



November 10, 2016

Dear Mr. Miller,

We thank the NFL for its letter of November 1, 2016, responding to our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*.¹ We appreciate the League's focused response, but wish to remind readers that the full Report offers 76 recommendations aimed at various stakeholders, only a small fraction of which are addressed here. Although we also offered the NFL Players Association (NFLPA) an opportunity to write a response, it has thus far declined to do so.² We hope to engage with the NFL, the NFLPA, and other stakeholders as part of an ongoing public conversation about the shared goal of protecting and promoting the health of NFL players.

To that end, we provide this reply to highlight areas of agreement raised by the NFL in its letter, as well as to clarify points of disagreement and misunderstanding about the recommendations on which the NFL chose to focus. Our hope is that this dialogue may serve as a starting point for further discussion, and ideally implementation of our full panoply of recommendations by the NFL and other stakeholders. The coming negotiations of the next collective bargaining agreement (CBA) provide an important opportunity for implementation, although we note and encourage that more immediate action may be possible through side letters and other initiatives. We hope that the NFL will continue to engage with the Football Players Health Study at Harvard University, including participation in public events scheduled for 2017 to discuss the Report and additional forthcoming work intended to improve NFL player health from various angles.

Points of Agreement

We are in agreement about the foundational importance of protecting and promoting player health. As your letter catalogues, and as also discussed at length in our Report, both the NFL and NFLPA have made a serious commitment to player health in recent years. This commitment is expressed by funding research as well as the multitude of programs and benefits offered to the players.

We are also heartened by our shared definition of health, which broadly includes physical, mental, emotional, social, familial, and financial components. This is consistent with the Football Players Health Study's focus on the whole player, over his whole life, and in particular with our focus on structural factors influencing player health, in addition to clinical aspects.

As the NFL expressed no disagreement with the specific ethical principles used to frame our Report and recommendations, we urge that promotion of these principles – respect,

¹ In addition, we thank the NFL for providing information and documents relevant to the Report, and also reviewing it and providing comments prior to publication.

² In declining our invitation to write a response, the NFLPA stated that “[O]ur primary objective in funding Harvard is to advance independent research on the many complex issues facing our members. Harvard's publications further that objective without formal comment by the PA.”



health primacy, empowered autonomy, transparency, managing conflicts of interest, collaboration and engagement, and justice – serve as a framework for future policy-making for player health, a metric against which priorities and proposals may be evaluated. That said, we acknowledge that the NFL took issue with how we distilled these principles down to a single question: **“In every scenario, ask what system and rules you would wish to be in place to protect and promote health if you or your son were an NFL player?”**

The NFL indicates that this is an unrealistic standard of care, but we remain convinced that it is the right question to ask. Indeed, we cannot articulate any lesser standard that would be acceptable: why would we expect NFL players to accept a system we would not accept ourselves or for our own families? Nor is this standard unattainable; it is our position that each of the recommendations in our Report, all based on this standard, is in fact implementable before or as part of the next CBA.³ Importantly, given the many steps the NFL has already undertaken to protect and promote player health, the NFL may already be more motivated to advance this standard than it has acknowledged or recognized.

With regard to NFL club doctors, we agree with the NFL that by many criteria they are extremely qualified and skilled. We make clear in the Report that this is not our concern. Instead, our concern is that the current structure for providing player health care problematically calls on even the most qualified and skilled club doctor to simultaneously perform two roles that are not necessarily compatible: caring for the player-patient and evaluating player health for a club’s business purposes. Importantly, the NFL has itself recognized this problem by mandating use of independent neurological consultants as part of the Concussion Protocol. We agree that independence of those responsible for diagnosing and treating NFL players is essential. Thus, we recommend that the NFL’s existing approach to concussion be extended to *all* aspects of player care. This point is further clarified below.

It appears that we are also in agreement with the NFL that medical service providers of all types ought to be barred from paying clubs for the right to provide medical services to players, an arrangement that would pose a serious conflict of interest. The NFL’s progress on this issue is commendable, given that the practice previously existed in the NFL and seemingly still exists in other sports leagues. We disagree, however, as to the extent the plain text of the current NFL Medical Sponsorship Policy actually prohibits such arrangements, as discussed on pages 92-95 of our Report. Although the NFL informed us that its Policy is in practice enforced to preclude such arrangements, and that no such arrangement presently exists in the NFL, our recommendation is to amend the policy to explicitly prohibit arrangements in which service providers pay to provide care so that the matter is no longer left to enforcement discretion.⁴ We also recommend that the Policy itself, to which the NFL provided confidential access as part of this

³ Your letter suggests that our employer, Harvard University, fails to satisfy the bar we have set for the NFL. However, we believe this is an inapposite comparison, one that fails to recognize that – unlike NFL players – our employment does not impose grueling physical demands, nor does it expose us to potentially serious health risks. Moreover, even if we were to accept the flawed analogy, Harvard’s benefit offerings do satisfy the criterion of reasonableness that we would seek for ourselves and our families.

