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

Chapter 2

Christopher R. Deubert
I. Glenn Cohen
Holly Fernandez Lynch

Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School

SUMMARY:
Club Doctors

This document is a summary of the full chapter on club doctors in the Report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations.* The full chapter includes the following sections: (A) Background; (B) Introduction to Current Legal Obligations and Ethical Codes; (C) Current Legal Obligations and Ethical Codes When Providing Services to Player; (D) Current Legal Obligations and Ethical Codes When Providing Services to Clubs; (E) Additional Ethical Obligations; (F) Current Practices; (G) Enforcement of Legal and Ethical Obligations; (H) Recommendations; and, (I) The Special Case of Medications. Here, we provide our recommendations, with only the minimum necessary background information. For more information and analysis of the role and responsibilities of club doctors, including relevant citations, please see the full chapter. Also as explained in the full chapter, the NFL and NFL Physicians Society (NFLPS), the professional organization for club doctors, declined our request to interview club doctors.

THE FOOTBALL PLAYERS HEALTH STUDY AT HARVARD UNIVERSITY

The 2011 CBA between the NFL and the NFLPA, the key document that governs the relationship between and among players, clubs, the NFL, and the NFLPA, requires that each club "retain" a board-certified orthopedic surgeon and at least one physician board-certified in internal medicine, family medicine, or emergency medicine. All physicians must also have a Certificate of Added Qualification in Sports Medicine (or be grandfathered in). In addition, clubs are required to retain consultants in the following fields: neurological; cardiovascular; nutritional; and, neuropsychological. While each club generally has a "head" club doctor, approximately 175 doctors work with NFL clubs in total, an average of 5.5 per club. Most (if not all) of the doctors retained by NFL clubs are members of the NFLPS.

Club doctors are chosen by, and report to, the club's executives. They are affiliated with a wide variety of private practice groups, hospitals, academic institutions, and other professional sports leagues; some of these institutions have long-standing relationships with clubs that often help lead to the doctor being retained by the club. The NFLPA currently plays no role in the selection of club doctors, other than ensuring that they have the required qualifications and credentials.

Club doctors are one component of the more expansive club medical staff. There are various medical professionals who provide healthcare to players, including but not limited to athletic trainers, physical therapists, massage therapists, chiropractors, dentists, nutritionists, and psychologists. Club doctors and athletic trainers have the most systematic and continuous relationships with players as compared to these other professionals, and are generally the principal healthcare providers for the players.

The club medical staff is responsible for keeping the club apprised of each player's medical condition. Players execute waivers (which are collectively bargained between the NFL and NFLPA) permitting the club doctors and athletic trainers to disclose the player's medical information to club employees, such as coaches and the general manager. As club doctors only have part-time relationships with the clubs, the responsibility generally falls on athletic trainers to keep coaches and general managers apprised of players' injury statuses during regular meetings to enable the general manager to decide whether or not to sign another player in the event a player is unable to play.

Club doctors have an inherent structural conflict of interest: they provide care to players while also having some type of contractual or employment relationship with, and thus obligations to, the club. Indeed, a club doctor's principal responsibilities are: (1) providing healthcare to the players; (2) helping players determine when they are ready to return to play; (3) helping clubs determine when players are ready to return to play; (4) examining players the club is considering employing, *e.g.*, at the NFL Combine or as part of free agency; and, (5) helping clubs to determine whether a player's contract should be terminated because of the player's physical condition, *e.g.*, whether an injury will prevent the player from playing. The first two responsibilities might be considered "Services to Player," a scenario in which the club doctor is treating and advising the player, including taking into consideration the player's athletic and other goals, whereas the last three responsibilities might be considered "Services to Club," a scenario in which the doctor is exclusively advising the club.

Nevertheless, in the current system the club doctor's two roles are not and cannot be separated in practice. The current structure forces club doctors to have obligations to two parties – the club and the player – and to make difficult judgments about when one party's interests must yield to another's.

This is not a moral judgment about club doctors as competent professionals or devoted individuals, but rather a simple fact of the current organizational structure of their position in which they simultaneously perform at least two roles that are not necessarily compatible.

On the one hand, club doctors are hired by clubs to provide and supervise player medical care. As a result, they enter into a doctor-patient relationship with the players and have a legal and ethical responsibility to protect and promote the health of their player-patients, in line with players' interests as defined by the players themselves. This means providing care and medical advice aligned with player goals, and also working with players to help them make decisions about their own self-protection, including when they should play, rest, and potentially retire.

