes the final assessment of the patient's status.
- **Standard 7:** Organization and Administration: All services are documented in writing by the Athletic Trainer and are part of the patient's permanent records. The Athletic Trainer accepts responsibility for recording details of the patient's health status.

* * *

- **Code 1.2:** Protects the patient from harm, acts always in the patient's best interests and is an advocate for the patient's welfare.
- **Code 1.4:** Maintains the confidentiality of patient information in accordance with applicable law.
- **Code 1.6:** Respects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain.

Nevertheless, the above Code provisions are generalized and thus difficult to apply to NFL athletic trainers without more guidance. According to the BOC's Professional Practice and Discipline Guidelines and Procedures, it is "standard procedure" to publicly release any discipline imposed on an athletic trainer.[63] However, despite closing 304 disciplinary cases in 2015,[64] the BOC's database of disciplinary decisions only contains 63 cases from 2015,

g Concerning Principles 4 and 4.3, one could imagine a situation in which an athletic trainer recommended a certain piece of equipment, apparel, or other product because he or she was being compensated or had a financial interest in the companies producing the product. For example, in the 1980s, according to former Los Angeles Raiders Club Doctor Rob Huizenga, the Professional Football Athletic Trainer's Society had an agreement with Gatorade that resulted in only Gatorade being available on NFL sidelines. Rob Huizenga, You're Okay, It's Just a Bruise 17 (1994). It is unclear whether any such conflicts exist today. Nevertheless, there remains the inherent conflict of interest between the athletic trainer treating the player but being employed and compensated by the club.

and only 99 in total, dating back to 2002.[65] Moreover, the 63 cases in 2015 that are publicly available are not helpful in interpreting the BOC's Standards of Professional Practice: 44 concern failure to receive continuing education credits; 11 concern practicing without a license; 7 concern criminal conduct; and 1 concerns voluntarily surrendering a license. The BOC stated that "[m]ost of our disciplinary cases were private censures and those are not public."[66,h]

(D) Current Practices[i]

Players and contract advisors we interviewed confirmed that athletic trainers are generally the player's first and primary source of medical care.[j] Club doctors are only with the club sporadically during the week of practice, while the athletic trainers are with the club at all times.[k] Players will first meet with the athletic trainer concerning a medical issue and the athletic trainer then typically determines whether the player should meet with the club doctor. Current Player 1:[l]

> *[Y]ou go to your team trainers first and then the doctor comes into the facility—I think it's like two or three times during the week. If they [the trainers] think it's necessary, they'll have you meet with the actual doctors.*

As discussed in the background section of this chapter, the athletic trainers and club doctors are in regular communication about players' conditions and treatment. The club doctors are responsible for directing and supervising the care of the players by the athletic trainers. Current Player 3 believes that the frequency of interaction between the players and the athletic trainers results in "better rapport" with the athletic trainers as compared to the club doctors.[m]

Nevertheless, other players expressed more concerns about athletic trainers' practices as compared to club doctors.[n] Not only do athletic trainers spend significantly more time with the players and the rest of the club's staff than the club doctor, the athletic trainers are also directly employed by the club whereas club doctors are generally independent contractors.[o] Current Player 1 described multiple incidents in which an athletic trainer did not disclose a player's actual diagnosis to the player (in one case a fracture and a torn ligament in another), which the player only discovered later from the club doctor.[p] The same player also indicated that he believes athletic trainers are pressured by the club and coaches to have players on the field. Multiple other current players we interviewed explained their distrust of athletic trainers:

- **Current Player 4:** *"I don't trust [athletic trainers] at all. I feel like 90 percent of the injuries I've had have been undiagnosed or misdiagnosed before I was able to really identify what was going on. So the first analysis they always make is underrepresentation of the actual injury. You feel like they always downplay the situation to try to convince me you don't need to take any time off whatsoever or maybe take off as little time as possible and get back on the job immediately."*[q]

- **Current Player 5:** *"You know they're paid by the team and their job is to keep us healthy, keep the parts healthy so that the team as a whole works. I think sometimes there's a little bit more of a trust issue there because a player knows as soon as the trainer clears me to be healthy and I go out on the field then I'm liable to get cut if I'm not performing."*

h NATA suggested athletic trainers under investigation often enter into consent agreements with the BOC and that those agreements generally require that the details of the investigation and agreement not be made public. E-Mail from NATA representative to author (May 20, 2016) (on file with author).

i As described more fully in the Introduction, Section 2(B): Description, citing ongoing litigation and arbitration, the NFL declined to consent to our request to interview current NFL club employees, including coaches, general managers, doctors, and athletic trainers. Therefore, we did not pursue interviews with these individuals.

j Current Player 2: "[W]hen it comes to the athletic trainers, that's really where most of our medical relationships take place." Current Player 9: "[T]he training staff is the first level of contact with the players."

k Consequently, peer reviewer and former Green Bay Packers executive Andrew Brandt refers to athletic trainers as the "bartenders" of the club. Andrew Brandt, Peer Review Response (Oct. 30, 2015).

l To repeat information provided in the Introduction, we conducted approximately 30-minute interviews with 10 players active during the 2015 season and three 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 the Law and Ethics Advisory Panel (LEAP) 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 (3.4 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 (not a kicker, punter, or long snapper). 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. These interviews were not intended to be representative of the entire NFL player population or to draw scientifically valid inferences, and should not be read as such, but were instead meant to be generally informative of the issues discussed in this Report.

m Current Player 8 agreed that there was more trust with athletic trainers "just because we see them more."

n Current Player 1: "[P]layers do trust the doctors. But I think it's more the trainers that they don't trust as much." Current Player 2 described the lack of trust in athletic trainers as "even more so than the doctors." Current Player 10: "I think there's less trust in the trainers than the team doctors."

o Current Player 2: "I don't think guys are satisfied [with the care provided by athletic trainers], that's for sure."

p 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.

q Current Player 4 also explained "I've had trainers try to convince me not to have a second opinion."

