



## Comparing Health-Related Policies & Practices in Sports:

The NFL and Other Professional Leagues

# Chapter 1

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## Club Medical Personnel



This Chapter discusses the role of club medical staff, including both doctors and athletic trainers, in each of the sports leagues as set forth in the leagues' various controlling policies, most principally, the CBAs. In particular, we focus on: (1) the types of medical personnel required, if any; (2) the medical personnel's obligations; (3) the obligations of the players concerning club medical personnel; (4) the relationship between the medical personnel and the clubs; and, (5) the existence of sponsorship arrangements between medical personnel and the clubs, if any.

Our focus here is on the structural issues that are generally governed by the CBA or other policies rather than how each individual club hires and supervises its medical personnel and how individual medical personnel interact with individual players, matters that are not the subject of extensive reporting or publicly available research. By understanding what is required or permitted pursuant to the CBA or other policies we can understand the scope of possible practices, including those that might be concerning as they relate to player health.

To provide context for the policies we examine in this Chapter, it is important to provide background on the subjects most relevant to player health. We discuss those below, and then provide background on two additional issues relevant to club medical personnel and this Chapter, before reviewing the policies of each league.

## 1 ) SUBJECTS RELEVANT TO PLAYER HEALTH

There are a wide variety of laws, statutes, regulations, and ethical codes that govern the actions of sports medical professionals. For example, the American Medical Association (“AMA”)’s Code of Medical Ethics (“AMA Code”)<sup>1</sup> governs the conduct of nearly all doctors, and contains multiple provisions applicable to the duties and obligations of club doctors. Similarly, the leading sports medicine organization, Fédération Internationale de Médecine du Sport (“FIMS”), publishes a Code of Ethics.<sup>2</sup> And, for athletic trainers, the National Athletic Trainers Association (“NATA”) has a fairly robust Code of Ethics.<sup>3</sup>

The full panoply of laws, statutes, regulations, and ethical codes and their application to professional sports is complex and discussed at length in our prior Report: *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*. Here, we identify some of the principles discussed in that Report most relevant to understanding the different leagues’ efficacy in protecting and promoting player health: (a) quality of medical care; (b) disclosure and player autonomy; (c) confidentiality; and, (d) conflicts of interest. While we do not organize the Chapter by these issues, they served as the framework for our analysis and we thus elaborate on them here.

### a ) Quality of Medical Care

Playing professional sports comes with a risk of injury that likely exceeds most traditional employment situations. Moreover, a player’s health is essential to his performance and career longevity. Consequently, it is important that players have access to high quality healthcare and healthcare that is suited to meet their sport-specific needs. In this respect, we are interested in whether the leagues have policies that require certain types of medical professionals and certain certifications that are likely to be most responsive to a professional athlete’s healthcare needs. Additionally, we are interested in whether the leagues clarify the standard of care to be provided to players.

### b ) Disclosure and Player Autonomy

There is broad support in law and ethics for a patient’s right to autonomy—the right to make his or her own

choices concerning healthcare.<sup>4</sup> A key correlate of a patient’s right to make his or her own decisions is the obligation of the healthcare provider to disclose relevant medical information. Players are patients too and deserve the same protections we all seek in our medical decision-making.<sup>a</sup> As it concerns professional sports leagues, we are interested in what types of information or records the clubs are required to provide to players, what type of healthcare options are available to players outside of the club, and what level of control the club retains over the player’s healthcare choices.

### c ) Confidentiality

One of the fundamental principles of the doctor-patient relationship is that a patient’s medical information must be treated confidentially.<sup>5</sup> However, this principle is put under pressure in situations where an employee’s health is relevant to the employee’s ability to perform his job, and his healthcare is provided in the employment context, both of which are the case in professional sports. While we recognize club interests and rights in accessing certain player health information, appropriate safeguards are needed in dictating the degree to which player medical information can be disclosed and disseminated. We look carefully to see which leagues have put such safeguards in place and to what extent. We also examine confidentiality protections when a player obtains care from a healthcare professional outside of the club, including whether the club has any rights to view that information.

### d ) Conflicts of Interest

Club medical staff—such as doctors and athletic trainers—are clearly fundamental to protecting and promoting player health. However, they face an inherent structural conflict of interest. This is not a moral judgment about them as competent professionals or devoted individuals, but rather a simple fact of the current organizational structure of their positions, in which they simultaneously perform at least two roles that are not necessarily compatible. On the one hand, they are hired by clubs to provide and supervise player medical care. As a result, they 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

a Indeed, as part of our prior Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, we included a Patient Bill of Rights for NFL Players, modeled on the Patient’s Bill of Rights common in hospitals and other healthcare settings.

self-protection, including when they should play, rest, and potentially retire.

On the other hand, clubs engage medical staff 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 medical staff 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 medical staff may sometimes conflict because players and clubs often have conflicting interests, but club medical staff are called to serve both parties. We examine what the leagues are doing (or are not doing) to protect players from these conflicts.

Similarly, many healthcare organizations are interested in being associated with professional sports clubs to enhance their reputation and exposure. Consequently, these organizations seek to enter into a variety of commercial arrangements with clubs, including some whereby a healthcare organization pays the club for the right to provide medical care to the players. Such arrangements may raise concerns about how medical professionals treating players are being selected (*e.g.*, skill or payment) and whether these relationships have the potential to undermine the care provided to players or trust in the healthcare professionals providing that care.

## 2 ) ADDITIONAL INTRODUCTORY ISSUES

### a ) Independent Contractors Versus Employees

Where possible, we have provided information concerning whether club doctors in a particular league are independent contractors or employees of the club. The distinction has important ramifications from a potential liability perspective vis-à-vis workers' compensation laws.

Workers' compensation statutes provide compensation for workers injured at work and thus generally preclude lawsuits against co-workers based on the co-workers' negligence.<sup>6</sup> Thus, in cases where the club doctor is an employee of the club—as opposed to an independent contractor as is the case for most club doctors—a player's lawsuit against the doctor is likely to be barred by the relevant state's workers' compensation statute. This has been the result in multiple cases brought by athletes against clubs and club doctors,<sup>7</sup> as well as in cases brought by athletes against athletic trainers,<sup>8</sup> who are almost always employees of the club. Where the club doctors are independent contractors instead of employees, the players can pursue medical malpractice cases against the doctor,<sup>9</sup> but the club is not

likely to be held legally responsible for any negligence by the doctor.<sup>10</sup>

### b ) Healthcare in Canada

The second issue worth mentioning now concerns Canadian clubs. MLB (one club), the NBA (one), NHL (seven), CFL (all nine), and MLS (three) have Canadian clubs. As Canadian and United States laws differ concerning healthcare, an understanding of the Canadian healthcare system is necessary for any discussion of the relationship between Canadian clubs and medical personnel.

The Canadian healthcare system is a social, welfare-based system, wherein “access to health care is viewed as a right” and is financed through government funding.<sup>11</sup> The ten Canadian provinces and three territories separately administer healthcare plans modeled off of the federal Canada Health Act of 1984.<sup>12</sup> The federal government ensures provincial compliance with the federal template through the threat of loss of federal funding.<sup>13</sup> Compliant plans must cover “insured services”—a defined term in the Canada Health Act that includes medically necessary hospital services, hospital facilities, drugs used in hospitals, medically necessary services rendered by medical practitioners, and medically required surgical/dental services performed in a hospital. In addition, plans must also meet the five principles of the Canada Health Act: public administration; provincial portability; universality; comprehensiveness; and, accessibility.<sup>14</sup> Given the gaps in coverage (for example, drugs outside of hospitals and vision/dental services performed outside of hospitals are generally not covered), private spending still makes up 29% of Canadian healthcare expenditures.<sup>15</sup>

“As far as delivery of services is concerned, most physicians are independent contractors operating on a fee-for-service basis.”<sup>16</sup> These physicians receive fees that are fixed through negotiations between medical associations and provincial governments, and there is no additional billing.<sup>17</sup> To collect payment, physicians directly bill the provincial medical services association.<sup>18</sup> Physicians providing non-covered services, however, directly bill patients, who pay through private insurance or out-of-pocket.<sup>19</sup> Of course, this is different from the United States. Outside of some specific populations, including but not limited to those covered by Medicare, Medicaid, or the Veterans Affairs healthcare system, most Americans have private health insurance either through their own insurance plan or one sponsored by their employer.

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With these introductory issues in mind to provide context, we turn now to analyzing club medical personnel policies in each of the leagues. For each league, we analyze: (1) Types of Medical Personnel; (2) Medical Personnel's Obligations; (3) Players' Obligations; (4) Relationship between Medical Personnel and Clubs; and, (5) Sponsorship Arrangements.



## A ) Club Medical Personnel in the NFL

### 1 ) TYPES OF MEDICAL PERSONNEL

#### a ) Doctors

The CBA obligates NFL clubs to retain certain kinds of doctors:

- **Club Physicians:** Clubs must retain<sup>20</sup> 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. In addition, clubs are required to retain consultants in the neurological, cardiovascular, nutritional, and neuropsychological fields.<sup>21</sup>
- **Physicians at Games:** “All home teams shall retain at least one [Rapid Sequence Intubation] RSI physician who is board certified in emergency medicine, anesthesia, pulmonary medicine, or thoracic surgery, and who has documented competence in RSI intubations in the past twelve months. This physician shall be the neutral physician dedicated to game-day medical intervention for on-field or locker room catastrophic emergencies.”<sup>22</sup>

Of note, these two provisions do not require clubs to retain and have available neurological doctors at the games. The absence of this requirement is offset by the Concussion Protocol's<sup>b</sup> requirement that for every game each club be assigned an Unaffiliated Neurotrauma Consultant to assist in the diagnosis of concussions.

Most (if not all) of the doctors retained by NFL clubs are members of the National Football League Physicians Society (“NFLPS”). The stated mission of the NFLPS, founded in 1966, “is to provide excellence in the medical and surgical care of the athletes in the National Football League and to provide direction and support for the athletic trainers in

charge of the care for these athletes.”<sup>23</sup> Approximately 175 doctors work with NFL clubs,<sup>24</sup> an average of 5.5 per club. The NFLPS holds annual meetings at the NFL Combine to discuss medical and scientific issues pertinent to its membership.<sup>25</sup>

According to the NFLPS, 22 of the 32 clubs' head orthopedists and 14 of the 32 clubs' head “medicine” doctors are board-certified in sports medicine.<sup>26</sup> In addition, although the 2011 CBA requires club doctors to have a Certificate of Added Qualification in Sports Medicine, currently only 11 out of the 32 head club doctors have such a Certificate. The remaining club doctors were with clubs before the 2011 CBA and were grandfathered in under the new policy.

Notably, the NFLPS does not have a code of ethics for its members.<sup>c</sup>

#### b ) Athletic Trainers

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.<sup>d</sup>

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.<sup>27</sup> In the 2014 season, 26 athletic trainers had at least 20 years of experience and eight had more than 30 years of experience.<sup>28</sup> Athletic trainers—unlike most club doctors—are full-time employees of the club and not independent contractors.

The Professional Football Athletic Trainers Society (“PFATS”) is an organization that represents the athletic trainers of NFL clubs.<sup>29</sup> “[M]embership in PFATS is limited to those professionally certified in accordance with the most

b The Concussion Protocol refers to the NFL Head, Neck and Spine Committee's Protocols Regarding Diagnosis and Management of Concussion.

c This information was provided by the NFLPS. In Recommendation 2:1-B of our Report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, we recommend the NFLPS adopt a code of ethics.

d 2011 NFL CBA, Art. 39, § 2. 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 Board of Certification for the Athletic Trainer (“BOC”). Nevertheless, all NFL athletic trainers are certified by the BOC.



current NFL Collective Bargaining Agreement and who are employed full-time as head or assistant athletic trainers by any of the 32 NFL franchises.”<sup>30</sup> 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.<sup>31</sup>

PFATS does have a Code of Ethics for its members. However, as discussed in greater depth in our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, the Code of Ethics is seriously flawed and requires substantial changes to be protective of player health.<sup>32</sup>

## 2 ) MEDICAL PERSONNEL’S OBLIGATIONS

The CBA requires each NFL club to “use its best efforts to ensure that its players are provided with medical care consistent with professional standards for the industry.”<sup>33</sup> The CBA expounds on this provision by articulating its conception of the club doctor’s standard of care:

[E]ach Club physician’s primary duty *in providing medical care* shall be not to the Club but instead to the player-patient. This duty shall include traditional physician/patient confidentiality requirements. In addition, all Club physicians and medical personnel shall comply with all federal, state, and local requirements, including all ethical rules and standards established by any applicable government and/or other authority that regulates or governs the medical profession in the Club’s city.<sup>34</sup> (Emphasis added.)