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

While the practical impact of these conflicts in the NFL almost certainly varies from club to club depending on the club's approach to player health and the medical staff's autonomy, the conflict itself is unavoidable whenever the club doctor is expected to wear both hats, with

simultaneous and sometimes conflicting obligations both to players and to clubs. A system that requires heroic moral and professional judgment in the face of a systemic structural conflict of interest is one that is bound to fail, even if there are individual doctors who manage to negotiate this conflict better than others. Moreover, even if a club doctor can successfully manage the conflicts, their mere existence can compromise player trust – a critical element of the doctor-patient relationship. That is why we describe the conflict of interest as inherent; the conflict is as rooted in the perceptions of others as it is in the decisions and actions of the conflicted party. Ultimately, it is the system that deserves blame, and thus, as will be discussed below, our recommendations are focused on improving that system.

In our research for this report we saw how the current structure may be corrosive of player trust. A 2016 *Associated Press* survey of 100 current NFL players addressed this issue. The survey asked players whether "NFL teams, coaches and team doctors have players' best interests in mind when it comes to injuries and aplayer health." 47 players answered yes, 39 of the players answered no, and 14 players were either unsure or refused to respond.

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

Some of the players we interviewed also indicated that the communications between the club medical staff and the coaches and general manager place pressure on players to practice and also cause them to withhold information from the medical staff. Players often do not want to tell the medical staff that they are not healthy enough to practice, for fear that the medical staff will then relay that message to the general manager, with the suggestion that the general manager should consider signing a potential replacement player.

To be sure, not all share this view of the relationship between players and club medical staff, and of course, as we acknowledge, the situation varies from club to club and over time. But the problem is structural and thus a structural solution is needed, as recommended in this chapter.

Recommendations Concerning Club Doctors

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

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

The CBA requires clubs to retain several different types of doctors. Currently, the use of these doctors and their opinions are largely filtered through the head club doctor, who is the doctor that visits the club's practices a few times a week, directs the athletic trainers, and otherwise generally leads the medical staff. Under our recommendation, this structure and process would largely remain, but with two important distinctions – doctors and the other medical staff for all of the clubs would: (1) be chosen, reviewed, and have their compensation determined by a committee of medical experts jointly

Recommendations Concerning Club Doctors – continued

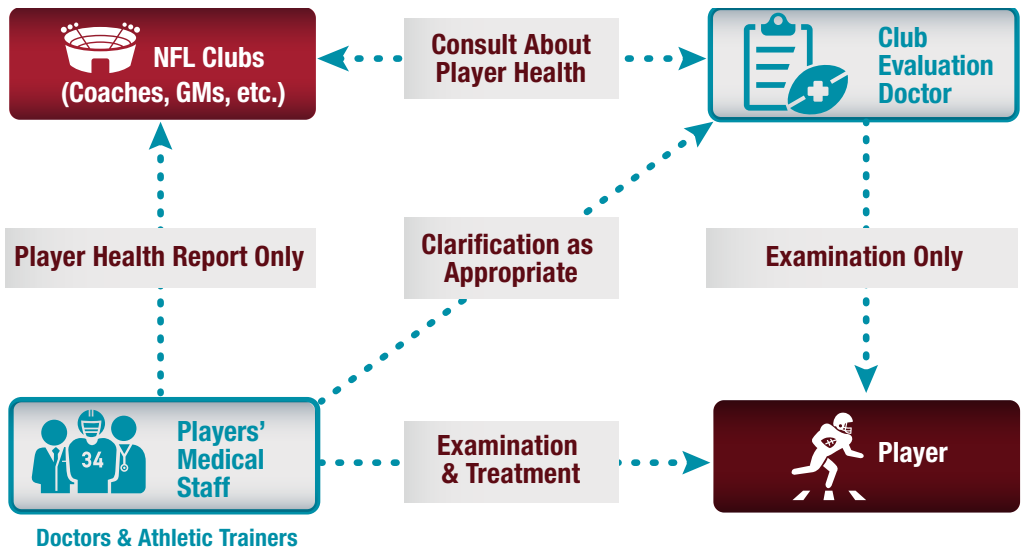
selected by the NFL and NFLPA ("Medical Committee") (but still paid by the club); and, (2) have as their principal obligation the treatment of players in accordance with prevailing and customary medical ethics and laws. For shorthand, we refer to the head doctor in this new role as the **Head Players' Doctor,** and to the collection of doctors and other medical personnel – including the Head Players' Doctor – as the **Players' Medical Staff.**

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

To further understand our recommendation, we next review our proposed Player Health Report; the club's access to player medical records; and, the remaining need for doctors to provide services to the clubs.