- **Current Player 8:** *"Usually the head [athletic trainer] is more of the coaches' friend than a player's friend . . . . The training staff is meant to rehabilitate you to play on Sunday. It is not meant to rehabilitate you for . . . every-day activities later in life. The thought of 'Your playing could [cause] further damage' isn't the concern – it's 'Can you play?'"*

As mentioned above, players execute collectively bargained waivers permitting the athletic trainer and club doctors to disclose the player's medical information to club employees, such as coaches and the general manager. Athletic trainers thus keep coaches and general managers apprised of players' injury statuses during regular meetings so the general manager can make a decision about whether or not to sign another player in the event a player is unable to play.[r] Players indicated that the communications between the athletic trainers and the coaches and general manager place pressure on players to practice and also cause them to withhold information from the athletic trainer.[s] Players do not want to tell the athletic trainer that they are not healthy enough to practice, for fear that the athletic trainer will then relay that message to the general manager with the suggestion that the general manager consider signing a potential replacement player.

Our communications with players revealed a meaningful level of distrust with athletic trainers. Of course, not all players feel this way about all trainers. Indeed, some of the players we interviewed had positive comments about athletic trainers:

- **Current Player 2:** *"[W]e're fortunate enough here where we do have a trainer who's willing to stand up to our coach if he feels that guy's not ready to get back on the field."*
- **Current Player 3:** *"[T]he trainers . . . a lot of them have been very cautious about the long term goals. 'I know you might be able to come back and play this week, but you risk more potential injury. If you sit out another week, you'd be better off next week.' So, I think we have some pretty decent trainers in that regard, but I don't know."*
- **Current Player 10:** *"[T]he trainers do what's best for the players."*
- **Former Player 2:** *"I would say . . . probably 80 percent trust the trainers, 20 percent don't."*

Moreover, during its review of a draft of this chapter, both PFATS and NATA provided citations to stories in which players praised club athletic trainers.[67] In addition, while not himself a player, peer reviewer and former NFL club executive Andrew Brandt noted he "rarely" saw trust between players and athletic trainers as an issue, in part due to the longevity of the club's training and medical staff. Nevertheless, Brandt also acknowledges the dynamic is "ripe for potential conflict."[68]

Similarly, in reviewing a draft of this chapter, NATA's representative stated that some athletic trainers "were (and some still are) told to get the athlete back out at all costs. They do it or risk losing their job. Some have left the pro-ranks because of this."[69] Nevertheless, NATA's representative also indicated there are times where players ignore athletic trainers' advice not to play, and then "come back and blame the medical staff for allowing them to play!"[70]

Additionally, when players are rehabilitating their injuries, they generally do it under the supervision of the athletic trainer and strength and conditioning coach on a separate practice field away from the coaches and other players. Players we interviewed also indicated that veteran and star players are often treated differently concerning injuries than younger or less marquee name players. Current Player 1:

> *You can definitely see a very different treatment of, let's say a rookie who's injured versus a guy who's in his eighth, ninth year in the NFL. Those guys could have the same injury but the veteran, the star, he definitely gets preferential treatment, gets the benefit of the doubt that maybe he really is injured and that he needs to take a few days off. Where that rookie, he definitely doesn't get that benefit of the doubt. They expect him to have to prove himself almost every day.*

Andrew Brandt also confirmed that younger or lesser skilled players often do not receive the same treatment as star players:

> *I can recall meetings discussing injured players who had no chance of making the team, and being asked to "get them out of here." I knew that meant to contact the agent and negotiate an injury settlement for the remaining term of his injury. Thus, we would move the player out of our training room, as he was taking up resources and training staff needed for higher caliber players who were going to be key contributors on the roster.*[71]

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r Current Player 1: "[O]ur head trainer has a meeting with our GM and head coach at least once a week about whatever injuries are going on in the team." Current Player 2: "Our trainer has a meeting with our head coach every day during the season. And they're constantly talking about the status of guys[.]" Current Player 6 described his communications with the club's medical staff as "not confidential." Current Player 9: "The head trainer meets with the coach every single day."

s Current Player 8: "I go into those meetings [with the athletic trainer] very conscious of the fact that anything I say or do, it's going to be relayed to the people who are there to determine my future." However, as discussed in Chapter 1: Players, players are obligated by the CBA and their contract to disclose their medical conditions at certain times.

Although we recognize that players may not be experts in treatment methods, multiple players we interviewed also complained that athletic trainers utilize outdated treatment methods:

- **Current Player 1:** *"[T]hey have the same treatment for every injury and that's just ice and [electrical] stim[ulation]."*
- **Current Player 2:** *Described his club's athletic trainers as "being dated with some of the ways that they treat us."*
- **Current Player 7:** *"A lot of us believe . . . they have the general treatment that everybody knows of . . . . It' just kind of like 'Oh, let's get an ice pack. You'll be okay.' It's for every injury."*

In reviewing a draft of this Report, the NFL stated that it believed these comments to be misplaced. Instead, the NFL believes the players' sentiments reflect that "(a) Athletic Trainers [are] not doing what doctors are supposed to do; and (b) a preference for less invasive therapies before getting to needles, drugs, MRIs, etc."[72] The NFL's point is reasonable, but to resolve the debate would require a comprehensive analysis of the type of treatments provided by athletic trainers and possible alternatives. Such an analysis is beyond our expertise and the scope of this Report.