⁴ We hope that the NFLPA will join us in requesting and pushing for enforcement of this explicit prohibition.



Report, be made publicly available for additional review and analysis, in particular to further public discussion about possible improvements to the Policy.

Finally, we agree that some evidence suggests that NFL players as a population may fare better on certain health metrics than non-players. For example, we discuss the NIOSH studies referenced in your letter in some detail in our Report (see pages 207 and 213). Nevertheless, there are still many important unanswered questions about the health of current and former NFL players. This is why the NFL has undertaken to fund additional health research⁵ – and it is also why the Football Players Health Study is collecting data on thousands of former NFL players to better understand the health effects of an NFL career.

Overall, we agree with the NFL that “there is always more that can be done” to protect and promote player health (p. 17 of your letter). We believe our Report specifically identifies opportunities to do exactly that, and we look forward to working together to accomplish this shared goal.

In the remainder of our letter, we will respond to those significant areas in which we perceive disagreement with the NFL, or misunderstanding of our approach, without the intention of exhaustively responding to every point raised by the NFL’s letter or covering the full scope of recommendations made in our Report. Our hope is that by providing further clarification, we can bridge some of the gaps. Specifically, we will address: (1) the NFL’s misunderstanding of the methodology behind our Report; and, (2) the NFL’s mistaken view of structural conflicts of interest faced by club medical staff, and its mischaracterization of our recommendation for restructuring the medical staff.

Our Methodology

The NFL’s letter mistakenly states that the “foundation” of our Report is comprised exclusively of interviews with thirteen current and former players (p. 10). In fact, the Report was painstakingly constructed over the course of two years via standard methods of legal and ethical analysis, using our combined expertise in sports law, health law, and bioethics to review and analyze existing literature, case law, statutes, codes of ethics, policies, and where available, evidence of real-world practices. Indeed, the Report contains over 3,000 citations to support our analysis. Unlike other components of the Football Players Health Study, this Report is not designed or intended to be an empirical analysis. However, like much legal and ethical scholarship, it includes quantitative and qualitative data to offer further support of key points.

⁵ As you note on page 4 of your letter, Quintiles performs epidemiological analysis on player injuries utilizing the vast amount of data contained in the NFL’s electronic medical record system. Nevertheless, the NFL and NFLPA do not make the full results of Quintiles’ analysis publicly available, nor does it seem that they share the full results with players (for example, only a limited subset of the data has been presented at the NFL’s Super Bowl Health and Safety Press Conferences). In the Report and here, we call on the NFL and NFLPA to publicly disclose the full season-end Quintiles reports in the name of transparency, to enable more informed decision-making by players as well as independent expert analysis of the data itself.



As stated throughout our Report, we agree with the NFL that the interviews we conducted are not representative of the NFL player population, nor were they intended to be. These interviews provided the important lived experiences of players in their own words, while also illustrating concepts, principles, problems, and perspectives *already demonstrated* through our foundational legal and ethical analysis. Other players may have different perspectives, but that surely does not negate the views held by players we quote in the Report. Moreover, as we noted in the Report, we engaged in informal discussions with many other current and former NFL players about player healthcare, as well as various additional stakeholders with insight on this issue, including contract advisors, financial advisors, and family members. Unfortunately, the NFL and NFL Physicians Society (NFLPS) refused multiple invitations to allow us interview club doctors and other club employees so that their perspectives could be taken into account.

Finding fault with our methodology also ignores the robust peer review process to which the Report was subjected. As explained in Appendix N of the Report, our analysis was first reviewed by the Football Players Health Study's Law & Ethics Advisory Panel, consisting of former players, attorneys, bioethicists, doctors, a former player's wife, and a former NFL coach. The Report was then reviewed by seven external peer reviewers, with expertise in sports law, sports medicine, health law, and bioethics; additionally, a lead peer reviewer - Gabriel Feldman, Professor, Tulane University Law School - certified that we were appropriately responsive to the feedback provided. This review process was modeled on that used by the National Academy of Sciences. Importantly, not one of these expert reviewers suggested that our Report was insufficiently supported by facts or evidence.