Figure 2-D below shows the permissible forms of communication concerning player health under our proposal, which will be elaborated on below.

Figure 2-D: Permissible Communications Concerning Player Health



The Player Health Report

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

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

The important distinction, however, is that under this recommendation, the Players' Medical Staff's determination as to the player's status would control the player's level of participation in any practice or game. If the Players' Medical Staff declares – via the Player Health Report – that the player cannot play, the player cannot play (except for the situation described below). If the club deviates from the limitations set forth in the Player Health Report, the club should be subject to substantial fines or other discipline under the CBA. The club, of course, would retain the right to not play the player for any number of reasons, including injury or skill.

As will be explained further below, in the event a doctor hired by the club for the purposes of advising the club (*i.e.*, not a member of the Players' Medical Staff) needs clarification from the Head Players' Doctor concerning a player's status, such communication should be permitted, as determined to be reasonably necessary by the Head Players' Doctor. While it is expected that the Players' Athletic Trainers would help create the Player Health Report, communications between the Club Evaluation Doctor (working solely on behalf of the club as explained below) and the Players' Medical Staff should only be with the Head Players' Doctor. Beyond these minimal levels of communication, there should be no need for the Players' Medical Staff (doctors and athletic trainers) to communicate with any club employee, including a coach or general manager. By minimizing the communication in this way, and formalizing it, the goal is to minimize the club's ability to influence the medical care provided to the player, including more subtle forms of influence, *e.g.*, occasional workplace conversations. We say "minimize" because, as we discuss below, our recommendation does still allow for some communications between the Players' Medical Staff and the club. We think that this reduced level of communication is necessary and appropriate to protect player health, but nevertheless acknowledge that the existence of any such communications may cause a player to be less trusting of the medical staff, even if designated as the Players' Medical Staff as we recommend.

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

Recommendations Concerning Club Doctors– continued

If the Head Players' Doctor declares that a player cannot play but the player nonetheless wants to do so, the player could receive a second opinion. The logistics of when and how the player obtained the second opinion would need to be well coordinated; it would likely have to be a local doctor or practice group prepared to handle these situations for the players on short notice. If the second opinion doctor says the player can play, then the player should be allowed to decide if he wants to play. Recognizing that players may shop for doctors who will clear them to play, it is our recommendation that the Medical Committee create a list of well-qualified and approved second opinion doctors for the players to consult. This compromise also helps resolve concerns that the Head Players' Doctor for one club might be overly conservative as compared to Head Players' Doctors for other clubs. Nevertheless, during in-game situations, the Head Players' Doctor would retain substantial control over the player's participation – as is currently the case. To minimize communication between the Players' Medical Staff and club personnel, in-game decisions about a player's status should be communicated through the Club Evaluation Doctor, discussed below.

The Club's Access to Player Medical Records

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

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

Club Evaluation Doctors

Under this new approach, clubs would be free to retain doctors and other medical professionals, as needed, who work solely for the clubs for the purposes of examining players and advising the club accordingly. These doctors, whom we call "Club Evaluation Doctors," could perform the pre-employment examinations at the Combine, during the course of free agency, and also examine players during the season. However, they would not *treat* the players in any way nor control their treatment. The Standard Player Contract's requirement that players make themselves available for an examination by the club doctor upon request would largely remain. Additionally, the Club Evaluation Doctor would have the opportunity to review the players' medical records at any time and communicate with the Head Players' Doctor about the Player Health Report, if clarification is needed and appropriate. As discussed below, the Player Health Report should substantially minimize the need for duplicative medical examinations. This arrangement would thus permit a Club Evaluation Doctor to provide an opinion as to a player's short- and long-term usefulness to the club, without relying on the Players' Medical Staff's opinion.

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

We recognize that there are many possible objections to our recommendation, from both a player-centric perspective, a view that might maintain that our recommendation is not sufficiently protective of player interests, and a club-centric perspective, a view that might maintain that our recommendation is unworkable or unnecessary. In the full chapter, we discuss and respond to objections to our recommendation from both player-centric and club-centric perspectives.

Recommendations Concerning Club Doctors– continued

In addition, in the full chapter we address additional comments about our recommendation from the NFL and NFL Physicians Society.

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

Club doctors are clearly one of the most important stakeholders in protecting and promoting player health. While identifying and seeking to improve this structural conflict of interest is the most important contribution of this chapter of the Report, we also make additional recommendations concerning club doctors that are worth highlighting, although *some of these might not be necessary or would need be altered if Recommendation 1-A above were adopted*. Nevertheless, we make all recommendations we believe can improve player health under the current structures and set of practices, even if they would become partially redundant or inconsistent if other primary recommendations are adopted.