Multiple current players explained that their concerns about athletic trainers and the club's healthcare operations caused them to self-treat or to seek care and treatment outside of the club, both during the season and in the offseason:[t]

- **Current Player 4:** *"[P]layers should seek out more outside help . . . . A lot of guys have chiropractors, massage therapists, and a number of other different people that they see that can really help to get [rehabilitation] done. The team has chiropractors and sometimes massage therapists but, again, I feel like they do the bare minimum."*
- **Current Player 5:** *"A lot of guys think the older you get the more you start working outside the system as far as not necessarily with doctors but with a different massage therapist or a different kind of trainer or a different kind of rehab . . . . The ability to go to an outside . . . physical therapy and rehab, I think that should be expanded or encouraged . . . . I go to an outside facility and hire someone to have one-on-one treatment for an hour instead of having to battle with being understaffed in our training room . . . . When you're going to an outside physical therapy joint, I'm paying this physical therapist money. They're giving me their time and attention. When the team is paying the trainer and I come in there, I'm demanding 100 percent of their attention but they're not giving it because they're paid to treat everybody. So they can't give you 100 percent of the treatment."*
- **Current Player 6:** *"I've learned you're better off if you don't trust [athletic trainers] in dealing with the training room . . . . It seems like some people have to deal with the bureaucracy and the politics in the training room . . . . [I]f you're in pain or have an injury, just take your ass back to the hotel room and you give yourself your own massage and you treat it yourself . . . . It seems like you're constantly being evaluated in the building and it's not even separate from the training room."*
- **Current Player 8:** *"[T]he majority of guys get their therapy outside of the building, not in the training room . . . . I think the reason is trust[.]"*

Additionally, there have been reports that when conventional treatment methods have not worked, some players have reportedly turned to the developing field of stem cell therapy treatments.[73] The efficacy of stem cell therapies is unclear and the U.S. Food and Drug Administration has argued successfully that stem cell therapies require its approval before being practiced on patients.[74] As a result, many prospective patients and some players have traveled overseas to receive treatments that are not approved in the United States. These practices raise concerns that should be monitored as stem cell therapies and their use by NFL players develop, including the role of club medical personnel in potentially helping players understand the risks of seeking unapproved therapies.

(E) Enforcement of Legal and Ethical Obligations[u]

The 2011 CBA provides a few options for players dissatisfied with their healthcare, including athletic trainers. Nevertheless, these options, discussed below, provide questionable remedies to the players.

First, a player could submit a complaint to the Accountability and Care Committee. The Accountability and Care Committee consists of the NFL Commissioner (or his

t Denver Broncos defensive lineman Antonio Smith told the Associated Press the same in 2016: "You've got to get yourself a good system. Chiropractor, massage therapist, stretch therapist. A lot of guys are doing IVs now . . . . Take care of your body. You've got to do that. If the team doesn't supply it, you spend the money." 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.

u 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.

designee), the NFLPA Executive Director (or his designee), and six additional members "experienced in fields relevant to healthcare for professional athletes," three appointed by the Commissioner and three by the NFLPA Executive Director.[75] "[T]he 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."[76] 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, both of which would have little incentive to find that a club medical official acted inappropriately and to compensate the injured player accordingly.

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 chosen by the NFLPA.[77] "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."[78] 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 on 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.[79]

In 2012, the NFLPA commenced the first and only Joint Committee investigation.[80] The nature and results of that investigation are confidential per an agreement between the NFL and NFLPA.[81]

Third, a player could try to commence a Non-Injury Grievance.[82] The 2011 CBA directs certain disputes to designated arbitration mechanisms[83] 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.[84] Importantly, Non-Injury Grievances provide players with the benefit of a neutral arbitration and the possibility of a "money award."[85]

However, there are several impediments to pursuing a Non-Injury Grievance against an athletic trainer (or any club employee). First, athletic trainers are not parties to the CBA and thus likely cannot be sued for violations of the CBA.[86] Instead, the player could seek to hold the club responsible for the athletic trainer's violation of the CBA.[87] Second, Non-Injury Grievances must be filed within 50 days "from the date of the occurrence or non-occurrence upon which the grievance is based,"[88] a timeframe that is much shorter than your typical statute of limitations. And third, players likely fear that pursuing a grievance against an athletic trainer could result in the club terminating him. Current Player 8 stated as much: "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,[89] such litigation would involve substantial time and money for an uncertain outcome. Moreover, given the precarious nature of players' employment and the considerable discretion the club has over the roster, any such retaliation would be challenging to prove.

Outside of the CBA, players can also attempt to bring civil lawsuits against NFL club athletic trainers for negligence or professional malpractice. However, there are serious impediments to such claims. First and foremost, the player's claim would likely be barred by workers' compensation statutes. Workers' compensation statutes provide compensation for workers injured at work and thus generally preclude lawsuits against co-workers based on the co-workers' negligence.[90] This was the result in the *Stringer* case (discussed in more detail below), in multiple cases brought by NFL players against club doctors,[91] and in a case against an NBA club athletic trainer.[92]

Our research has revealed only two cases in which an NFL club athletic trainer was sued by a player.

First, in 1989, former Seattle Seahawks safety Kenny Easley sued the Seahawks, the Seahawks doctor and athletic trainer, and Whitehall Laboratories, a maker of Advil, alleging that Easley's use of Advil had caused him kidney damage necessitating a transplant.[93] Easley alleged the Seahawks medical staff negligently provided him with large doses of the drug and did not tell him when he developed kidney problems.[94] Easley ultimately reached

an undisclosed settlement with the doctor and Whitehall Laboratories in 1991.[95] The result of the case as against the athletic trainer is unclear. News reports discussed a pending workers' compensation case, which suggests that Easley's case against the athletic trainer, a co-worker, was dismissed.

In 2001, Minnesota Vikings Pro Bowl offensive tackle Korey Stringer died of complications from heat stroke after collapsing during training camp.[96] Stringer's family later sued the Vikings, Vikings coaches, athletic trainers and affiliated doctors, the NFL, and the equipment manufacturer Riddell. Of specific relevance, Stringer's family sued three Vikings athletic trainers.