This CBA provision is susceptible to multiple interpretations. On a generous reading (*i.e.*, one that does not give the italicized language any special emphasis), club doctors’ primary duty is to the player at all times. On a less generous reading, the CBA provision demands a primary duty to the player-patient *only* in situations where the club doctor

is “providing medical care,” and thus is inapplicable when the club doctor is rendering services to the club. Importantly, however, the way club doctors are currently situated within the club precludes the two roles from being truly separated, and thereby precludes club doctors from having their exclusive duty be to the players. This is because at the same time that the club doctor is providing care to the player, he is simultaneously performing duties for the club by judging the player’s ability to play and help the club win.

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

Relatedly, the CBA provision also seems to require that the care relationship between players and club doctors be afforded “traditional” confidentiality protections. However, clubs request or require players to execute collectively-bargained waivers effectively waiving this requirement—and no player refuses to sign the waiver.<sup>e</sup> Questions might be raised as to whether the players are providing meaningful and voluntary informed consent in their execution. Players are being compelled to waive certain legal rights concerning their health without meaningful options. There is no doubt that players execute the waivers because they fear that if they do not, they will lose their job. Indeed, the waivers (which are collectively bargained with the NFLPA)<sup>35</sup> permit the athletic trainer and club doctors to disclose the player’s medical information to club employees, such as coaches and the general manager. Thus, it is unclear what work this CBA language is doing. Of course, given this communication, it is inevitable that players will be less

<sup>e</sup> For more on this issue, see our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*. A copy of the waiver at issue is included as Appendix L to that Report.

than forthcoming about their medical needs, lest it negatively affect their career prospects.

In reviewing a draft of our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, the NFL rejected our claim that the CBA provision “requires the traditional patient-physician confidentiality requirements of a private system,”<sup>36</sup> even though the provision in question specifically says club doctors have a duty to provide “traditional physician/patient confidentiality requirements.” The CBA provision does not qualify the club doctor’s duty in the context of the employer-employee relationship. The NFL should abide by its obligations under the CBA.

The CBA also imposes disclosure requirements on club doctors:

All Club physicians are required to disclose to a player any and all information about the player’s physical condition that the physician may from time to time provide to a coach or other Club representative, whether or not such information affects the player’s performance or health. If a Club physician advises a coach or other Club representative of a player’s serious injury or career threatening physical condition which significantly affects the player’s performance or health, the physician will also advise the player in writing. The player, after being advised of such serious injury or career-threatening physical condition, may request a copy of the Club physician’s record from the examination in which such physical condition was diagnosed and/or a written explanation from the Club physician of the physical condition.<sup>37</sup>

Additionally, club doctors are obligated to permit a player to examine his medical records once during the pre-season and once after the regular season. Club doctors are also obligated to provide a copy of a player’s medical records to the player upon request in the off-season.<sup>38</sup> Nevertheless, in reality, the NFL now has an electronic medical record system that permits players to obtain access to their medical records at any time.

Finally, there are no CBA provisions that address an athletic trainer’s obligations.

### 3) PLAYERS’ OBLIGATIONS

The CBA and Standard NFL Player Contract impose certain obligations on players concerning their relationship with club medical personnel.

First, players are required to “undergo the standardized minimum pre-season physical examination and tests” that are agreed to as part of the CBA.<sup>39</sup>

Second, players are obligated to “undergo a complete physical examination by the club physician upon club request, during which physical examination Player agrees to make full and complete disclosure of any physical or mental condition known to him which might impair his performance . . . and to respond fully and in good faith when questioned by the Club physician about such condition.”<sup>40</sup>

Third, players seemingly have an ongoing obligation to report injuries to the club. The CBA permits clubs to fine players up to \$1,770 if the player does not “promptly report” an injury to the club doctor or athletic trainer.<sup>41</sup> We are not aware of any guidance on what constitutes “promptly report[ing].”

Fourth, whenever a player seeks a second medical opinion or exercises his right to have the surgeon of his choice perform an operation, the player must first consult with the club doctor if he wishes to have the club pay for the second medical opinion or surgery.<sup>42</sup> Additionally, if the player sees a second opinion doctor and wants the club to pay for it, “the Club physician must be furnished promptly with a report concerning the diagnosis, examination and course of treatment recommended by the other physician.”<sup>43</sup>

## 4) RELATIONSHIP BETWEEN MEDICAL PERSONNEL AND CLUBS

As a preliminary matter, each member of an NFL club’s medical staff is typically chosen by the club’s front office executives, *e.g.*, the club president or general manager.<sup>44</sup>

### a) Doctors

Club doctors are affiliated with a wide variety of private practice groups, hospitals, academic institutions, and other professional sports leagues. Some of these institutions have long-standing relationships with clubs which often help lead to the doctor being retained by the club. The NFLPA plays no role in the selection of club doctors other than ensuring they have the qualifications required by the CBA and are properly licensed in the relevant state(s), via Synernet, a third-party vendor jointly selected by the NFL and NFLPA.<sup>45</sup> Additionally, of the NFL’s 32 head club doctors, two are employees and 30 are independent contractors.<sup>46</sup>

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

Actual statistics and practices of club doctor compensation are difficult to ascertain. In the course of our research, we were informed by some familiar with the industry that club doctors are generally paid in relatively nominal amounts compared to what one might expect (\$20,000–\$30,000).<sup>f</sup> In reviewing a draft of our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, the NFL stated that this estimate “grossly underestimates compensation to Head Team Physicians, Head Team Orthopedists and Head Team Internists.”<sup>47</sup> Nevertheless, the NFL did not provide alternative compensation statistics.

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

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

## b ) Athletic Trainers

Athletic trainers—unlike most club doctors—are full-time employees of the club and not independent contractors.

Athletic trainers are generally an NFL player’s first and primary source of medical care.<sup>48</sup> Club doctors are only with the club sporadically during the week of practice and then attend the games, whereas the athletic trainers are with the club at all times. 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. 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.

Players execute 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.<sup>8</sup> Athletic trainers—in consultation with the club doctors—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.<sup>49</sup> These waivers effectively undermine the confidentiality protections outlined in the CBA.

## 5 ) SPONSORSHIP ARRANGEMENTS

The NFL first instituted a Medical Sponsorship Policy in 2004.<sup>h</sup> At its core, the Policy, most recently amended in 2014, permits clubs to enter into a Sponsorship Agreement with a medical services provider (“MSP”), but prohibits such agreements that also include the provision of medical services. Stated another way, “[n]o Club may enter into a contract for the provision of medical services to its players that is interdependent with, or in any way tied to a Sponsorship Agreement with a [MSP].” The Medical Sponsorship Policy does not define “interdependent” and instead the NFL reviews the arrangements to ensure there is no interdependence.<sup>50</sup>

The Policy also explicitly declares that clubs are permitted to enter into agreements with MSPs whereby the MSP obtains the right to advertise itself as an “official” or “proud” “sponsor,” “partner,” or “provider.”<sup>51</sup> A review of club websites and media guides shows that at least 25 clubs currently have some type of “official” healthcare sponsor or partner.

Additionally, the Medical Sponsorship Policy does not prohibit MSPs from paying for the right to provide medical services to players, although, according to the NFLPS, no MSP currently pays for the right to provide medical services to players. The Policy also does not limit an MSP’s ability to bargain for the right to provide healthcare to a club by offering discounted or free services.

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

g These waivers are included as Appendices L and M in our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*.

h For a complete history of the NFL’s Medical Sponsorship Policy, see Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 2(A) (2016).

i The 2014 Medical Sponsorship Policy defines “Sponsorship Agreements” as “agreements with MSPs involving the sale or license by the club of commercial assets such as naming rights, stadium signage, advertising inventory within club-controlled media, promotional inventory (e.g., day-of-game promotions), hospitality, and rights to use club trademarks for marketing and promotional purposes.”

j According to the Policy, MSPs include “hospitals, universities, medical practice groups, rehabilitation facilities, laboratories, imaging centers and other entities that provide medical care and related services.” Although doctors are not specifically included in the definition of MSPs, the NFL includes doctors as MSPs for purposes of the Policy. Email with Larry Ferazani, Vice President, Labor Litigation & Policy, Nat’l Football League (Apr. 15, 2015) (on file with author).

**Table 1-A:**  
**Arrangements *Prohibited* by Medical Sponsorship Policy**

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

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

*We track phone calls coming in from new patients . . . The No. 1 driver of our calls is the association with our local teams. People say they heard that Methodist is where the players go, so it must be the best. It's not a coincidence that we are the best, but there isn't a better way to convince them. That's a win-win situation.<sup>52</sup>*

Finally, it is worth noting that institutional MSPs can be a party to the doctor's contract with the club to the extent

that such an arrangement is necessary for medical malpractice insurance or for practice privileges.

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

Above and below are examples of relationships between MSPs, including doctors, and clubs with a discussion of whether these relationships would be prohibited or permitted by the 2014 Medical Sponsorship Policy. However, it is important to keep in mind that the 2014 Medical



**Table 1-B:**  
**Arrangements Permitted by Medical Sponsorship Policy**

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

Sponsorship Policy is complex and, at times, unclear. Additionally, the document is not collectively bargained and there is no generally available guidance. Thus, what follows is our best interpretation of the Policy. A more detailed discussion of the Medical Sponsorship Policy can be found in our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*.<sup>53</sup>

In reviewing a draft of our Report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, the NFL stated that it "disagree[d] entirely with the conclusions reached in Table [1]-B,"<sup>54</sup> without explaining why it reads the plain text of the Policy so differently than we do. The fact that two sets of trained

attorneys (those who authored this Report and those at the NFL) interpret the Policy differently demonstrates that it should be clarified. Ideally, the NFL will make the Policy public to allow for further discussion and review.<sup>k</sup>

<sup>k</sup> In a written response to our Report, the NFL again disagreed with us, stating: "Despite the clear language in the policy prohibiting the exchange of medical services for sponsorship, the initial draft of the Report asserted, '[a]dditionally the Medical Sponsorship Policy does not prohibit medical service providers from paying for the right to provide medical services to players.' The NFL identified this inaccurate statement, and advised the authors that, '[t]he Policy on Medical Services Agreements and Sponsorships does [prohibit a physician from paying for the right to provide medical care to NFL Players].' Incredibly, the Report rejected the NFL's interpretation of the language in its own policy, which we enforce, by asserting the interpretation of the language was unclear to the authors, and as result refused to remove this reference from the Report. The Report cites no example where the policy has not been followed." For the reasons stated above, we continue to disagree with the NFL's interpretation and recommend that it be clarified.

As these charts demonstrate, while the NFL has made progress in regulating the payment to and from club doctors for sponsorship, on a plain reading of the Policy, there are still a number of ethically fraught arrangements the current Policy appears to leave in place.<sup>1</sup>

With this understanding of the NFL policies, we are now ready to begin the comparison to the other leagues.



## B ) Club Medical Personnel in MLB

As explained in the Introduction, Section C: Collective Bargaining Agreements, in the fall of 2016, MLB and the MLBPA agreed to and ratified the terms of a new CBA. However, as of the date this Report went to press, the parties had not yet published the new CBA. Thus, this Section summarizes the information contained in the 2012 CBA, with relevant changes revealed in a joint press release issued by the parties summarizing the changes agreed to in 2016. Additional details, nuance or context may be contained in the full length CBA when it is publicly released.

### 1 ) TYPES OF MEDICAL PERSONNEL

#### a ) Doctors

MLB policy requires “[t]he home Club [to] have a Club physician (medical or surgical) present for every game.”<sup>55</sup> The home club doctor is also “expected to provide medical coverage for the visiting Club.”<sup>56</sup> In addition, MLB policy requires each club to appoint a head doctor to be “responsible for all medical decisions of the Club, and [to] serve as the primary liaison between the Club and the Office of the Commissioner’s Medical Director on all medical issues.”<sup>57</sup>

A club’s head doctor must be “licensed to practice medicine in the club’s home state and be Board Certified in his or her specialty.”<sup>58</sup> In addition, club doctors providing medical coverage at games must be “able to handle all common injuries and illnesses that would be expected during a professional baseball game, including the evaluation and management of concussions.”<sup>59</sup>

MLB’s policies concerning club doctors differ from the NFL’s in four important respects. First, while there are several provisions referencing club doctors in the CBA,<sup>60</sup> there is no CBA provision that explicitly requires clubs to retain doctors. Second, of the policies that do exist, none are in the CBA, which permits MLB to change them without MLBPA input or approval. Third, neither MLB policy nor the CBA requires clubs to retain certain kinds of doctors, whereas the NFL CBA requires clubs to retain a board-certified orthopedic surgeon at least one physician board-certified in internal medicine, family medicine, or emergency medicine, and consultants in the neurological, cardiovascular, nutritional, and neuropsychological fields.<sup>61</sup> Fourth, unlike the NFL, MLB does not require that all club doctors have a Certificate of Added Qualification in Sports Medicine.