Recommendation 2:1-B: The NFLPS should adopt a Code of Ethics.

Club doctors have many codes of ethics relevant to their practice, dependent on their particular medical specialties. However, none of them are specific to their unique role as doctors for NFL clubs. Club doctors face a variety of complex situations that are not adequately contemplated or addressed by existing codes of ethics, most notably balancing their obligations to provide care to the player while also advising the club about players' health. A code of ethics adopted by NFLPS would supplement the club doctors' existing codes of ethics by providing guidance and tenets for the unique and competitive environment in which they must operate.

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

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

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

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

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

Recommendations Concerning Club Doctors– continued

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

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

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

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

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

The CBA contains a requirement regarding this issue:

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

However, we have learned that in practice some players believe club doctors regularly disclose information to the club that is not disclosed to the player. In addition, many players do not believe they are ever advised about their conditions in writing, despite the CBA's requirement. As a result, players may be unaware of the full extent of their medical conditions

Recommendations Concerning Club Doctors– continued

and also how the club might take adverse employment action against the player due to his medical condition. In particular, club doctors might not be providing players with a copy of medical evaluations that the club doctor has provided to the club. Players are entitled by the CBA and by their status as patients to this information. It is thus imperative that club doctors comply with the CBA and that the NFLPA enforce this provision against club doctors who do not.

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

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

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

The NFL has a League Policy on Club Medical Services Agreements and Sponsorships ("Medical Sponsorship Policy") governing the relationship and arrangements between medical service providers ("MSPs") and the clubs. According to the Medical Sponsorship Policy, MSPs include "hospitals, universities, medical practice groups, rehabilitation facilities, laboratories, imaging centers and other entities that provide medical care and related services." Although doctors are not specifically included in the definition of MSPs, the NFL includes doctors as MSPs for purposes of the Policy.

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

If the incentive exists for MSPs to pay for the right to provide medical services, clubs would likely prefer to sell these services to the highest bidder. This scenario again raises the problematic question of whether clubs might choose MSPs based on their qualifications or instead on the amount they are willing to pay. While the NFLPS says no MSPs are currently paying for the right to provide medical services, we know that the practice existed in the past. Consequently, it is possible that the practice could return or proliferate. To ensure that clubs are choosing MSPs based solely on whether or not they will do the best job in providing care to the players, it is appropriate to strictly prohibit MSPs from providing consideration of any kind – whether in the form of payment or free/discounted services – for the right to provide medical services to the club, exclusively or non-exclusively.

In reviewing a draft of this chapter, the NFL stated that the Medical Sponsorship Policy does prohibit MSPs from paying for the right to provide medical services and from offering discounted or free services. As we explain in much greater

Recommendations Concerning Club Doctors– continued

depth in the full chapter, we disagree with the NFL's reading. While the NFL may enforce the Medical Sponsorship Policy in such a way, we disagree that the plain text of the Policy prohibits such arrangements. In any event, it appears that the NFL agrees with us that the Policy should prohibit any club doctor from paying for the right to pay for the right to provide healthcare to players. If the Policy is intended to prohibit club doctors from paying for the right to provide medical services to players, the text of the Policy should be clarified.

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

As discussed throughout this chapter, club doctors play two roles: providing care to players; and, providing services to the club. When the players are under contract with the club, the club doctor is often performing both roles at the same time. Even if the club doctor is principally concerned with providing an injured player the best possible care, conflict may arise to the extent the club doctor is also working with clubs on business decisions about the player, leading to potential confusion and distrust.

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

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

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

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

As discussed in Section G: Enforcement, there are challenges to adjudicating club doctors' legal obligations to players. Arbitration is a favored dispute resolution system – it generally minimizes costs for all parties and leads to faster and more accurate resolutions of legal disputes. The CBA contains many arbitration mechanisms for almost every reasonably possible scenario involving NFL players and the NFL almost always argues in court that a player's claims must be resolved through the CBA's arbitration mechanisms. The one exception appears to be the NFL's position that club doctors can be sued in court – and not via arbitration. However, changes to the 2011 CBA likely increase the chances that a player's civil court claims would be preempted by the terms of the CBA and create confusion about players' rights and enforcement options. Moreover, because club doctors are not parties to the CBA, a Non-Injury Grievance against them would be unlikely to proceed. A robust arbitration process is the fairest and most efficient way of ensuring that players have the same legal rights as regular patients. It is our intention that such a system would provide players with roughly comparable remedies to those currently available to them in civil litigation – only now in a private and more efficient forum.