A Minnesota trial court granted summary judgment[v] in favor of the Vikings, the athletic trainers, and others in an unpublished order.[97] Of relevance, the trial court determined that the athletic trainers did not owe a personal duty to Stringer and that they were not grossly negligent.[98] Stringer's representatives were required to prove both elements to avoid preemption by Minnesota's workers' compensation statute.[99]

The Minnesota Court of Appeals determined that the athletic trainers against whom appeal was sought[w] *did* owe a personal duty to Stringer but affirmed judgment in their favor by finding that they were not grossly negligent as a matter of law.[100]

The Supreme Court of Minnesota affirmed the decisions in favor of the athletic trainers and held that they *did not* owe a personal duty to Stringer.[101] Under Minnesota law, an employee owes a personal duty to an injured employee only where the employee acts "outside the course and scope of employment."[102] Because the Vikings' athletic trainers were acting within their scope of their employment when treating Stringer, they did not owe Stringer a personal duty and thus any claims against them were barred by workers' compensation laws.[103]

The fact that as a matter of Minnesota workers' compensation law the athletic trainers did not owe a personal duty to Stringer does not mean that the athletic trainers did not have obligations to Stringer or that the athletic trainers' only concern was for the club. As part of their obligations to the Vikings, the athletic trainers provided care to Stringer and other Vikings players. However, so long as the care being provided to Stringer was within the scope of the athletic trainers' employment, Minnesota's workers' compensation statutes prevented them from being held personally liable for any alleged negligence.

The CBA also presents a potential obstacle against any such claim. This is because the Labor Management Relations Act (LMRA)[104] bars or "preempts" state common law[x] 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."[105] In order to assess an athletic trainer's duty to an NFL player, an essential element of a negligence claim, the court may have to refer to and analyze the terms of the CBA, resulting in the claim's preemption.[106] Preemption occurs even though athletic trainers are not parties to the CBA and thus likely cannot be a party in any CBA grievance procedure. So long as the player's claim is "inextricably intertwined" with the CBA, it will be preempted. 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.

PFATS' Code of Ethics also provides two purported enforcement mechanisms. First, according to PFATS, its "Constitution expressly authorizes disciplinary action against members for violations of the Constitution," of which the Code of Ethics is part.[107] However, "[d]isciplinary action for alleged violations of the PFATS Code of Ethics can only be initiated by the Executive Committee."[108] PFATS' Code of Ethics empowers the Executive Committee to "fine, suspend, or expel any member[.]"[109] When we inquired as to how often this provision had been invoked, we were informed that "[i]n the last 10 years, the Executive Committee has not initiated disciplinary action against a PFATS member for violations of the PFATS Code of Ethics."[110]

Second, PFATS' Code of Ethics also declares that any violation of the Code of Ethics may be referred to NATA.[111] According to PFATS, "[d]isciplinary actions for violations of the PFATS Code of Ethics and the NATA Code of Ethics are separate and independent. If the Executive Committee initiates disciplinary action for an alleged PFATS Code of Ethics violation, there is no requirement for such matter to be referred to the NATA. Similarly, if the Executive Committee or a PFATS member refers an alleged violation of the NATA Code of Ethics to the NATA for disciplinary

v Summary judgment is "[a] judgment granted on a claim or defense about which there is no genuine issue of material fact and on which the movant is entitled to prevail as a matter of law." Black's Law Dictionary (9th ed. 2009).

w Stringer's estate did not appeal the trial court's decision with respect to one of the athletic trainers. *See* Stringer v. Minn. Vikings Football Club, 705 N.W.2d 746, 748 n.1 (Minn. 2005).

x 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.*

action, there is no requirement for the Executive Committee to initiate disciplinary action based on a violation of the PFATS Code of Ethics."[112] However, "[i]n the last 10 years, there have been no referrals by the Executive Committee or a PFATS member to the NATA for disciplinary action for violations of the NATA Code of Ethics."[113] Moreover, even if PFATS did refer a member's conduct to NATA, NATA's possible sanctions are limited to suspension or cancellation of membership, public censure or private reprimand.[114] NATA has no authority to compensate the injured player.[115]

In sum, there has been no enforcement action related to the PFATS Code of Ethics for at least the past decade. Of course, it is impossible to tell if this is a result of superb compliance or lax enforcement. Regardless of compliance, however, we believe that the Code of Ethics is insufficient for the reasons described above, and also recommend a more robust enforcement mechanism.

A player could also file a complaint with the BOC if he believes the athletic trainer has violated one of the BOC's Standards of Professional Practice.[116] While the BOC has the authority to revoke the athletic trainer's certification, the BOC has no authority to compensate the player.[117] In addition, the BOC has never disciplined an NFL club athletic trainer.[118]

(F) Recommendations Concerning Athletic Trainers

Athletic trainers are the player's principal source of healthcare. For this reason, it is important that they hold player health as their paramount responsibility and act in accordance with their legal and ethical obligations at all times. Nevertheless, as discussed above in the Current Practices Section, some players expressed concerns about athletic trainers' practice because of their close relationship to the club. To address this concern, we make the below recommendations.

Additionally, because the roles of the athletic trainer and the players' doctors are so intertwined, all recommendations made in Chapter 2: Club Doctors, Section H: Recommendations, Chapter 4: Second Opinion Doctors, Section F: Recommendations, Chapter 5: Neutral Doctors, Section F: Recommendations, and Chapter 6: Personal Doctors, Section F: Recommendations have some application to the athletic trainers. In addition to the recommendations in those chapters, and while we were unable to interview athletic trainers to gauge their viewpoints,[y] we make the recommendations below to help improve the care relationship between athletic trainers and players.

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.

Recommendation 3:1-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").