Conflicts of Interest in Player Healthcare

Identifying the Structural Conflict

The principal recommendation in our Report, Recommendation 2:1-A, focuses on the inherent and facially obvious structural conflict created by NFL club doctors' current dual role of providing medical care to players as well as evaluating players for clubs, roles that at times may be incompatible. As noted above, and explained in detail in the Report, 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.

To see why the status quo is problematic, consider an analogy to the way in which structural conflicts of interest are avoided in organ donation. Both law and ethics require two separate care teams: one to care for dying patients and pronounce them dead, and one to conduct the transplant and care for the recipient. If a single medical team served both roles, it would face the structural problem of dual loyalty, to the dying patient and to the patient in need of transplant, even though the interests of the two parties may conflict. In the organ transplantation context, this bifurcation of roles is well established and mandatory – even if, for example, an individual doctor would swear that he or she is not influenced in declaring a donor's death by the desire to get his or her patient an organ and even though it would be impossible in any particular case to prove or disprove such influence. In the NFL context, however, a single medical team is presently called upon



to provide services to both players and clubs, even though their interests may not always align.

Nonetheless, the NFL in its letter (p. 12), and the NFLPS in a separate publication,⁶ deny the existence of any conflict, calling it merely “theoretical” or “theorize[d]” and suggesting that any possibility of conflict is avoided by language in the CBA dictating that club doctors have a “primary responsibility” to the player. In fact, the CBA provision states in relevant part that the “Club physician’s primary duty in providing medical care shall be not to the Club but instead to the player-patient.” As noted in our Report (p. 98-100), we remain unsatisfied with this CBA language for two reasons. First, club doctors are not always providing medical care; they may also be providing information to clubs to assist in evaluating players for business purposes. In that context, then, it would appear that the CBA does not demand a primary duty to the player-patient in every instance. Second, we note that *primary* is not synonymous with *exclusive*. Referring to a duty as “primary” indicates that there are additional duties that may compete or be in conflict with that primary duty. However, to promote and protect player health, players must receive care from providers *exclusively* concerned with their interests, without simultaneous consideration of what may be in a club’s best interest.

Ultimately, we find the NFL and NFLPS denial of the structural conflict of interest remarkable given the facts at hand. There is also an overwhelming body of bioethical and legal literature agreeing with our perspective, recognizing the inherent structural conflict of interest in having medical staff treat players while also having relationships with and obligations to sports clubs.

Indeed, we have authored a Special Report of The Hastings Center Report, entitled *A Proposal to Address NFL Club Doctors’ Conflicts of Interest and to Promote Player Trust*, about our principal recommendation, scheduled to be published on or about November 21, 2016. Several of the commentators to that report agreed that there is an inherent conflict of interest in the NFL healthcare structure: [Mark A. Rothstein](#), a professor of law and bioethics, described the structure as leading to “entrenched conflicts of interest”; [Art Caplan](#), a bioethicist, and his colleagues Lee Igel and Brendan Parent, stated that “it is hard to imagine that those working for teams do not face difficult conflicts when the interests of the team clash with those of the athlete”; [Dr. Ross McKinney](#), a bioethicist and NFLPA consultant, stated that “the inevitable conflicts of interest affect[] the judgment of team physicians”; and finally, [Laurent Duvernay-Tardif](#), a current NFL player and medical student in the offseason, expressed that, “if the conflicts can be reduced or avoided by making structural changes to medical practice, doing so seems laudable.”

Many other experts have also recognized this structural conflict of interest in the triad between player, club, and medical professional. For example:

⁶ The National Football League Physicians Society, *NFL Physicians: Committed to Excellence in Patient-Player Care*, 46:6 Hastings Center Report (2016).