The professional organization for MLB club doctors is the MLB Team Physicians Association (“MLBTPA”). MLBTPA’s “mission is to maintain the earned trust of the athletes and teams of Major and Minor League Baseball, as well as the public, by providing the highest quality medical care and services aimed at securing and enhancing their safety, health and well-being.”<sup>62</sup> The MLBTPA website lists 117 members, an average of 3.9 per MLB club. Research did not reveal an MLBTPA code of ethics specific to its members.

The 2012 CBA did not require clubs to retain doctors and the publicly released details of the 2016 CBA do not indicate that anything has changed in that regard. However, the 2016 CBA did make two relevant additions: (1) clubs are now required to provide access to a sports psychologist;<sup>63</sup> and, (2) MLB and the MLBPA agreed to jointly retain a dietician to provide recommendations to players and clubs on nutrition and supplements.<sup>64</sup>

#### b ) Athletic Trainers

Like the NFL CBA, the MLB CBA requires the employment of certified athletic trainers:

Each Club shall employ two Certified Athletic Trainers on a full-time basis. Both trainers will travel with the Club on the road; provided, that one trainer may remain in the Club’s home city if necessary for the Club to fulfill its obligations to disabled players who do not travel with the Club.

Individuals newly appointed as trainers shall be certified by the National Athletic Trainers Association (NATA) or the Canadian Athletic Therapists

<sup>1</sup> In reviewing our Report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, the National Athletic Trainers Association stated that “[p]hysician practices paying Clubs to serve as team physicians may result in significant conflicts of interest (COI) in the care of the NFL athlete. Health care should be based on best practices.”

Association (CATA), or shall be physical therapists licensed by an appropriate state authority.<sup>65,m</sup>

The professional organization for MLB club athletic trainers is the Professional Baseball Athletic Trainer Society (“PBATS”). “PBATS mission is to serve as an educational resource for the Major League and Minor League Baseball athletic trainers. PBATS serves its members by providing for the continued education of the athletic trainer as it relates to the profession, helping to improve his understanding of sports medicine so as to better promote the health of his constituency—professional baseball players.”<sup>66</sup> Research did not reveal a PBATS code of ethics specific to its members.

In reviewing a draft of this Report, MLB stated as follows:

The insinuation in the report that MLB team physicians and certified athletic trainers do not have a code of ethics is patently untrue. All MLB physicians are board certified in their respective specialties and are obligated to practice medicine under general ethical codes that govern all licensed physicians, as well as the more specific codes of ethics of the appropriate licensing bodies and other professional organizations by which they are a member (e.g., AAOS, AMSSM, etc.). Since all MLB athletic trainers are members of the National Athletic Trainers Association and are also licensed by their respective state authorities, these codes of ethics apply to and govern this group of medical professionals. MLB takes the position that the duties and obligations of Club medical representatives are **not** negotiable subjects of bargaining, and are not an appropriate part of our CBA.

We understand MLB’s point and revised the report to clarify that there are not codes of ethics *specific* to members of the MLBTPA and PBATS. Nevertheless, we disagree with MLB that medical personnel working with professional sports clubs do not need their own codes of ethics. Club medical personnel 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. Codes of ethics adopted by professional organizations for club medical personnel would

supplement existing codes of ethics by providing guidance and tenets for the unique and competitive environment in which they must operate.<sup>n</sup>

## 2 ) MEDICAL PERSONNEL’S OBLIGATIONS

### a ) Doctors

The CBA contains the following provisions concerning the club doctor’s duties or obligations.<sup>o</sup>

First, club doctors are “prohibited from making any public disclosure of a Player’s medical information absent a separate, specific written authorization from the Player authorizing such public disclosure.”<sup>67</sup> The NFL CBA does not contain a specific prohibition such as this, but the AMA’s Code of Ethics does.<sup>68</sup>

Second, “[i]f a player on a visiting Club receives medical treatment from the home Club’s physician, certified athletic trainer or other medical professional for a work-related injury, a copy of any written medical evaluation prepared by the home Club’s medical professional shall be provided to the Player and his Club’s physician.”<sup>69</sup>

Third, if a player is a free agent and requests a copy of his medical records from his prior club, the “Club shall provide such records within 10 days of such request.”<sup>70</sup>

Fourth, the CBA requires club doctors to use a standardized medical history questionnaire when conducting initial physical examinations of players.<sup>71</sup>

Fifth, the CBA requires that for a player to be placed on the Disabled List, a standard form of diagnosis, including an estimated time period for recovery, must be submitted by the club doctor, a copy of which must be provided to the player.<sup>72</sup>

Sixth, the CBA sets forth MLB’s policy concerning the assessment and management of concussions.<sup>73</sup> Club doctors are involved in determining whether a player has suffered a

m The MLB CBA’s requirement that athletic trainers be certified by NATA or CATA is actually in error and a requirement with which athletic trainers cannot comply. NATA and CATA are voluntary professional associations but do not *certify* athletic trainers. Athletic trainers are certified by the Board of Certification for the Athletic Trainer (“BOC”). The NFL CBA also erroneously requires athletic trainers to be certified by NATA.

n In reviewing a draft of this Report a second time, MLB stated that “MLB maintains our position regarding a code of ethics, and do not find it appropriate to ask physicians to comply with a code of ethics that differs from the Hippocratic Oath or other professional/ethical oaths they took as a physician.” To be clear, we do not recommend the addition of codes of ethics that differ from or conflict with existing codes. Instead, we believe it is appropriate that additional codes of ethics tailored for the specific circumstances of professional sports supplement existing codes. For more discussion on the challenges of the sports healthcare environment, see our Special Report, *NFL Player Health: The Role of Club Doctors*, 46 Hastings Center Rep. 2 (2016).

o In addition to those obligations listed here, club doctors are also involved in determining whether a player’s injury will prevent him from playing in the All-Star Game. 2012 MLB CBA, Art. XV, § 0.

concussion, whether the player should be placed on the Disabled List, and clearing the player to return to play.<sup>74</sup>

We turn now to the standard of care for MLB club doctors. When asked specifically about this issue, MLB directed us to its minimum game day standards and the MLBTPA mission statement, both of which were discussed above. However, neither the game day standards nor the mission statement sets forth a standard of care for club doctors specific to MLB club doctors or that goes beyond what is already required by codes of ethics and relevant law applicable to all doctors. By comparison, the NFL, NHL and MLS CBAs all set forth standards of care for their club doctors which, in particular, attempt to address the conflict of interest inherent in having doctors that treat players while also providing services to the club.<sup>p</sup>

Also unlike the NFL, MLB policies do not: require club medical staff to inform players about communications between the medical staff and the club; entitle players to the surgeon of their choice (discussed further below); or, entitle players to their medical records as a general matter.

## Neither MLB game day standards nor the MLBTPA mission statement sets forth a standard of care for club doctors specific to MLB club doctors.

Concerning medical records, in reviewing a draft of this Report, MLB “dispute[d] . . . that players are not entitled to their medical records as a general matter. The medical records maintained in MLB’s league-wide electronic medical records system is a player’s legal medical file, and players are entitled to this information upon request.” While it is useful that players can obtain their medical records upon request, players would likely view their records more if they were able to access their records without having to obtain the club’s assistance, as NFL players can.

### b ) Athletic Trainers

The CBA is also sparse concerning athletic trainers’ obligations. The only provision governing athletic trainers is their

involvement in MLB’s protocol for assessing and managing concussions. MLB’s concussion protocol requires that players “involved in an incident during a game that is associated with a high risk of concussion . . . will be evaluated on the field for a potential concussion by a Certified Athletic Trainer (‘ATC’) following the National Athletic Trainers’ Association (‘NATA’) guidelines for management of sports-related concussions.”<sup>75</sup> As stated above, the player cannot return to play until he has been cleared by the club doctor.<sup>76</sup>

Additionally, MLB regulations require that “[a]ll ATCs comply with the NATA definition of an athletic trainer, which states that ‘athletic trainers work under the direction of physicians, as prescribed by state licensing statutes.’”<sup>77</sup>

## 3 ) PLAYERS’ OBLIGATIONS

Players are subjected to the following requirements concerning their relationships with club medical personnel.

First, MLB’s Uniform Player Contract requires players, “when requested by the Club, [to] submit to a complete physical examination at the expense of the Club, and if necessary to treatment by a physician, dentist, certified athletic trainer or other medical professional in good standing.”<sup>78</sup> While the NFL CBA requires players to submit to physical examinations, it does not directly require players to submit to treatment. Nevertheless, in practice, if an NFL player failed to undergo treatment recommended by the club medical staff, the club could argue that the player failed to fulfill his obligations under the contract.

Second, “[p]rior to undergoing a ‘second evaluation,’ a Player shall inform the Club in writing of his decision to seek a second medical opinion, and the name of the physician who will be performing the diagnosis and medical evaluation.”<sup>79</sup> In order for the club to pay for the cost of the second medical opinion, the doctor providing the opinion must be on a list of doctors created by MLB’s Medical Advisory Committee and a medical professional designated by the MLBPA.<sup>80</sup> The NFL CBA similarly requires players to consult with the club before seeking a second medical opinion but does not limit a player’s options to a pre-approved list.

Third, if a player seeks medical treatment from a doctor unaffiliated with the club for a baseball-related injury, the player must advise the club in advance and obtain the club’s authorization for the treatment.<sup>81</sup> The player does not have to notify the club of consulting with another doctor if the player does not receive treatment for the injury, and is not invoking his right to have the club pay for a second medical opinion.<sup>82</sup> Additionally, a player does not have to advise

<sup>p</sup> In our Report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations* we set forth a comprehensive recommendation to address this issue. We propose restructuring NFL club medical staff in such a way that the doctor treating the players has as his or her only concern the well-being of the player-patient and has no advisory role to the club.



the club about treatment for a non-baseball-related injury, provided the injury does not affect his ability to play.<sup>83</sup>

#### 4) RELATIONSHIP BETWEEN MEDICAL PERSONNEL AND CLUBS

MLB does not have any policies concerning how clubs select or monitor medical personnel.<sup>84</sup> Club-doctor relationships, including compensation, duration of a contract, supervisory control, and hiring and termination, are decisions made by each individual club.<sup>85</sup> Perhaps partially as a result, club doctors' roles, employment situations, and compensation vary significantly around MLB.<sup>86</sup> In 2004, MLB attorneys reportedly suggested that clubs consider classifying their doctors as employees in order to reduce medical malpractice insurance premiums.<sup>87</sup> Despite this report, as in the NFL, most club doctors are independent contractors and "only a few" club doctors are employees.<sup>88</sup>

Clubs retain certain rights concerning a player's healthcare. Specifically, "the Club has the right to designate the doctors and hospitals when a Player is undergoing a surgery for an employment related injury," but are required to "take a Player's reasonable preferences into account when designating doctors to perform surgery[.]"<sup>89</sup> In contrast, NFL players have the right to a surgeon of their choice.

MLB and the MLBPA have collectively bargained a form that permits club medical personnel to disclose any of the player's health information to "the Owner, President, General Manager, Assistant General Manager, Field Manager, Physicians and such medical personnel as they may designate, Certified Athletic Trainer, Assistant Certified Athletic Trainer, Club Rehabilitation Coordinator, In-House Counsel, Risk Manager and Workers' Compensation Coordinator of the Club" "for any purpose relating to [the player's] employment as a player for the Club[.]"<sup>90</sup> The player has the right to revoke the authorization (assuming he signed it).<sup>91</sup> However, any revocation appears to be effectively meaningless because, as part of the Uniform Player Contract, the player agrees "that the Club's physician and any other physician or medical professional consulted by the Player . . . may furnish to the Club all relevant medical information relating to the Player."<sup>92</sup> The club also has the right to provide the player's medical information to clubs with which the player's club is in trade negotiations.<sup>93</sup> MLB's practices in this regard are comparable to the NFL, where players generally sign broad waivers permitting clubs to obtain, use, and disclose their medical information.