This recommendation also appears in and is described at length in Chapter 2: Club Doctors. We recommend that club doctors and athletic trainers be treated the same way. This recommendation contemplates that athletic trainers (in addition to the other medical professionals treating players) be chosen, reviewed, and terminated (as necessary) by a League-wide independent Medical Committee whose members are jointly selected by the NFL and NFLPA. The athletic trainers' principal day-to-day duties would remain largely the same as they are now—providing medical care to the players and updating the club on player health status (just in a different way). However, the key distinction is that this recommendation eliminates the athletic trainer's obligations to and relationship with the club.[z] The athletic trainer would no longer report to or meet regularly with coaches and club executives concerning player health. Instead, player health status would be

y As described in the background of this chapter, citing ongoing litigation and arbitration, the NFL declined to consent to our request to interview persons currently employed by or affiliated with NFL clubs, including coaches, general managers, doctors, and athletic trainers. Therefore, we did not pursue interviews with these individuals.

z Current Player 10: "If protecting the health of players always takes precedence, as Roger Goodell has stated, then trainers need to have players', not owners', best interests in mind at all times."

Recommendations Concerning Athletic Trainers – continued

transmitted to the club through a Player Health Report completed by the Players' Medical Staff.[aa] Additional logistics concerning the recommendation are discussed in Chapter 2: Club Doctors and Appendix G: Model Article 39 of the Collective Bargaining Agreement – Players' Medical Care and Treatment. Nevertheless, most importantly, the proposed structure removes any conflict of interest in the care being provided to players by athletic trainers and other medical staff. This recommendation concerns both club doctors and athletic trainers and is an important recommendation for the improvement of player health. Like club doctors, athletic trainer best practices include the avoidance and minimization of conflicts of interest.[119] Indeed, in reviewing a draft of this chapter, NATA described this recommendation as "possibly controversial," but "sound."[120] One positive sign as to the feasibility of our recommendation is that PFATS did not express any opposition to this recommendation when it reviewed a draft of this chapter.

Recommendation 3:1-B: The Professional Football Athletic Trainers Society should revise its Code of Ethics.

As discussed above, PFATS' existing Code of Ethics is contradictory and reflects the inherent conflicts of interest in the current structure of club medical staff that runs counter to the best interests of the players. The Code of Ethics should be revised to eliminate the contradictions and problematic provisions we identified above. More specifically, the PFATS Code of Ethics should emphasize the principle of health primacy and minimizing conflicts of interests by indicating (like the NATA Code of Ethics) that the athletic trainer's foremost duty is the furthering of the best interests of the player under the athletic trainer's care, regardless of the club's policies or wishes.

In addition, enforcement is essential. Violations of a professional code of ethics should include meaningful punishments, ranging from warnings and censures to fines and suspensions. However, PFATS has not initiated any enforcement proceedings in at least the last 10 years. In order to be effective, the enforcement and disciplinary schemes might need to be included in the CBA.

aa As explained in Chapter 2: Club Doctors, Recommendation 2:1-A, The Player Health Report would briefly describe: (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); (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.

Endnotes

1 E-mail from MaryBeth Horodyski, Nat'l Ath. Trainers Assoc., to Christopher R. Deubert (June 20, 2016).

2 CBA, Art. 39, § 2.

3 This information was provided by the NFLPA.

4 This information was provided by PFATS during its review of a draft of this chapter.

5 These figures were determined by compiling the data available on the Professional Football Athletic Trainers Society website. *See Member Directory,* Prof. Football Athletic Trainers Soc'y, http://www.pfats.com/directory/ (last visited Aug. 7, 2015), *archived at* http://perma.cc/PG2S-C2KH.

6 See *Athletic Training,* Nat'l Athletic Trainers Ass'n, http://www.nata.org/athletic-training (last visited Aug. 7, 2015), *archived at* http://perma.cc/8S2G-9VMJ; *Becoming an Athletic Trainer*, Professional Football Athletic Trainers Society, http://www.pfats.com/becoming-and-atc/education/ (last visited Aug. 7, 2015), *archived* at http://perma.cc/H5N8-CTQV.

7 *See Map of State Regulatory Agencies*, Board of Cert. for Athletic Trainers, http://www.bocatc.org/state-regulation (last visited Aug. 7, 2015), *archived at* http://perma.cc/5PZC-39PR.

8 *See* 68 Ill. Adm. Code 1160.20 (discussing Board of Certification for the Athletic Trainer certification as requisite to obtaining license under state law); Vt. Admin. Code 20-4-5:2; Neb. Admin. R. & Regs. Tit. 172, Ch. 17, § 002.

9 *Map of State Regulatory Agencies, supra* note 7.

10 *See e.g.,* West's F.S.A. § 468.701 ("'Athletic training' means the recognition, prevention, and treatment of athletic injuries.").

11 ILCS 5/3.

12 *See, e.g.,* Tex. Admin. Code tit. 22, § 871.13 ("An athletic trainer shall work under the direction of a licensed physician or another qualified, licensed health professional who is authorized to refer for health care services within the scope of the person's license when carrying out the practice of prevention, recognition, assessment, management, treatment, disposition, and reconditioning of athletic injuries"); Fla. Admin. Code r. 64B33-4.001 ("Each licensed Athletic Trainer is required to practice under a written protocol established between the athletic trainer and a supervising physician licensed.")

13 *See Practices,* Prof. Football Athletic Trainers Soc'y, http://www.pfats.com/nfl-workplace/practices/ (last visited Aug. 7, 2015), *archived at* http://perma.cc/HTK8-ULXB (describing an NFL athletic trainer's practice duties).

14 *See* Chapter 1: Players, Table 1-C (showing that, generally, there are about 16 percent as many injuries from regular season practices as compared to regular season games).

15 *See Game Day,* Prof. Football Athletic Trainers Soc'y, http://www.pfats.com/nfl-workplace/game-days/ (last visited Aug. 7, 2015), *archived at* http://perma.cc/BU36-CFHD (describing an NFL athletic trainer's duties on game days).