1. Dominic Malcolm, *Confidentiality in Sports Medicine*, 35 Clin. Sports Med. 205 (2016) (“Sports medicine physicians are likely to experience multiple and conflicting obligations”);
2. Brad Patridge, *Dazed and Confused: Sports Medicine, Conflicts of Interest, and Concussion Management*, 11 J. Bioethical Inquiry 65 (2014) (“conflicts of interest between doctors, patients [players], and teams may present a substantial obstacle to the proper adherence of concussion guidelines”);
3. Ron Courson et al., *Inter-Association Consensus Statement on Best Practices for Sports Medicine Management for Secondary Schools and Colleges*, 49 J. Athletic Training, 128 (2014) (“The potential for conflict of interest is omnipresent in sports medicine. When sports medicine team members provide care to athletes but are employees or appointees of the institution, the potential exists for medical decisions to be made that do not reflect the athlete’s best interest.”);
4. Daniela Testoni et al., *Sports Medicine and Ethics*, 13:10 Am. J. Bioethics 4 (2013) (“The types of decisions that must be made by the athlete–team–physician triad generate important ethical conflicts in sports medicine”);
5. Nancy M.P. King & Richard Robeson, *Athletes Are Guinea Pigs*, 13:10 Am. J. Bioethics (2013) (“The conflict of interest that obtains between the company doc, his client, and his patient is a well-understood phenomenon in bioethics”);
6. Bruce H. Greenfield & Charles Robert West, *Ethical Issues in Sports Medicine: A Review and Justification for Ethical Decision Making and Reasoning*, 4 Sports Physical Therapy 475 (2012) (“The strong pressure creating conflicts of interest for the team physician may cause one to compromise one’s medical judgment”);
7. Brian Meldan Devitt & Conor McCarthy, *“I am in blood Stepp’d in so far...”: ethical dilemmas and the sports team doctor*, 44 Br. J. Sports Med. 175 (2010) (“The emergence of a doctor–patient–team triad has created a scenario in which the team’s priority can conflict with or even replace the doctor’s primary obligation to player well-being”);
8. Warren R. Dunn et al., *Ethics in Sports Medicine*, 35:5 Am. J. Sports Med. 840 (2007) (“the ethics of the classic doctor-patient dyad, in which the physician has a primary obligation to the patient’s well-being, is challenged by the emergence of the doctor-patient-team triad, in which the team’s priorities can conflict with or even replace those of the patient-athlete”);
9. Barry R. Furrow, *The Problem of the Sports Doctor: Serving Two (Or is it Three or Four?) Masters*, 50 St. Louis U. L.J. 165 (2005) (“The sports doctor is in a conflict of interest situation from the moment he or she contracts to serve a sports team”);
10. Steve P. Calandrillo, *Sports Medicine Conflicts: Team Physicians v. Athlete-Patients*, 50 St. Louis U. L.J. 185 (2005) (“Team physicians for professional sports franchises face a conflict of interest created by the competing loyalties they owe to the team that employs them and to the athlete-patient they must treat”);
11. Matthew J. Mitten, *Team Physicians as Co-Employees: A Prescription that Deprives Professional Athletes of an Adequate Remedy for Sports Medicine Malpractice*, 50 St. Louis U. L.J. 211 (2005) (“team physicians encounter competing loyalties and inherent conflicts of interest”);



12. Charles V. Russell, *Legal and Ethical Conflicts Arising from the Team Physician's Dual Obligation to the Athlete and Management*, 10 Seton Hall Legis. J. 299 (1987) (discussing “[t]he ethical dilemma faced by team physicians”); and,
13. Thomas H. Murray, *Divided Loyalties in Sports Medicine*, 12:8 The Physician & Sportsmedicine 134 (1984) (“Sports medicine physicians share one divided loyalty dilemma... when they are torn between the welfare of the athlete and the welfare of the team”).

Additional support is provided by the results of a recent Associated Press survey of 100 current NFL players.⁷ When asked whether “NFL teams, coaches and team doctors have players’ best interests in mind when it comes to injuries and player health,” 47 players answered yes, but 39 answered no, and 14 players were either unsure or refused to respond.

In contrast to this extensive literature, neither the NFL nor NFLPA has identified an expert analysis that either supports their denial of the existence of the present structural conflict of interest, or defends the current arrangement as ethically optimal.

Consequently, we are confident in our conclusion that a problematic conflict exists when club medical staff are hired by clubs to both treat players and evaluate them from a business perspective – a conflict that inevitably impacts player trust in their medical care. Indeed, as you note on page 2 of your letter, in 2016, the NFL and NFLPA conducted a player survey concerning health and safety issues. If the NFL maintains that there is no issue with player trust, we would expect that to be reflected in the survey’s results. Therefore, as recommended in Recommendation 7:1-D, we call on the NFL and NFLPA to publicly release the de-identified, aggregate results of that survey.