Turning to athletic trainers' practices specifically, like in the NFL, MLB athletic trainers are the primary caregivers for injuries suffered during the season.<sup>94</sup> Indeed, club doctors are not permitted by MLB regulations to sit in the dugout.<sup>95</sup> Club doctors reportedly do not travel to regular season away games, and, instead, the home club's doctors are responsible for overseeing the healthcare of both the home and visiting clubs, as well as all managers, coaches, and umpires.<sup>96</sup> MLB regulations also require that athletic trainers "comply with the [National Athletic Trainers Association] definition of an athletic trainer, which states that 'athletic trainers work under the direction of physicians, as prescribed by state licensing statutes.'"<sup>97</sup>

#### 5) SPONSORSHIP ARRANGEMENTS

In 2004, MLB prohibited sponsorship arrangements between clubs and medical providers that included "the right of the [sponsor] to be the medical service provider for the club's players and employees."<sup>98</sup> Under MLB's policy, clubs must negotiate at arm's length for medical services, and the Commissioner must approve all sponsorship agreements with healthcare providers.<sup>99</sup> The Commissioner has approved such sponsorship arrangements with medical providers where "the Club has had a pre-existing relationship with the hospital or doctors prior to the sponsorship, and the terms of the health care agreement were unaffected by the sponsorship."<sup>100</sup> Additionally, MLB's medical sponsorship policy is the result of negotiations with the MLBPA.<sup>101</sup>

Nevertheless, MLB's policy does not prohibit clubs from "enter[ing] into traditional sponsorship arrangements with [medical service providers] involving, for example, advertising, hospitality or the use of trademark rights, provided that such agreements are otherwise consistent with Major League Baseball policy and applicable law."<sup>102</sup> Thus, it appears that MLB clubs are permitted to enter into sponsorship agreements with medical service providers so long as those agreements do not involve the provision of medical care to the players. Indeed, many MLB clubs have sponsorship relationships with regional healthcare providers.<sup>103</sup>

MLB's medical sponsorship policy is substantially similar to the NFL's. While there are gaps and room for interpretation, the general purpose of both policies is to prevent healthcare providers from paying for the right to provide medical care to the players. Additionally, MLB's medical sponsorship policy is slightly less concerning from a player perspective since it was negotiated with the MLBPA. In contrast, the NFL's Medical Sponsorship Policy is unilaterally imposed.



## C ) Club Medical Personnel in the NBA

### 1 ) TYPES OF MEDICAL PERSONNEL

#### a ) Doctors

Like the NFL CBA, the NBA CBA requires clubs to retain doctors with certain qualifications:

Each Team agrees to secure the services of at least two (2) physicians as team physicians. Beginning with the 2017–18 Season, each individual hired for the first time to perform services as a team physician must be a duly licensed physician who as of the hiring date: (i) is board certified and fellowship trained in his/her field of medical expertise; (ii) has at least five (5) years of post-fellowship clinical experience; and (iii) has successfully completed a fellowship in sports medicine, has a Certification of Added Qualification (CAQ) in sports medicine, or has other “sports medicine” qualifications as the parties may agree.<sup>104</sup>

In addition, the CBA provides that:

Each Team has the sole and exclusive discretion to select any doctors, hospitals, clinics, health consultants, or other health care providers (“Health Care Providers”) to examine and/or treat players pursuant to the terms of this Agreement and the Uniform Player Contract; provided, however, no Team will engage any such Health Care Provider based primarily on a sponsorship relationship (or lack thereof) with the Team, and without considering the Health Care Provider’s qualifications (including, *e.g.*, medical experience and credentials) and the goal of providing high quality care to all of its players.<sup>105</sup>

This provision’s application to potential sponsorships will be discussed below.

The professional organization for NBA club doctors is the NBA Physicians Association (“NBAPA”).<sup>q</sup> A review of NBA club websites and media guides demonstrates that NBA clubs are typically affiliated with two to three doctors. Research did not reveal an NBAPA code of ethics specific to

its members. However, according to the NBA, the NBAPA By-Laws provide that the first purpose of the organization is “to achieve the best possible medical care for the professional basketball player.” Finally, NBPA representatives are permitted to participate in meetings of the NBAPA “for the purpose of discussing matters related to the medical care and treatment of players.”<sup>106</sup>

#### b ) Athletic Trainers

Like the NFL CBA, the NBA CBA dictates the required presence, education, and certification of athletic trainers:

Each Team agrees to secure the services of at least one (1) athletic trainer to serve as the Head Athletic Trainer and one (1) athletic trainer to serve as an Assistant Athletic Trainer on a full-time basis. Beginning with the 2017–18 Regular Season: (i) each individual hired for the first time to perform services as an athletic trainer for a Team must as of the hiring date: (a) be certified by the National Athletic Trainers Association (NATA)<sup>r</sup> or the Canadian Athletic Therapists Association (CATA) (or a similar organization as the parties may agree), and (b) hold a current certification in Basic Cardiac Life Support or Basic Trauma Life Support; and (ii) each individual hired for the first time to perform services as a Head Athletic Trainer for a Team must, as of the hiring date, have at least three (3) years of experience as an athletic trainer since he/she first received the foregoing NATA/CATA certification.<sup>107</sup>

The professional organization for NBA club athletic trainers is the National Basketball Athletic Trainers Association (“NBATA”). The NBATA describes itself as “a professional organization of highly skilled certified athletic trainers who provide specialized health care and critical support services to the athletes and organizations of the National Basketball Association.”<sup>108</sup> The NBATA further describes its purpose as to: “[l]ead the management and practice of exceptional health care; [p]rovide continuing education to our members; [p]rovide education and conduct basketball-related sports medicine research to benefit our athletes, the National Basketball Association, and the National Basketball Athletic Trainers Association, and our communities; [and,] [u]phold the athletic training profession’s highest moral and ethical standards.”<sup>109</sup> According to the NBATA,

q The NBAPA’s website is password-protected and thus additional information is not available.

r The NBA CBA’s requirement that athletic trainers be certified by NATA or CATA is actually in error and a requirement with which athletic trainers cannot comply. NATA and CATA are voluntary professional associations but do not *certify* athletic trainers. Athletic trainers are certified by the Board of Certification for the Athletic Trainer (“BOC”). The NFL CBA also erroneously requires athletic trainers to be certified by NATA.

there are 57 athletic trainers, approximately 1.9 per club. Research did not reveal an NBATA code of ethics specific to its members, beyond its statement of purpose.

The role of NBA athletic trainers is similar to that of athletic trainers in the other leagues. Athletic trainers are typically with the club at all times, are the player's first line of medical care and will liaise with doctors and other medical professionals as necessary.<sup>110</sup>

## 2) MEDICAL PERSONNEL'S OBLIGATIONS

The NBA CBA contains two notable provisions concerning club medical personnel's obligations.<sup>5</sup>

First, the CBA requires that “a player requiring the care and treatment of an orthopedic surgeon will, as far as practicable, be referred to and treated by one (1) orthopedic surgeon (rather than several.)”<sup>111</sup>

Second, the club must provide a player with his medical records within 48 business hours of the player's request.<sup>112</sup> In contrast, the NFL CBA only entitles players to their medical records once during the pre-season, once after the regular season, and upon request in the off-season.<sup>113</sup> However, in practice, the NFL's electronic medical records system provides players with 24/7 access to their medical records. Similarly, the NBA CBA says that one of the goals of its electronic medical records system is to “give players the ability to easily access their own health information” but it is unclear whether there is a portal through which players can access their medical records 24/7.

In addition to the above CBA provisions, according to the NBA, the NBA Operations Manual also regulates medical personnel's obligations including but not limited to their “timing of presence at games, handling of situations involving blood, gloves, washing skin surfaces, cleaning procedures for skin, and additional obligations under cardiac and concussion screenings, prescription drug policies, etc.”

Notably, unlike the NFL, no NBA policy sets forth the standard of care for club doctors. Also unlike the NFL, NBA policies do not: require club medical staff to inform players about communications between the medical staff and the club; or, entitle players to the surgeon of their choice. The

NBA CBA—like the NFL's—does entitle players to their own medical records.

The 2017 NBA CBA did, however, introduce an interesting CBA provision that is worth discussing. In the event the NBA, a club or the NBPA

has been advised by a physician that a player is medically unable and/or medically unfit to perform his duties as a professional basketball player as a result of a potentially life-threatening injury, illness or other health condition and/or that performing such duties would create a materially elevated risk of death for the player, then the NBA, a Team, or the Players Association may refer the player to a Fitness-to-Play Panel . . . . Once so referred, the player will not be permitted to play or practice in the NBA until he is cleared to do so by the Panel[.]<sup>114</sup>

Beginning in 2017, the NBA and NBPA are creating Fitness-to-Play Panels with respect to: (i) cardiac illnesses and conditions; and, (ii) blood clots and other blood conditions and disorders, and will consider others as necessary.<sup>115</sup> The three-member Panels are to consist of expert doctors in these fields, with one doctor appointed by the NBA, one doctor appointed by the NBPA, and the third doctor appointed by the first two doctors.<sup>116,t</sup>

The determination to be made by the Panel is whether, in the panel's reasonable medical judgment and experience, and having considered current medical knowledge and the best available objective evidence: (i) the player is medically able and medically fit to perform his duties as a professional basketball player; and (ii) performing such duties would not create a materially elevated risk of death for the player.<sup>117</sup>

If a player's condition is referred to a Fitness-to-Play Panel, prior to the Panel's review of his condition, he must “(on behalf of himself, his heirs and assigns) . . . sign a release and covenant not to sue agreement in the form agreed upon” by the NBA and NBPA.<sup>118</sup> Similarly, if the player is cleared to play, the player must sign an “informed consent and assumption of risk agreement” in a form agreed to by

s In reviewing a draft of this Report, the NBA stated “[t]here are other terms governing obligations of medical personnel, including additional provisions regarding furnishing relevant information, not making public certain medical information, conducting certain health screenings, etc.” Information concerning confidential player health information is discussed below. Otherwise, while other provisions of the CBA reference club doctors, they do not necessarily create obligations for them and thus we do not discuss them here.

t The creation of a committee of medical experts with members selected by the league, the union, and the members of the committee matches the composition of the Medical Committee we proposed for the NFL in our report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*. We proposed a neutral Medical Committee be responsible for the hiring, compensation levels, review and possible termination of doctors treating NFL players as part of a process to remove the structural conflict of interest inherent in having doctors that both treat players and provide services to the club. Additional details and explanation can be found in our report.

the NBA and NBPA.<sup>119</sup> These forms are not publicly available, and thus we cannot opine on whether they comport with applicable law and codes of ethics.

Nevertheless, even if the Panel clears the player to play, the club is not required to let him play or practice.<sup>120</sup> Instead, if the club continues to believe that the player should not play, within 60 days the club must trade the player, release him from the club or amend his contract in such a way that might enable him to play.<sup>121</sup>

The “Fitness-to-Play” provision is, as far as we know, unprecedented in professional sports and seemingly arises out of a challenging situation in the NBA. In February 2015, Miami Heat star player Chris Bosh was diagnosed with a blood clot in his calf muscle, that later spread to his lungs.<sup>122</sup> As a result, Bosh missed a significant portion of the Heat’s games in the 2014–15 and 2015–16 seasons.<sup>123</sup> Then, in September 2016, with the 2016–17 season approaching, Bosh failed his physical with the club when the Heat’s doctor determined Bosh’s need for blood thinners made playing professional basketball too risky.<sup>124</sup> Bosh’s desire to continue playing may have prompted the creation of the Fitness-to-Play Panels though, as of February 2017, it is unclear whether Bosh intends to utilize the process.<sup>125</sup>

The new Fitness-to-Play Panels are interesting and innovative but new. Thus, we recommend that the NFL monitor their use and consider their potential application to the NFL. In its review of the Report, the NBA indicated its belief that the Fitness-to-Play Panels are an important new right for players. However, we note that NBA clubs retain considerable discretion in choosing whether to play players and thus it is unclear how much value the Panels provide to players. Lastly, we note that the Fitness-to-Play provision may implicate the Americans with Disabilities Act and/or the Genetic Information Nondiscrimination Act. For more on the intersection of these statutes and professional sports, see our law review article, *Evaluating NFL Player Health and Performance: Legal and Ethical Issues*, 165 U. Penn. L. Rev. 227 (2017).