16 This information was provided by the NFLPA.

17 *Id.*

18 *Id.*

19 *Id.*

20 *Id.*

21 *Id.*

22 *Id.*

23 *See, e.g.* Greg Hanlon, *He Might Be Giants: Is Longtime Trainer Ronnie Barnes the Most Powerful Man in New York Football?,* New York Observer, Sept. 10, 2013, http://observer.com/2013/09/he-might-be-giants-is-longtime-trainer-ronnie-barnes-the-most-powerful-man-in-new-york-football/#ixzz3EAG6kCh9, *archived at* http://perma.cc/T67L-HPQ4 (discussing importance of Ronnie Barnes, the New York Giants' longtime trainer and Senior Vice President of Medical Services, within the organization).

24 *Id.* (mentioning Barnes' role in negotiating new multi-million dollar sponsorship deal with Quest Diagnostics).

25 *See, e.g.,* Fla. Stat. § 468.713 (2016) ("An athletic trainer shall practice under the direction of a physician licensed"); Tex. Occupations Code § 451.001 (2015) ("'Athletic training' means the form of health care that includes the practice of preventing, recognizing, assessing, managing, treating, disposing of, and reconditioning athletic injuries under the direction of a physician licensed"); *BOC Standards of Professional Practice,* Board of Cert. for Athletic Trainers, http://www.bocatc.org/images/stories/resources/boc_standards_of_professional_practice_1401bf.pdf ("The Athletic Trainer renders service or treatment under the direction of a physician") (last visited Aug. 7, 2015), *archived at* https://perma.cc/A36B-KM9B?type=pdf.

26 *Mission,* Prof. Football Athletic Trainers Soc'y, http://www.pfats.com/about/mission (last visited May 31, 2016), https://perma.cc/SV92-L2FC.

27 *History,* Prof. Football Athletic Trainers Soc'y, http://www.pfats.com/about/history (last visited Aug. 7, 2015), *archived at* http://perma.cc/6P8N-PZTV.

28 *Mission,* Prof. Football Athletic Trainers Soc'y, *supra* note 26.

29 *See, About the NATA,* Nat'l Athletic Trainers Ass'n, http://www.nata.org/aboutNATA (last visited Aug. 7, 2015), *archived at* http://perma.cc/5YC5-4K93.

30 *NATA Mission,* Nat'l Athletic Trainers Ass'n, http://www.nata.org/mission (last visited Aug. 7, 2015), *archived at* http://perma.cc/D96V-JL5E.

31 NATA Comments (July 14, 2016).

32 Interview with MaryBeth Horodyski, Vice President, NATA, and Jim Thornton, President, NATA (Aug. 20, 2014).

33 *See BOC Vision & Mission*, Board of Cert. for Athletic Trainers, http://bocatc.org/about-us/boc-vision-mission (last visited Aug. 7, 2015), *archived at* http://perma.cc/3J98-WU2T.

34 This information was provided by PFATS.

35 *See BOC Standards of Professional Practice,* Board of Cert. for Athletic Trainers, http://www.bocatc.org/images/stories/resources/boc_standards_of_professional_practice_1401bf.pdf.

36 *Id.* at 2.

37 Searles v. Trustees of St. Joseph's Coll., 695 A.2d 1206, 1210 (Me. 1997); *see also* Howard v. Mo. Bone and Joint Ctr., 615 F.3d 991 (8th Cir. 2010) (holding that evidence was sufficient to show that athletic trainer breached the standard of care for certified athletic trainers when the athletic trainer instructed college football player to continue to work out after the player felt back pain).

38 *See, e.g.,* Morris v. Adm'rs of Tulane Educ. Fund, 891 So.2d 57 (La. Ct. App. 2004) (holding that Louisiana's medical malpractice statute did not apply to athletic trainers); Ga. Physical Therapy v. McCullough, 466 S.E.2d. 635 (Ga. Ct. App. 1996) (holding that Georgia's medical malpractice statute did apply to athletic trainer).

39 *See Map of State Regulatory Agencies*, Board of Cert. for Athletic Trainers, http://www.bocatc.org/state-regulation (last visited Aug. 7, 2015), *archived at* http://perma.cc/5PZC-39PR (collecting states' statutes and regulations governing athletic trainers).

40 *See, e.g.,* 22 Tex, Admin. Code § 871.13 (Standards of Conduct for Texas-licensed athletic trainers).

41 *See* 49 Pa. Code § 18.503 (exempting from licensure "[a]n athletic trainer from another state, province, territory or the District of Columbia, who is employed by an athletic team or organization that is competing in this Commonwealth only on a visiting basis, from providing athletic training services, provided the practice of the athletic trainer is limited to the members of the team or organization.")

42 *See* Fla. Stat. §§ 468.70-723 (governing the licensure of athletic trainers in Florida).

43 CBA, Art. 40, § 2(a).

44 This information was provided by the NFLPA.

45 "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.*

46 *Id.*

47 *Id.*

48 *Id.*

49 NFL Comments and Corrections (June 24, 2016).

50 C.F.R. § 164.512(b)(v).

51 C.F.R. § 1904.4.

52 C.F.R. § 164.512(l).

53 *See* Joy Pritts et al., *The State of Health Privacy: A Survey of State Health Privacy Statutes* (2d ed. 2003), http://sharps.org/wp-content/uploads/PRITTS-REPORT1.pdf, *archived at* https://perma.cc/C72H-R3LK?type=pdf (describing 21 states with statutes restricting doctors from disclosing healthcare information, subject to various exceptions).

54 *See id.*; Joy L. Pritts, *Altered States: State Health Privacy Laws and the Impact of the Federal Health Privacy Rule*, 2 Yale J. Health Pol'y, L. & Ethics 325, 335–36 (2002) (discussing variance in state laws on use and disclosure of medical information).