Understanding Recommendations to Address Structural Conflict

Beyond its rejection of the existence of a structural conflict, the NFL also mistakes key features of our recommendation to address it. We ultimately recommend bifurcating the responsibilities to provide care and to evaluate players for clubs between different individuals, with the medical staff responsible for providing player care (“Players’ Medical Staff”) being chosen and subject to review and termination by a committee of medical experts selected equally by the NFL and the NFLPA. As explained in detail in our Report (pp. 129-32), clubs would still receive the information about player health needed for their business decisions through a Player Health Report completed by the Players’ Medical Staff and consultation with a Club Evaluation Doctor, a newly-created role under our recommendation. The Club Evaluation Doctor would not treat the players – that responsibility would be reserved exclusively for Players’ Medical Staff – but would instead evaluate players solely for the club’s business purposes. Because the NFL seemingly misunderstood the logistics we recommend, it is important to state this again: **under our approach, players would receive care and treatment *only* from the Players’ Medical Staff, who would be largely isolated from the clubs to protect**

⁷ 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>.



against influence or conflict in their care determinations; players could also be evaluated for purposes of club’s strategic roster decisions by a separate medical professional, but this Club Evaluation Doctor would bear no responsibility – and indeed would not be permitted – to treat players.

While we acknowledge that our proposal is complex (necessitated by the complex nature of player healthcare), the NFL’s criticisms are based on a system we have not proposed or recommended. In contrast to the NFL’s assertions:

- There would not be two groups of medical professionals treating the player. Players would be treated *only* by the Players’ Medical Staff, which would have players’ interests as their sole (and not only “primary”) consideration.
- The Players’ Medical Staff, consisting of athletic trainers and doctors, would have the same access to players as club medical staff currently does, and would be present during practices and games for the same number of hours as they currently are, providing care through examination and conversation with players.
- The Players’ Medical Staff would not provide care based solely on the Player Health Report, but instead would be responsible for creating that Report to provide to the club for its business use.
- The new Club Evaluation Doctor would utilize the Player Health Report and his or her own examination of the player to assist the club with its business decisions. We recognize that clubs have a legitimate business interest in understanding whether a player’s health status will impede his ability to perform, and thus preserve a path for clubs to obtain the necessary information.
- The Players’ Medical Staff would be responsible for determining whether and when an injured player could return to play from a clinical perspective, but would have no role in making business decisions about a player’s status with a club.
- Players would not be any more likely to withhold information relevant to determining their fitness for play from the Players’ Medical Staff than they are under the current system. In fact, by improving trust in a medical staff that has the players’ interests as their sole concern, we anticipate that our recommendation may improve communication and disclosure.

The NFL expresses concern that our proposed structure for NFL player healthcare does not exist “anywhere in the world” (p. 16). Even if this were true, we would remain untroubled by it, as progress often demands experimentation with new approaches, and we cannot be limited by a failure of imagination when it comes to player health. However, our view is that the recommendation is not in fact so foreign to the NFL. As noted above, the value of our recommended approach is exemplified by the required use of independent neurological consultants to examine and clear players to return to play as part of the Concussion Protocol. In adopting this approach, the NFL and NFLPA have recognized and endorsed the importance of a player receiving healthcare free from conflicts of interest, *i.e.*, provided by a medical professional without any interest in outcomes from a club’s perspective. It is our view that player healthcare should be free of conflicts of interest at all times, not only during examination for a possible concussion.



We understand that our recommendation may not be perfect, and that it will not cure all player health problems. But neither players, nor clubs, nor club doctors should prefer the status quo. Our recommendation is a significant step towards ensuring that players can access care from professionals that are exclusively concerned with players' interests, and not those of the clubs. While we expect that this will have the impact of improving player trust in their care, an essential feature of the doctor-patient relationship, we welcome the opportunity to work with the NFL, NFLPA and NFLPS on the specifics of our proposal.

In closing, we recognize the NFL as not only a partner in protecting and promoting NFL player health, but a leader. The NFL has made great progress – but, as it acknowledges, there is room to do still more.

Among the important things the NFL and NFLPA can do immediately is increase the sharing of relevant data and information, including: (1) the de-identified, aggregate results of the 2016 player survey concerning health and safety issues; (2) the complete season-end player injury reports prepared by Quintiles; and, (3) the NFL's Medical Sponsorship Policy. Public disclosure of such information would allow interested parties to scrutinize and analyze the data in any number of ways, likely elucidating statistical events, trends and figures that have the opportunity to improve player health, as well as simply providing independent verification of any analysis done by the NFL, NFLPA or their contractors for added public trust.

We hope that the NFL will join us in further conversation about our recommendations as we engage in public dialogue and programming on these issues. We also propose a meeting with relevant NFL officials to further discuss the recommendations in our Report, and will be in touch about scheduling shortly.

Thank you again for your engagement with our work.

Sincerely Yours,

I. Glenn Cohen

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