### 3) PLAYERS’ OBLIGATIONS

NBA players are entitled to a second medical opinion at the club’s expense provided the player’s injury or illness meets one of the following criteria:

- (i) has prevented the player from participating in a Regular Season or playoff game for two (2) weeks or more; (ii) in the opinion of a Team physician for the player’s Team, is more likely than not to prevent the player from being able to participate

in an NBA game for two (2) weeks or more (or during the off-season, from participating in competitive basketball without restriction for two weeks or more); (iii) in the opinion of the Team physician will not be significantly aggravated by the player continuing to participate in NBA games (or during the offseason participating in basketball without restriction) when the player reasonably believes that continued participation will significantly aggravate his injury, illness or condition; (iv) results in direction from the Team physician that the player should undergo surgery; or (v) results in direction from the Team physician that the player should not undergo surgery when the player reasonably believes that surgery is necessary for the injury, illness or other health condition.

Additionally, the club will only cover the cost of the second medical opinion if: (1) the doctor providing the second medical opinion is from a list of doctors jointly maintained by the NBA and NBPA;<sup>126</sup> and, (2) prior to obtaining the second medical opinion, the player provides the club with the “name of the physician who will be performing the evaluation, and the date and location of the evaluation.”<sup>127</sup>

The circumstances under which NBA players can obtain second opinions are limited as compared to players’ options in the NFL. NBA players can only obtain second opinions in the above described scenarios whereas NFL players can obtain a second opinion whenever they would like, provided that if the club is to pay for the second opinion, the player first consults with the club doctor. Nevertheless, NBA players’ rights to a second opinion was only added as part of the 2017 CBA. It thus remains to be seen how the provision operates in practice. For example, NBA players may be able to obtain second opinions as freely as NFL players.

Despite the player’s right to obtain a second medical opinion, the club is only required to “consider the second opinion in connection with [the player’s] diagnosis or treatment” (emphasis added).<sup>128</sup> In other words, the club doctor’s opinion as to the proper course of treatment controls even if it conflicts with the second opinion doctor’s opinion. If the player fails to comply with the club doctor’s recommended course of treatment, it is possible the player could be found to be in violation of his obligations under his contract, including “to keep himself throughout each NBA Season in good physical condition.”<sup>129</sup> While this provision potentially provides club doctors with the authority to determine the course of treatment against a player’s wishes, we are not aware of any circumstance in which that has been the case. Nevertheless, this arrangement contrasts



with the situation in the NFL, where the CBA does not grant club doctors the ultimate authority to determine the diagnosis and treatment for the player. In practice, players are generally free to follow the course of treatment recommended by the second opinion doctor, a clear positive for NFL players.

In addition to obligations in order to obtain a second medical opinion, the NBA Uniform Player Contract imposes several requirements on players concerning their cooperation with the club's medical personnel.

First, a player must "provide to the Team's coach, trainer, or physician prompt notice of any injury, illness, or medical condition suffered by him that is likely to affect adversely the Player's ability to render the services required under [his] Contract, including the time, place, cause, and nature of such injury, illness, or condition."<sup>130</sup> NFL players are similarly obligated to report their injuries.

Second, "[s]hould the Player suffer an injury, illness, or medical condition, he will submit himself to a medical examination, appropriate medical treatment by a physician designated by the Team, and such rehabilitation activities as such physician may specify."<sup>131</sup> NFL players are also obligated to submit to a medical examination but are not obligated to follow the treatment recommended by the club medical staff. Instead, NFL players are entitled to a second medical opinion and the surgeon of their choice.

Third, a player must "submit to a physical examination at the commencement and conclusion of each Contract year . . . and at such other times as reasonably determined by the Team to be medically necessary."<sup>132</sup> Relatedly, players are required to "submit to reasonable screening and baseline testing (*e.g.*, pursuant to NBA cardiac and concussion protocols) and, in connection with such screening and testing, shall accurately and completely answer all reasonable health questions (including, upon request, providing accurate and complete medical histories)."<sup>133</sup> Again, NFL players are also obligated to submit to medical examinations and to provide an accurate medical history.

Fourth, a player must "at the commencement of [his] Contract, and upon the request of the Team . . . provide a complete prior medical history."<sup>134</sup> Similarly, the Standard NFL Player Contract and standardized minimum pre-season physical both require NFL players to provide a complete medical history.

Fifth, a player must "supply complete and truthful information in connection with any medical examinations or requests for medical information authorized by [his] Contract."<sup>135</sup> "A player who knows he has an injury, illness, or

condition that renders, or he knows will likely render, him physically unable to perform the playing services required under a Player Contract may not validly enter into such Contract without prior written disclosure of such injury, illness, or condition to the Team."<sup>136</sup> If a player does not make the required disclosure, he risks having his contract voided. The Standard NFL Player Contract imposes similar disclosure obligations on NFL players.

Sixth, if a player "consults or is treated by a physician (including a psychiatrist) or a professional providing non-mental health related medical services (*e.g.*, chiropractor, physical therapist) other than a physician or other professional designated by the Team [the player] shall give notice of such consultation or treatment to the Team and shall authorize and direct such other physician or professional to provide the Team with all information it may request concerning any condition that in the judgment of the Team's physician may affect the Player's ability to play skilled basketball."<sup>137</sup> The NBA CBA imposes this obligation on players regardless of whether the club is paying for the outside consultation or treatment. In contrast, the NFL CBA does not require NFL players to make their clubs aware of treatment sought outside of the club's medical staff unless the player wishes to have that care paid for by the club.

Seventh, "[a] Player who engages in five (5) or more training or workout sessions with a trainer, performance coach, strength and conditioning coach, or any other similar coach or trainer other than at the direction of the Team (each a "Third-Party Trainer"), shall give notice of such training or workout to the Team prior to the first such training or work out (*sic*) session, provided that if the player does not initially plan to continue working with any such Third-Party Trainer for five (5) or more sessions, such notice must be provided no later than prior to the fifth such session."<sup>138,u</sup> The NFL does not contain any requirement for players to give notice to their clubs of training with third-party trainers.

Eighth, a player is required to "execute such individual authorization(s) as may be requested by the Team . . . or as may be required by health care providers who examine or treat the Player."<sup>139</sup> Although the NFL CBA does not require players to execute authorizations permitting disclosure of their medical information, in practice all players execute such authorizations.

u "This notice requirement [does] not apply to workouts or training that exclusively involve jogging, road bicycling, swimming, yoga, Pilates and/or dance." NBA Uniform Player Contract, § 7(h)(ii).

#### 4) RELATIONSHIP BETWEEN MEDICAL PERSONNEL AND CLUBS

Our research was unable to determine how many NBA club doctors are employees versus independent contractors. We also were unable to find reliable information about the typical compensation of NBA club doctors. The NBA also did not provide non-public information concerning club doctors' employment relationships and structures.<sup>140</sup>

Clubs are permitted broad access to player medical information. Club doctors are permitted to “disclose all relevant medical information concerning a player to (i) the General Manager, coaches, and trainers of the Team by which such player is employed, (ii) any entity from which any such Team seeks to procure, or has procured, an insurance policy covering such player's life or any disability, injury or illness such player may suffer or sustain, and (iii) . . . the media or public on behalf of the Team.”<sup>141,v</sup> Clubs considering acquiring a player via trade are also entitled to a player's medical records.<sup>142</sup> Additionally, according to the NBA, “[e]ach player in the NBA signs a health information authorization form each season that references disclosure to the media.” These policies are similar to the practices of NFL clubs, whereby players execute waivers permitting broad disclosure and use of their medical information.

#### 5) SPONSORSHIP ARRANGEMENTS

As discussed above, the NBA CBA prohibits clubs from retaining medical personnel or entering into agreements with healthcare providers to treat players if those agreements are “based primarily on a sponsorship relationship.”<sup>143</sup> Thus, the NBA does not prohibit agreements whereby a healthcare provider pays for the right to be the club doctor and to be a sponsor of the club, provided the sponsorship is not the *primary* reason for the relationship. Consequently, it is not surprising that several clubs are engaged in sponsorship relationships with healthcare providers that include the provision of care to the players.<sup>144</sup> In this respect, the NBA policy falls short of the NFL and MLB's general prohibitions on healthcare providers paying for the right to provide care to players. However, in reviewing a draft of this Report, the NBA noted the possible difference between policy and practice: stating that “[t]he practical differences of the NBA and NFL/MLB policies may not be as pronounced as the statement in the report

implies.” We acknowledge this distinction between policy and practice. Without additional information concerning medical sponsorship arrangements, which the leagues were generally unwilling to provide, we cannot fully evaluate the effects of the leagues' different medical sponsorship policies.

## D) Club Medical Personnel in the NHL



### 1) TYPES OF MEDICAL PERSONNEL

The NHL CBA, like the NFL CBA, contains robust requirements for club medical personnel.

#### a) Doctors

The CBA requires doctors to be present at all games:

Each Club shall have a minimum of two (2) team physicians in attendance at all home games. At least one of the team physicians shall have successfully completed hockey-specific trauma management training or Advanced Trauma Life Support training during the previous three (3) years. Each Club shall have consultant specialists at each home game (the selection of whom shall be at the discretion of the head team physician) to complement the skill set of the two (2) team physicians. Each Club's team physicians in attendance at home games shall include, either as part of the two (2) main team physicians or as consultants, (i) an orthopedist, and (ii) an internal medicine, emergency medicine or primary care sports physician. At least one of the team physicians shall have familiarity with the NHL Modified SCAT2 or other comprehensive standardized acute concussion assessment tool as recommended by the NHL/NHLPA Concussion Working Group.<sup>145</sup>

Since the execution of the CBA, the above requirements have been amended. Clubs are now required to have three doctors in attendance at each home game, including: (1) an orthopedic surgeon; (2) an internal medicine or primary care physician; and, (3) a doctor certified and active in emergency medicine. In addition, now the club's two primary doctors, their athletic trainers, and any doctor that travels with the club to away games must be proficient with the X2 SCAT3 App used for evaluating possible concussions.

v A club is then permitted to “make public information relating to the players in its employ, provided that such information relates solely to the reasons why any such player has not been or is not rendering services as a player.” 2017 NBA CBA, Art. XXII, § 4(d). In the NFL, players similarly sign waivers permitting the public disclosure of such information.

The CBA also dictates club doctors' required qualifications:

Each medical doctor hired or otherwise retained by the Club after the Effective Date of [the CBA] to treat its Players as part of the Club's primary medical team shall, in the United States be board certified in his or her respective field(s) of medical expertise, and in Canada be board certified by either the Royal College of Physicians and Surgeons (for specialists) or the College of Family Practice of Canada (for family physicians). Each Club medical doctor who is part of the primary medical team hired or retained after the Effective Date of this Agreement, and any head team physician hired or promoted to such position after the Effective Date of this Agreement, shall have successfully completed a fellowship in Sports Medicine or have other "sports medicine" qualifications as the parties may agree.<sup>w</sup>

Nevertheless, our research did not reveal a code of ethics specific to NHL club doctors, which was confirmed to us by one NHL club athletic trainer that reached out to us concerning our work.<sup>x</sup>

## b ) Athletic Trainers

The NHL CBA also requires the full-time employment and presence of athletic trainers:

Each Club shall employ at least two (2) ATs on a full-time basis. In the event both ATs do not travel with the Club on the road, and to the extent reasonably necessary in the Club's reasonable discretion to provide adequate services and treatment, the Club shall arrange for alternative means to provide athletic training services by providing at least one AT, and either an additional AT or other person of equal or greater medical training, or a massage therapist. All ATs employed or retained by a Club to provide services to Players must be certified by the National Athletic Trainers Association ("NATA") or the Canadian Athletic Therapists Association ("CATA"), or shall be

physical therapists licensed by an appropriate state or provincial authority and/or certified as a specialist in physical therapy, and shall hold current certification in Basic Cardiac Life Support or Basic Trauma Life Support. At least one of the ATs shall have familiarity with the NHL Modified SCAT2 or other comprehensive standardized acute concussion assessment tool as recommended by the NHL/NHLPA Concussion Working Group.<sup>y</sup>

An AT shall be available on the bench at all times during games and practices. If the AT must leave the bench for any reason, either (A) another AT must be available to immediately replace such AT on the bench, or (B) another person with equal or greater medical training must be available to immediately replace the AT on the bench.<sup>146</sup>

As with the CBA provision governing club doctors, the parties have also amended the policies governing athletic trainers. The new policy requires that, when on the road, each club shall arrange to have at least one athletic trainer and either an additional athletic trainer or a person of equal or greater medical training available to the players. The revised policy eliminates discretion clubs previously enjoyed as to whether to provide such services, and now makes this mandatory.