55 *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).

56 In reviewing a draft of this Chapter, PFATS provided us with a copy of its Code of Ethics.

57 *See NATA Code of Ethics,* Nat'l Athletic Trainers Ass'n, http://www.nata.org/codeofethics (last visited Aug. 7, 2015), *archived at* http://perma.cc/A82B-2PLZ.

58 The various statements can be found on NATA's website at http://www.nata.org/press-room, *archived at* http://perma.cc/8PLT-LZUH.

59 Kevin M. Conley, Delmas J. Bolin, Peter J. Carek, Jeff G. Konin, Timothy L. Neal & Danielle Violette, *National Athletic Trainers' Association Position Statement: Preparticipation Physical Examinations and Disqualifying Conditions*, 49(1) Journal of Athletic Training 102–20 (2014).

60 *Id.* at Recommendation No. 27.

61 *Id.* at Recommendation No. 22.

62 *See BOC Standards of Professional Practice,* Board of Cert. for Athletic Trainers, http://www.bocatc.org/images/stories/resources/boc_standards_of_professional_practice_1401bf.pdf (last visited Aug. 7, 2015), *archived at* https://perma.cc/A36B-KM9B?type=pdf.

63 *BOC Professional Practice & Discipline Guidelines,* Board of Cert. for Athletic Trainers § 8.4 (2014), http://www.bocatc.org/images/stories/resources/boc_disciplinary_guidelines_1401bf.pdf (last visited Aug. 7, 2015), *archived at* https://perma.cc/Y3X5-YTSJ?type=pdf.

64 *The BOC 2015 Annual Report,* Board of Cert. for Athletic Trainers, 11 (2015), http://bocatc.org/images/stories/multiple_references/2015%20boc%20annual%20report%20vf.pdf (last visited May 18, 2016), *archived at* https://perma.cc/M4F8-GR2L.

65 *See Disciplinary Action Exchange,* Board of Cert. for Athletic Trainers, http://bocatc.org/public/disciplinary-action-exchange (last visited May 18, 2016), *archived at* https://perma.cc/GKH3-W43C.

66 Email with Shannon Leftwich, Director of Credentialing and Regulatory Affairs, Board of Certification for the Athletic Trainer (Apr. 7, 2015).

67 *See* Kyle Melnick, *Understanding risk and protocols key to concussion management*, USA Today (June 23, 2016), http://usatodayhss.com/2016/understanding-risk-and-protocols-key-to-concussion-management, *archived at* https://perma.cc/8LR7-JH73; Jayson Jenks, *Seahawks' Ricardo Lockette says he nearly died, thanks trainers, firefighters*, Seattle Times, Mar. 7, 2016, http://www.seattletimes.com/sports/seahawks/seahawks-receiver-ricardo-lockette-thanks-redmond-firefighters-and-paramedics-for-saving-his-life/, *archived at* https://perma.cc/3JJP-5CRG; *Eric Berry Health and Football Timeline Press Conference,* Kansas City Chiefs (July 29, 2015), http://www.chiefs.com/news/article-2/Eric-Berry-Health-and-Football-Timeline-Press-Conference/6c4dc83e-82a8-4c7a-883b-738126add317, *archived at* https://perma.cc/C6PS-XC37.

68 Andrew Brandt, Peer Review Response (Oct. 30, 2015).

69 E-Mail from NATA representative to author (May 23, 2016, 12:34 PM) (on file with author).

70 *Id.*

71 *Id. See also* 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 (players discussing differences in treatment between starters and non-starters).

72 NFL Comments and Corrections (June 24, 2016).

73 Timothy Caulfield, What Does It Mean When Athletes Get 'Stem Cell Therapy'?, The Atlantic, Oct. 22, 2012, http://www.theatlantic.com/health/archive/2012/10/what-does-it-mean-when-athletes-get-stem-cell-therapy/263875/, archived at https://perma.cc/6PWN-3BYD; Ryan Jones, Jonathan Vilma affidavit details road to recovery from knee surgery, Times-Picayune (New Orleans, LA), July 16, 2012, http://www.nola.com/saints/index.ssf/2012/07/jonathan_vilma_affidavit_detai.html, archived at https://perma.cc/FFX4-H2U3.

74 R. Alta Charo, On the Road (to a Cure?) – Stem-Cell Tourism and Lessons for Gene Editing, 374; 10 New Engl. J. Med. 901 (2016); What are stem cells? How are they regulated?, U.S. Food and Drug Admin., http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194655.htm (last visited Mar. 23, 2016), archived at https://perma.cc/EB4S-FHDL.

75 CBA, Art. 39, § 3(a).

76 CBA, Art. 39, § 3(d).

77 CBA, Art. 50, § 1(a).

78 CBA, Art. 50, § 1(d).

79 In Stringer v. Nat'l Football League, the court also expressed concerns about the effectiveness of the Joint Committee: "While the NFL is required to give 'serious and thorough consideration' to recommendations of the Joint Committee, the CBA imposes no independent duty on the NFL to consider health risks arising from adverse playing conditions, or to make recommendations for rules, regulations or guidelines for the clubs to follow." 474 F.Supp.2d 894, 896 (S.D. Ohio 2007).

80 This information was provided by the NFLPA.

81 *Id.*

82 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 which are considered "Non-Injury Grievances" because they do not fit within the limited confines of an "Injury Grievance."

83 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.

84 *See* 2011 CBA, Art. 43, § 1.

85 *Id.* at § 6 (discussing constitution of Arbitration Panel); *Id. at* § 8 (discussing Arbitrator's authority, including to grant a "money award").

86 *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).

87 *See* 2011 CBA, Art. 2, § 2 (generally discussing CBA's binding effect on NFL, NFLPA, players and clubs but no other party).