The professional organization for NHL club athletic trainers is the Professional Hockey Athletic Trainers Society ("PHATS"). PHATS' stated mission is to:

1. Encourage and promote the consistent application of the most advanced knowledge and techniques of the science of athletic training in the prevention, treatment, and rehabilitation of sports injuries to professional hockey players.
2. Function as a professional association for professional hockey athletic trainers to promote the welfare of its members, the profession of athletic training, and safe participation in the sport of hockey.
3. Provide for the exchange among its members of current ideas, techniques, and scientific data relating to the prevention and care of hockey injuries.
4. Support the continued advancement of the athletic training profession.<sup>147</sup>

w 2013 NHL CBA, § 34.2(a). Similarly, when the 2011 NFL CBA added a requirement that all club doctors have a Certificate of Added Qualification in Sports Medicine, the existing club doctors were not required to obtain the Certificate.

x For the reasons described in the Introduction, Section E: Goals and Process, we did not seek to survey NHL medical club personnel. Nevertheless, in response to our report, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, one NHL club athletic trainer reached out to us and provided us information via email and telephone. At the athletic trainer's request, we do not identify him or the club for which he works. It is important to recognize that the opinions of the athletic trainer are only that of one individual and cannot be considered representative of the viewpoints of all NHL club athletic trainers or medical staff. Nevertheless, we believe the athletic trainer's personal experiences are informative and thus include them here.

y The NHL's concussion protocol does not require the use of an independent neurologist. In contrast, the NFL's concussion protocol requires that, during games, any player suspected of having suffered a concussion be examined by an unaffiliated neurotrauma consultant. The difference in policies might result at least in part for practical reasons. There are 256 regular season NFL games versus 1,312 regular season NHL games.

Nevertheless, research did not reveal a PHATS code of ethics specific to its members, which was confirmed to us by an anonymous NHL club athletic trainer.

The role of NHL athletic trainers is similar to that of athletic trainers in the other leagues. Athletic trainers are typically with the club at all times, are the player's first line of medical care, and will liaise with doctors and other medical professionals as necessary.<sup>148</sup>

## 2) MEDICAL PERSONNEL'S OBLIGATIONS

The NHL CBA directs that “[e]ach Club shall provide its Players with high quality health care appropriate to their needs as elite professional hockey players, including access to health care professionals[.]”<sup>149</sup> Seemingly in accordance with this obligation, the CBA also outlines the required relationship between the club medical personnel and the players:

The primary professional duty of all individual health care professionals, such as team physicians, certified athletic trainers/therapists (“ATs”), physical therapists, chiropractors, dentists and neuropsychologists, shall be to the Player-patient regardless of the fact that he/she or his/her hospital, clinic, or medical group is retained by such Club to diagnose and treat Players. In addition, all team physicians who are examining and evaluating a Player pursuant to the Pre-Participation Medical Evaluation (either pre-season and/or in-season), the annual exit examination, or who are making a determination regarding a Player's fitness or unfitness to play during the season or otherwise, shall be obligated to perform complete and objective examinations and evaluations and shall do so on behalf of the Club, subject to all professional and legal obligations vis-a-vis the Player-patient.<sup>150</sup>

Above, we discussed problems with a similar standard of care outlined in the NFL CBA. The NFL's provision requires that “each Club physician's primary duty in providing medical care shall be not to the Club but instead to the player-patient.” However, the NFL's standard of care fails to account for the club doctor's obligations to the club—namely to perform fitness-for-play evaluations. The NHL's provision seemingly resolves this concern in part, by requiring—without limitation to the circumstances of providing medical care—that the Club doctor be subject to

his or her obligations to the player “regardless of the fact that he/she . . . is retained by such Club[.]”<sup>z</sup>

The CBA imposes other health-related requirements on clubs and club medical personnel.

First, “If a Player on a visiting team receives medical and/or health diagnosis, treatment, or fitness to play determination(s)” from the home club medical personnel, the home club must send the visiting club a written medical report.<sup>151</sup> The NFL CBA has no such provision.

Second, “[e]ach Club shall identify one (1) individual who is responsible for monitoring on an ongoing basis, or auditing on a regular basis, prescription drugs that have been given to each Player on the Club, with a particular emphasis on monitoring controlled substances and sleeping pills, if any, that have been prescribed.”<sup>152</sup> The NFL has no such provision, however, NFL clubs do not store controlled substances and any prescription drugs are obtained from a retail pharmacy.<sup>153</sup>

Third, the club is required to provide a doctor giving a second opinion all relevant medical information regarding the player, as long as the second opinion doctor is on a “list of medical specialists mutually agreed upon” by the Joint Health and Safety Committee,<sup>154</sup> a medical advisory committee consisting of five NHL members and five NHLPA members.<sup>aa</sup> The NFL does not explicitly require such cooperation but, in practice, the second opinion doctor receives all relevant medical information.<sup>155</sup>

Fourth, “[a]t the conclusion of each season, the Club shall provide each Player with a complete copy of his medical records at the time of his annual exit physical (to the extent the Club maintains physical possession of the Player's medical records; otherwise the Club's physician will provide the Player with a complete copy of his medical records upon the Player's direction to do so). The exit physical shall document all injuries that may require future medical or dental treatment either in the near future or post-career.”<sup>156</sup>

<sup>z</sup> The NHL club athletic trainer who contacted us believes the club for which he works treats players “poorly.” The athletic trainer believes there is an “inherent conflict of interest” where club doctors treat players while also reporting to the club. As a result, the athletic trainer believes club doctors often place the interests of the club ahead of those of the player. Although the athletic trainer believes there is “widespread” agreement in the NHL medical community about these problems, we remind the reader that the opinions of this particular athletic trainer should not be considered representative of all NHL club athletic trainers.

<sup>aa</sup> The athletic trainer who contacted us expressed his belief that this process does not adequately protect player health. As an initial matter, the athletic trainer believes club doctors often try to dissuade players from receiving a second medical opinion, including by telling players that the club doctor has already consulted with other club doctors. Second, the athletic trainer expressed his belief that many of the second opinion consultations are with doctors from other clubs, who are unlikely to render an opinion that disagrees with the initial club doctor's opinion.



This provision is outdated, as the NHL's electronic medical record system now provides players with access to their medical records. NFL players are also able to access their electronic medical records at any time.<sup>157</sup>

### 3) PLAYERS' OBLIGATIONS

Like the NFL CBA, the NHL CBA provides players the right to a second medical opinion concerning diagnoses or courses of treatment<sup>ab</sup> and the surgeon of their choice, but imposes obligations on players related to that care.

When seeking a second medical opinion, the player must "advise the Club in writing of his decision to seek a Second Medical Opinion and the name of the Second Medical Opinion Physician."<sup>158</sup> The club is only obligated to pay for the second medical opinion if the player consults with a doctor from the Joint Health and Safety Committee's list or otherwise obtains the approval of the club.<sup>159</sup> If the player uses a doctor from the approved list or approved by the club, the player (or the second opinion doctor) must provide the club doctor "with a report concerning the diagnosis, examination, and course of treatment recommended by the Second Medical Opinion Physician[.]"<sup>160</sup> Players do not have to provide the club with information from a second opinion doctor if the second opinion is obtained outside of the process outlined in the CBA and if the player arranges and pays for the consultation himself.

If the club doctor and second opinion doctor disagree, the two doctors can agree to have the player examined by a third doctor.<sup>161</sup> Nevertheless, in the NHL, the club doctor is ultimately entitled to "determine the diagnosis and/or course of treatment,"<sup>162</sup> including whether "a surgical procedure is the appropriate course of treatment for the Player."<sup>163</sup> If the player fails to comply with the recommended course of treatment, it is possible the player could be found to be in violation of his obligations under his contract, including "to keep himself in good physical condition[.]"<sup>164ac</sup> Nevertheless, we are not aware of any circumstances in which surgery was performed or recommended against the player's wishes. In contrast, the NFL CBA does not set forth how to resolve a dispute between

the club doctor and second opinion doctor. More importantly, the NFL CBA does not grant club doctors the ultimate authority to determine the diagnosis and treatment for the player. In practice, players are generally free to follow the course of treatment recommended by the second opinion doctor, a clear positive for NFL players.

An NHL player is entitled to the surgeon of his choice, but the club will only cover the cost of the surgery if the doctor is on the Joint Health and Safety Committee's list or is otherwise approved by the club.<sup>165</sup> After any such surgery, the player (or his doctor) must provide the club doctor "with all relevant records from the surgeon regarding the surgery[.]"<sup>166</sup> The NFL CBA imposes similar requirements.

Finally, if a player wishes to rehabilitate an injury during the off-season in a city of his choice, the player must obtain permission from the club and send periodic status reports to the club.<sup>167</sup> If the club is not satisfied with the player's progress, the club can require the player to continue his rehabilitation in the club's city.<sup>168</sup> The NFL CBA does not address player's off-season training locations.

### 4) RELATIONSHIP BETWEEN MEDICAL PERSONNEL AND CLUBS

The NHL declined to provide any information concerning the employment or financial relationships between NHL clubs and their doctors, and our independent research did not uncover more information.<sup>169</sup> The only information we received on this issue was from the anonymous athletic trainer discussed above, who explained that the club medical staff is typically hired by the club's general manager.

Most of our information about the relationship between NHL clubs and their medical staff is based on the CBA itself. The CBA permits clubs to disclose player medical information in a variety of situations. The CBA requires players to execute three different health-related authorizations: (1) the NHL/NHLPA Authorization Form for Health Care Providers to Release Health Information; (2) the NHL/NHLPA Concussion Program Authorization; and, (3) the Authorization for Management and Release of Neuropsychological Test Results.<sup>170</sup> The content of the authorization forms is unknown, but the CBA does explicitly allow disclosure of player medical information "as reasonably required for professional sports operations, between and among a Club's Club Personnel<sup>ad</sup> for purposes related to the Player's employment as an NHL hockey Player."<sup>171</sup>

ab NHL players are also entitled a second medical opinion where a club doctor has determined the player is physically unable to perform his duties as a hockey player. 2013 NHL CBA, § 17.7. The player is responsible for the costs of this consultation. If no consensus is reached between the club doctor and the player's second opinion doctor in the fitness for play context, a third physician chosen by them decides the matter. *Id.* The club and player share the costs for the third physician's opinion. *Id.*

ac If there is a question as to whether the player is disabled or unable to perform his duties, the Standard Player Contract sets forth a process by which that determination is made by an independent doctor. See Standard Player Contract, § 5, included as Exhibit 1 to the 2013 NHL CBA. If the player is found to be physically able to play and refuses to do so, he can be immediately suspended without pay. *Id.* at § 5(j).

ad "'Club Personnel' means a Club's coaching staff, owners, presidents, executives, hockey operations staff, general managers, assistant general managers, human resources personnel, and Club Health Professionals." 2013 NHL CBA, Art. 1.

Additionally, club personnel, the NHL and the NHLPA may disclose a player's medical information: (1) as required by the player's Standard Player Contract or the CBA, *e.g.*, determining a player's fitness to play; (2) when the information is relevant to a grievance; (3) when the information is relevant to an investigation of whether the player or club violated the CBA or Standard Player Contract; (4) as permitted by the authorization forms discussed above; (5) for purposes of the club seeking advice regarding its rights and obligations; (6) for purposes of injury surveillance and as authorized by the electronic medical record system; (7) to a club considering acquiring the player via trade; (8) to the player's agent; (9) as part of the player obtaining a second opinion; (10) to treat the player in an emergency; (11) to doctors and individuals involved in managing the Performance Enhancing Substances Program or the Substance Abuse and Behavioral Health Program; and, (12) to vendors and administrators as necessary.<sup>172</sup> These disclosure policies are similar to the practices of NFL clubs.

## 5) SPONSORSHIP ARRANGEMENTS

Our research has not revealed whether the NHL has a medical sponsorship policy and the NHL declined to provide any information on the matter. In 2012, the Canadian newspaper *The Globe and Mail* reported that at least ten US-based NHL teams had an "official medical provider."<sup>173</sup> According to the report, these clubs had a variety of relationships with their healthcare providers, with some clubs paying their club doctors a salary, others exchanging perks for pro bono services, and a minority of clubs accepting payment from medical groups.<sup>174</sup> Additionally, some clubs entered into a sponsorship agreement with a medical service provider but independently retained club doctors from outside of that service provider's network.<sup>175</sup>

The anonymous athletic trainer who contacted us confirmed that in his experience these sponsorship arrangements exist. The athletic trainer expressed his belief that many NHL clubs enter into long-term agreements whereby medical service providers such as local hospitals pay the club millions of dollars per year for the right to provide medical services to the club's players, including the right to select the club's doctors. Moreover, the athletic trainer indicated to us that under these agreements, medical specialists needed by the players, such as neurologists and ophthalmologists, are chosen by the hospital. In sum, the athletic trainer expressed his belief that players are "forced" to see doctors from a specific hospital, rather than the best doctors for the players' needs. The NHL did not respond to an email asking if the athletic trainer's assertions are accurate.

In contrast, as discussed above, the NFL has indicated that its medical sponsorship policy prohibits the type of arrangement that might occur in the NHL, *i.e.*, where medical service providers pay for the right to provide care to players. Nevertheless, also as discussed above, the boundaries of the NFL's medical sponsorship policy are not clear. Additionally, the NFL's medical sponsorship policy prohibits agreements whereby medical service providers provide exclusive care to players, which might be a problem in the NHL.

## E ) Club Medical Personnel in the CFL



### 1) TYPES OF MEDICAL PERSONNEL

Unlike the NFL CBA, the CFL CBA does not require clubs to retain doctors. However, like the NFL CBA, the CFL CBA does require clubs to retain certified athletic trainers, known in Canada as "Athletic Therapists":

Member Clubs shall employ or retain a minimum of one trainer who is certified by the Canadian Physiotherapists Association and/or the Canadian Athletic Therapists Association (CATA) or equivalent qualifications. All head therapists in the C.F.L. must be certified athletic therapists in good standing with CATA. The head therapists from each Member Club will be required to submit their CATA certification indicating that they are in good standing with CATA to the C.F.L. Office on an annual basis.<sup>176</sup>

Nevertheless, a review of CFL club websites reveals that CFL clubs are typically affiliated with five to ten medical professionals.<sup>177</sup> These professionals typically include orthopedists, emergency physicians, sports medicine physicians, chiropractors, and optometrists.<sup>178</sup> The clubs also generally employ 3–4 athletic trainers.<sup>179</sup>

## 2) MEDICAL PERSONNEL'S OBLIGATIONS

The CFL CBA's only requirement of medical personnel is that they provide players with their medical records upon request.<sup>180</sup>

Unlike the NFL, the CFL lacks policies concerning: (1) the standard of care for club medical personnel; (2) communications between medical personnel and the club; (3) a player's right to a second opinion; and, (4) a player's right to a surgeon of his choice. The CFL CBA—like the NFL's—does entitle players to their own medical records.

## 3) PLAYERS' OBLIGATIONS

The CFL's Standard Player Contract imposes only one medical personnel-related obligation on players:

Prior to the start of each football season, the Player shall attend before the Club's Medical Committee for a complete physical and medical examination, and, shall answer completely and truthfully all questions asked of him with respect to his physical and medical condition[.]<sup>181</sup>

The NFL CBA similarly requires players to submit to a pre-season physical and “to make full and complete disclosure of any physical or mental condition known to him which might impair his performance . . . and to respond fully and in good faith when questioned by the Club physician about such condition.”<sup>182</sup>

## 4) RELATIONSHIP BETWEEN MEDICAL PERSONNEL AND CLUBS

According to the CFL, all CFL club doctors are independent contractors.<sup>183</sup> The CFL's characterization of its relationship with club doctors accords with Canadian physicians' general status as independent contractors within its government-sponsored healthcare system; however, two 1980s Canadian cases that considered whether NHL Canadian club doctors were independent contractors or employees for liability purposes both looked beyond the parties' understanding of their relationship.<sup>184</sup> Based on the differing factual scenarios, the British Columbia Supreme Court—which heard both cases—concluded that club doctors were employees in one case and independent contractors in another. In both cases, the perceived level of control proved to be dispositive. Thus, a court considering the status of CFL club doctors for vicarious liability purposes may look beyond the manner in which the club doctors receive

compensation or the title that the league ascribes to clubs' relationships with doctors. In doing so, the court will likely examine the degree of control clubs have over the doctors.

Concerning the duties of CFL club doctors, the CBA provides that a club has “the right to conduct a medical examination at any time[.]”<sup>185</sup> However, the CBA also dictates that a pre-season physical “to determine the status of any pre-existing condition” is to be performed by a neutral physician.<sup>186</sup>

Although there is limited information available on CFL club doctors, in 2007, the Saskatchewan Roughriders' club doctor, Dr. Robert McDougall, acknowledged the complications in being a club doctor:

*You have a responsibility to the organization for which you work . . . but in addition you have a responsibility to the athlete and you can't function independently from that athlete. Because you administer care to the athlete, he/she needs to be fully informed of the events. . . . So I feel like there is a triad of duties: the organization you work with, the athlete, and in the end, yourself as a physician. Above all, you have a responsibility as a physician to make the right medical decision.*<sup>187</sup>

These concerns were echoed by CFL Hall of Fame player Chris Walby, who explained that there are many situations “where the physician definitely supports the team before the player.”<sup>188</sup> According to Walby, the club doctor's “job is to get you back on the field in as short a time frame as possible.”<sup>189</sup>

## 5) SPONSORSHIP ARRANGEMENTS

According to the CFL's former President and Chief Operating Officer, Michael Copeland, no CFL clubs engage in sponsorship arrangements whereby a healthcare provider pays the club for the right to provide healthcare to the club's players.<sup>190</sup> The practice of leagues and their member clubs accepting payment from medical groups is reportedly “frowned upon” in Canada.<sup>191</sup>



## F ) Club Medical Personnel in MLS

MLS' most recent CBA was agreed to in March 2015. In addition, MLS' Medical Policies & Procedures Manual ("MLS Medical Manual"), which is not collectively bargained, provides guidance on these issues.<sup>192</sup> The MLS Medical Manual is a league-imposed manual with which MLS clubs and their doctors and athletic trainers are required to comply.<sup>193</sup>

### 1 ) TYPES OF MEDICAL PERSONNEL

The MLS CBA declares that after its execution, MLS and the MLSPU would "meet to agree on a side letter/provision to include in the CBA regarding the required number of medical/training personnel each Team shall retain (e.g., Team physician, athletic trainers, therapists, and appropriate minimum certification requirements for such personnel)."<sup>194</sup> As of the date of publication, it is unclear whether the side letter has been executed. Nevertheless, the MLS Medical Manual suggests that MLS clubs "establish a network" of the following medical professionals:

- Head club physician/ chief medical officer;
- Orthopedic sub-specialists (special attention given to foot and ankle specialists);
- Primary care sports medicine;
- Internal medicine;
- Head athletic trainer;
- Assistant athletic trainer;
- Strength and conditioning coach;
- Cardiologist;
- Neuropsychologist;
- Neurosurgeon;
- Dentist;
- Oral and maxillofacial surgeon;
- Massage therapist;
- Physical therapist;
- Chiropractor;
- Nutritionist;
- Podiatrist;
- Dermatologist;
- Ophthalmologist; and,
- Imaging center.<sup>195</sup>

The professional organization for MLS club doctors is the MLS Team Physicians Society ("MLSTPS"). MLSTPS' stated mission is "[t]o be a global leader and collaborator in the science of soccer medicine focused on research, education and athlete care."<sup>196</sup> Research did not reveal an MLSTPS code of ethics specific to its members.

The corresponding organization for MLS club athletic trainers is the Professional Soccer Athletic Trainers' Society ("PSATS"). According to PSATS, the organization "serves to enhance the personal and professional development of its membership. PSATS strives to provide educational opportunities for its members so they may better serve Major League Soccer, their organization, and the professional soccer players under their care."<sup>197</sup> Our research did not reveal a PSATS code of ethics specific to its members.

According to the MLS Medical Manual, MLS athletic trainers are required to be certified by the National Athletic Trainers Association ("NATA").<sup>198</sup> However, this is an 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.<sup>199</sup> The BOC used to be part of NATA, but split from the voluntary association in 1989.<sup>200</sup>

As in all of the leagues, MLS athletic trainers are the players' first line of medical care.<sup>201</sup> The athletic trainers are with the club on a constant basis, preparing them for practices and games, treating conditions as needed, and updating the club on players' health statuses.<sup>202</sup> In addition, the athletic trainers liaise with club doctors when the players need more extensive care.<sup>203</sup>

### 2 ) MEDICAL PERSONNEL'S OBLIGATIONS

The CBA directs that "[e]ach Team shall provide its Players with high quality health care that is reasonably appropriate to their needs as elite professional soccer players, including access to health care professionals[.]"<sup>204</sup> Seemingly in accordance with this obligation, the CBA also outlines the required relationship between the club medical personnel and the players:

The primary professional duty of all individual health care professionals (such as Team physicians, athletic trainers, physical therapists chiropractors, dentists and neuropsychologists) providing health care to a Player, shall be to the Player-patient regardless of the fact that the health care professional or his/her hospital, clinic, or medical group is retained by such Team to diagnose and treat Players. In addition, all individual health care professionals, such as Team physicians who are examining and evaluating a Player shall be obligated to perform complete and objective examinations and evaluations and shall do so on behalf of the Team and League, subject to all professional and legal obligations vis-a-vis the Player-patient.<sup>205</sup>



These provisions are almost verbatim replicas of the NHL CBA provisions. Above, we discussed problems with a similar standard of care outlined in the NFL CBA as compared to the NHL CBA. The same analysis applies here. The NFL's provision requires that "each Club physician's primary duty in providing medical care shall be not to the Club but instead to the player-patient." However, the NFL's standard of care fails to account for the club doctor's obligations to the club—namely to perform fitness-for-play evaluations. The NHL's and MLS' provision seemingly resolves this concern in part, by requiring—without limitation to the circumstances of providing medical care—that the club doctor be subject to his or her obligations to the player "regardless of the fact that he/she . . . is retained by such Club[.]" Nevertheless, we still do not believe the NHL's and MLS' provisions sufficiently protect player health as discussed in the Analysis Section.

In addition to the CBA provision, the MLS Medical Manual directs in multiple provisions some form of the following: "Club physicians and Athletic Trainers are always expected to comply with the highest standards of medical care and to use their best professional judgment."<sup>206</sup>

Finally, the MLS CBA also requires clubs to "cooperate with all requests by a Player or former player and/or his representative(s) for copies of the Player's or former player's medical recording, including athletic trainers' notes, and shall provide such records and notes within fourteen (14) days of any request by a Player or former player."<sup>207</sup>

### 3) PLAYERS' OBLIGATIONS

The CBA imposes numerous health-related obligations on players.

First, as part of the Standard Player Agreement, the player represents that "he knows of no physical or mental conditions that could impair his ability to play skilled professional soccer during the Term of th[e] Agreement and he has not knowingly concealed any such conditions[.]"<sup>208</sup> The standard NFL Player Contract also requires players to represent that they are in "excellent physical condition."<sup>209</sup>

Second, the Standard Player Agreement also obligates a player to "maintain a high level of physical and mental conditioning and competitive skills, not engage in alcohol abuse, not use drugs or any other substances in contravention of the MLS Player Substance Abuse and Behavioral Health Program and Policy, and generally develop and maintain a physical and mental readiness necessary to play for the Team."<sup>210</sup> The NFL Player Contract also requires players to "maintain" themselves in "excellent physical condition."<sup>211</sup>

Third, a player must "immediately . . . notify the Team's coach, trainer or physician of any illness or injury contracted or suffered by him which may impair or otherwise affect, either immediately or over time, his ability to play skilled professional soccer."<sup>212</sup> The CBA does not describe the punishment in the event a player fails to disclose an injury. NFL players are similarly required to report their injuries.

Fourth, "[p]rior to the start (including, during the season, when a Player first joins his Team) and at the conclusion of each League season, Players shall submit to complete medical examinations by a physician designated by MLS, at times designated by MLS and at MLS's expense. Such medical examinations may include, without limitation, blood tests . . . . The Player shall answer completely and truthfully all questions asked of him concerning his physical and mental condition."<sup>213</sup> The NFL CBA imposes similar requirements on its players.

Fifth, "[i]n addition to the Pre-season and end of League Season medical and physical examinations, Players may also be required to submit, on reasonable dates and times at the expense of MLS, to such reasonable additional medical examinations (including blood tests . . . ) as may be requested by his Team or MLS."<sup>214</sup> NFL players are also required to submit to medical examinations.

Sixth, a "Player is required to execute any authorizations required to release all of his medical records to MLS and/or Team physicians, relevant officials, and to the workers' compensation insurance carrier of MLS . . . . It is understood that medical information relating solely to the reasons why such Player has not been, is not or may not be rendering services as a Player may be released to the public by MLS or a Team. A medical information release . . . shall be executed by each Player during Pre-Season each year or upon joining MLS during the League Season."<sup>215</sup> Although the NFL CBA does not require players to execute authorizations permitting disclosure of their medical information, in practice, all players execute such authorizations.