88 CBA, Art. 43, § 2.

89 *N.L.R.B. v. City Disposal Systems Inc.,* 465 U.S. 822, 835–36 (1984).

90 *See* Alexander Cornwell, *Trapped: Missouri Legislature Seeks to Close Workers' Compensation Loophole with Some Co-Employees Still Inside*, 77 Mo. L. Rev. 235, 235 (2012); David J. Krco*, Case Note: Torts – Narrowing the Window: Refining the Personal Duty Requirement for Coemployee Liability Under Minnesota's Workers' Compensation System – Stringer v. Minnesota Vikings Football Club, LLC*, 33 Wm. Mitchell L. Rev. 739, 739 (2007); John T. Burnett, *The Enigma of Workers' Compensation Immunity: A Call to the Legislature for a Statutorily Defined Intentional Tort Exception*, 28 Fla. St. U. L. Rev. 491, 497 (2001).

91 *See* Lotysz v. Montgomery*,* 766 N.Y.S.2d 28 (N.Y. 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* 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). For more information on the possibility of players suing coaches, see Timothy Davis, *Tort Liability of Coaches for Injuries to Professional Athletes: Overcoming Policy and Doctrinal Barriers*, 76 UMKC L. Rev. 571 (2008).

92 *See* McLeod v. Blase*,* 659 S.E.2d 727 (Ga. Ct. App. 2008) (former Atlanta Hawk's claim against athletic trainer for alleged negligent treated barred by workers' compensation statute).

93 *See* Glenn Nelson, *Courting Danger Krueger's Advice to Easley: Put Up Fight*, Seattle Times, May 31, 1989, *available at* 1989 WLNR 654489 (discussing nature of Easley's claims); Tom Farrey, *Easley Settle with Doctors, Drug Maker,* Seattle Times, Sept. 18, 1991, *available at* 1991 WLNR 984467 (identifying Whitehall Laboratories as the maker of Advil).

94 Tom Farrey, *Easley Settle with Doctors, Drug Maker,* Seattle Times, Sept. 18, 1991, *available at* 1991 WLNR 984467 (identifying Whitehall Laboratories as the maker of Advil).

95 *Id.*

96 Stringer v. Minnesota Vikings Football Club, 705 N.W.2d 746, 748 (Minn. 2005).

97 *See* Memorandum and Order, Stringer v. Minnesota Vikings Football Club*,* No. 02-415, (Minn. Dist. Ct. Apr. 25, 2003); Stringer v. Minnesota Vikings Football Club*,* No. 02-415, 2003 WL 25766738 (Minn. Dist. Ct. Dec. 8, 2003) (discussing Court's prior order). Following Stringer's death, the NFL now issues an annual memorandum to NFL Clubs warning them about the risks of players overheating during training camp. *See, e.g.,* Memorandum from NFL Injury and Safety Panel (Elliott Hershman, M.D., Chairman), to General Managers, Head Coaches, Team Physicians, and Team Athletic Trainers re: 2014 Training Camps – Adverse Weather Conditions (July 11, 2014) (on file with author).

98 *See Stringer*, 705 N.W.2d at753 (discussing trial court's order).

99 *Id.* at 754.

100 Stringer v. Minnesota Vikings Football Club*,* 686 N.W.2d 545, 551–52 (Minn. Ct. App. 2004).

101 *Stringer*, 705 N.W.2d 746.

102 *Id.* at 757–58.

103 *Id.* at 761–63. The result would likely have been the same under other states' workers' compensation laws. *See* Hendy v. Losse, 819 P.2d 1 (Cal. 1991) (NFL player's medical malpractice claim against Club doctor barred by workers' compensation statute where Club doctor was co-employee and acting within scope of employment); Macchirole v. Giamboi, 762 N.E.2d 346 (N.Y. 2001) (co-employee's negligence claims barred by worker's compensation statute where co-employee was acting within scope of employment).

104 U.S.C. § 185.

105 Allis-Chambers Corp. v. Lueck, 471 U.S. 202, 213, 200 (1985).

106 *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). However, for reasons that are not clear, LMRA preemption was not cited by any of the Minnesota state court decisions in the *Stringer* case.

107 This information was provided by PFATS.

108 *Id.*

109 PFATS Code of Ethics, Art. X.

110 E-mail from Meghan Carroll, NFL, to authors (June 20, 2016) (providing information on behalf of PFATS).

111 PFATS Code of Ethics, Art. XII, ¶ 7(b).

112 This information was provided by PFATS.

113 *Id.*

114 *See* Membership Standards and Sanctions, Nat'l Athletic Trainers Ass'n, http://www.nata.org/membership/about-membership/member-resources/membership-standards (last visited May 31, 2016), *archived at* https://perma.cc/A4AM-DZNU.

115 *See id.*

116 *See Consumer Complaints,* Board of Cert. for Athletic Trainers, http://www.bocatc.org/public/file-a-complaint (last visited Aug. 7, 2015), *archived at* http://perma.cc/L4CL-8D7T.

117 *See BOC Professional Practice & Discipline Guidelines*, Board of Cert. for Athletic Trainers § 8.4 (2014), http://www.bocatc.org/images/stories/resources/boc_disciplinary_guidelines_1401bf.pdf (last visited Aug. 7, 2015), *archived at* https://perma.cc/Y3X5-YTSJ?type=pdf.

118 Email with Shannon Leftwich, Director of Credentialing and Regulatory Affairs, Board of Certification for the Athletic Trainer (Apr. 6, 2015).

119 Ron Courson et al., *Inter-Association Consensus Statement on Best Practices for Sports Medicine Management for Secondary Schools and Colleges*, 49 J. Ath. Training 128 (2014).

120 E-Mail from NATA representative to author (May 20, 2016, 11:46 PM) (on file with author).