Seventh, if a player seeks a second medical opinion and the second opinion doctor disagrees with the club doctor, "[t]he physician for the player shall evidence his determination by completing [a form], which shall be provided to the Player's Team no later than forty-eight (48) hours after completion of the examination."<sup>216</sup> If the second opinion doctor and club doctor are unable to resolve the disagreement, the "relevant medical issue(s)" are determined by a neutral doctor agreed upon by the club's doctor and the second opinion doctor.<sup>217</sup> The player is obligated to "promptly submit to treatment recommended by" the club doctor or the neutral doctor, as applicable.<sup>218</sup> If the player refuses to submit to

the treatment recommended by the club doctor, the player is considered in breach of his contract and thus subject to suspension or termination.<sup>219</sup>

In contrast, the NFL CBA does not set forth how to resolve a dispute between the club doctor and second opinion doctor. More importantly, the NFL CBA does not grant club doctors the ultimate authority to determine the diagnosis and treatment for the player, or require players to submit to any treatment. In practice, players are generally free to follow the course of treatment recommended by the second opinion doctor. However, it is important to remember that NFL players have an obligation to maintain themselves in excellent physical condition.<sup>220</sup> If the player does not take certain steps to recover from an injury—including perhaps the treatment recommended by one or more doctors—it is possible that the player could be found to have breached his contract and thus subject to suspension or termination.

#### 4 ) RELATIONSHIP WITH CLUBS

The MLS Medical Manual dictates that clubs are responsible for negotiating agreements with doctors and athletic trainers for the treatment of players.<sup>221</sup> In addition, while the MLS Medical Manual requires that athletic trainers be “year-round employees,”<sup>222</sup> there is no direction on whether club doctors should be employees or independent contractors. Otherwise, we were unable to discover information about the financial relationships between MLS clubs and their doctors. MLS declined to provide any information related to these issues. Additionally, according to the MLSPU, there are no “collectively bargained provisions regarding the relationships between team medical personnel and the clubs.”<sup>223</sup>

Some information about the relationships between MLS clubs and their doctors can be gleaned from a 2012 lawsuit filed by former D.C. United player Bryan Namoff against the club, the club’s coach, Tom Soehn, the club doctor, Christopher Annunziata, and the club athletic trainer, Brian Goodstein.<sup>224</sup> Namoff alleged that the D.C. United medical staff had failed to properly treat his concussion, resulting in a variety of physical and mental conditions.<sup>225</sup>

In a May 8, 2014, order, a District of Columbia court determined that Namoff’s claims against D.C. United, Soehn, and Goodstein were barred by workers’ compensation laws.<sup>226</sup> The court noted that Goodstein was employed by D.C. United as an athletic trainer,<sup>227</sup> and found that MLS and D.C. United were “concurrent employers” of Namoff.<sup>228</sup> Consequently, the workers’ compensation laws barred Namoff’s lawsuit against his co-employee Goodstein.

In an August 12, 2014, order, the court found that Annunziata was an independent contractor.<sup>229</sup> The court based its decision largely on Annunziata’s ethical requirements as a doctor to “make clinical decisions and exercise his independent professional medical judgment when managing, caring for, and treating patients.”<sup>230</sup> Additionally, the court found that the MLS Medical Policies and Procedures Manual “directs team physicians to provide care based on their own ‘best professional judgment’ and recognizes that they are ultimately responsible’ for treating players.”<sup>231</sup> Thus, because D.C. United could not direct his work, Annunziata was not an employee of the club.

The court’s order also revealed some interesting details about the relationship between Annunziata and D.C. United. There was no written contract between the parties and Annunziata was not paid for his work.<sup>232</sup> Instead, D.C. United provided Annunziata “tickets to games, permissions to use his association with D.C. United in his promotional and marketing materials, and paid travel expenses.”<sup>233</sup>

The arrangement revealed by the Namoff lawsuit comports with the typical arrangements in the NFL, where the club doctor is generally an independent contractor and the athletic trainer is an employee.

As mentioned above, MLS players are required to sign an authorization permitting disclosure of their medical information. The authorization form is broad.<sup>ae</sup> The authorization form permits “all physicians, hospitals, laboratories, pharmacies, clinics, and other health care providers (including, but not limited to, all athletic trainers/therapists) (collectively, ‘Health Providers’)” to release the player’s medical information to:

- (a) the Health Providers, coaches, soccer operations staff, player operations staff, legal staff, human resources staff, owners, executives, general managers, assistant general managers, and other officials (collectively “Soccer Personnel”) of Major League Soccer, L.L.C., MLS Canada LP, and the Major League Soccer (“MLS”) Team or Teams (and such MLS Team Operators) for which [the player] ha[s] agreed (or may agree) to play while this authorization is in effect, (and, in the event of any contemplated assignment of my playing services to another MLS Team or Teams, the Soccer Personnel of such other MLS Team or Teams (and such MLS Team Operators); (b) at the direction of

<sup>ae</sup> The authorization’s breadth stands in contrast to the MLS Medical Manual’s multiple provisions requiring that “[c]onfidentiality regarding a Player’s medical condition will be maintained at all times.” MLS Medical Policies & Procedures Manual § I (2015). See also *id.* § IV.4; *id.* § IX.A.1.

MLS and consistent with the collective bargaining agreement, to the Soccer Personnel of the United States Soccer Federation, the Canadian Soccer Association, and any other National Federation (and their respective Teams) for which [the player] ha[s] agreed (or may agree) agree [*sic*] to play while this authorization is in effect; and (c) at the direction of MLS, any individual or entity from which MLS or an MLS Team may receive services in furtherance of uses and disclosure of [the player's] Health Information permitted by this authorization, such as electronic medical records vendors and worker's [*sic*] compensation insurance carriers, provided that such individual or entity shall be required to maintain the confidentiality of my Health Information.<sup>234</sup>

These disclosure policies are similar to the practices of NFL clubs.

## 5) SPONSORSHIP ARRANGEMENTS

Research has not revealed an MLS medical sponsorship policy. However, some MLS clubs have entered into sponsorship arrangements with healthcare providers and

hospitals while at the same time retaining a doctor from that healthcare provider as the club doctor. For example, the Hospital for Special Surgery in New York is the “Official Hospital of the New York Red Bulls,”<sup>235</sup> and a doctor affiliated with the Hospital for Special Surgery is listed as one of the Red Bulls’ two club doctors.<sup>236</sup> Similarly, Orlando Health is both the jersey sponsor and “official medical team” of the Orlando City Soccer Club,<sup>237</sup> and a doctor from Orlando Health serves as Orlando City’s club doctor.<sup>238</sup>

In addition, the MLS Medical Manual tangentially admits that medical sponsorship is permitted. In outlining policies concerning whether certain healthcare costs are the responsibility of the league or the club, the MLS Medical Manual states that clubs are responsible for healthcare costs where “[c]lubs have created either written or verbal marketing agreements in which clubs funnel billable therapy to a particular club sponsor group.”<sup>239</sup> This provision thus strongly suggests that MLS permits sponsorship arrangements whereby healthcare providers pay for the right to provide care. In contrast, the NFL does not permit such arrangements.



## G) Analysis

Table 1-C below summarizes the leagues' handling of certain issues concerning the different principles identified at the beginning of this Chapter.

**Table 1-C:**  
**Summary of Club Medical Personnel Policies and Practices**

Do the Leagues' policies:	NFL	MLB	NBA	NHL	CFL	MLS
<b>QUALITY OF MEDICAL CARE</b>						
Require retention of doctors?	Yes	Yes	Yes	Yes	No	No
Require retention of athletic trainers?	Yes	Yes	Yes	Yes	Yes	No
Require sports-specific certification for doctors?	Yes	No	Yes	Yes	No	No
Set forth a standard of care?	Yes	No <sup>af</sup>	No	Yes	No	Yes
<b>DISCLOSURE AND PLAYER AUTONOMY</b>						
Require medical staff to disclose communications with club to player?	Yes	No	No	No	No	No
Require club to pay for second opinion?	Yes	Yes	Yes	Yes	No	Yes
Provide club doctor right to determine a player's course of treatment?	No	No	Yes	Yes	No	Yes
Entitle players to surgeon of their choice?	Yes	No <sup>ag</sup>	No	Yes	No	No
Entitle players to medical records?	Yes	Yes	Yes	Yes	Yes	Yes
Require players to submit to physicals upon request?	Yes	Yes	Yes	No	Yes	Yes
<b>CONFIDENTIALITY</b>						
Permit non-medical club personnel to obtain and disclose player health information?	No	Yes	Yes	Yes	No	Yes
Require players to inform club of care by other medical professionals, regardless of payment source?	No	If baseball-related	Yes	No	No	No
<b>CONFLICTS OF INTEREST</b>						
Insulate club medical staff from influence by coaches and other club personnel?	No	No	No	No	No	No
Prohibit healthcare providers from paying for right to provide care?	Yes	Yes	Partially	Unknown	No	No

<sup>af</sup> As discussed above, when asked specifically about this issue, MLB directed us to its minimum game day standards and the MLBTPA mission statement, both of which were discussed above. However, neither the game day standards nor the mission statement sets forth a standard of care for club doctors specific to MLB club doctors or that goes beyond what is already required by codes of ethics and relevant law applicable to all doctors. By comparison, the NFL, NHL and MLS CBAs all set forth standards of care for their club doctors which, in particular, attempt to address the conflict of interest inherent in having doctors that treat players while also providing services to the club.

<sup>ag</sup> In reviewing a draft of this Report, MLB stated that our indication that MLB players do not have the right to the surgeon of their choice was "inaccurate." We disagree. As discussed above, while MLB clubs are directed to "take a Player's reasonable preferences into account when designating doctors to perform surgery," "the Club has the right to designate the doctors and hospitals when a Player is undergoing a surgery for an employment related injury[.]" 2012 MLB CBA, Attachment 35. In addition, "in no event should they force a Player to have a surgery performed by the Club physician but should instead, in any case in which a Player has objected to the surgery being performed by the Club physician, designate another physician to perform the surgery." *Id.* Thus, the decision of which surgeon to use ultimately rests with the club, subject to player's ability to object to the club doctor performing the surgery.



Before analyzing the results of the above Table, it is important to note that some of the leagues' practices concerning these issues might be positive towards player health but are not codified in the CBA or other policy document. Therefore we cannot capture them in our analysis, especially since some leagues were unwilling to provide us information we requested. With that caveat in mind, we turn to our analysis of the leagues' policies concerning medical personnel. In particular, our focus is on how the NFL compares to the other leagues.

The above Table suggests that the NFL's policies concerning club medical personnel are the most protective of player health in almost all cases by providing players with superior control and information about their healthcare. The NHL's policies are similarly protective of player health, with one worrisome provision that permits club doctors to "determine the diagnosis and/or course of treatment,"<sup>240</sup> including whether "a surgical procedure is the appropriate course of treatment for the Player."<sup>241</sup> The NHL's policy would seemingly permit players to be compelled to undergo a surgery even if they (or their own doctor) believe it inappropriate, at risk of having their contract voided should they refuse. That the NFL and NHL lead on these issues is perhaps not surprising considering they are generally the two leagues with the highest rates of serious injuries (*See* Chapter 2: Injury Rates and Policies) and the most controversies concerning player health. The CFL is a football league too of course, but it does not compare in size to the NFL or NHL and thus does not engage in the same level of collective bargaining, policy making, or litigation.

While overall the NFL appears to offer the medical personnel policies most protective of player health, there are, however, four areas in which the NFL might learn lessons as compared to one or more of the other leagues. We explain these areas below, including those resulting in recommendations for the NFL.

First, it appears the NFL might learn lessons when it comes to players' access to medical records. The NBA requires club medical personnel to provide players with medical records within 48 hours of a player's request. In contrast, the NFL CBA only entitles players to their medical records once during the pre-season, once after the regular season, and upon request in the off-season.<sup>242</sup> However, in practice, the NFL's recently implemented electronic medical records system provides players with 24/7 access to their medical records. Consequently, the NFL's deviation on this issue is no longer relevant.

Similarly, the NHL CBA requires club medical personnel to provide players with a complete copy of their medical

records during their end-of-season physical. In contrast, while NFL players have 24/7 access to electronic versions of their records, there is no NFL CBA provision that obligates clubs to provide players with their medical records as a matter of course. It is not clear whether providing players with paper copies of their medical records versus electronic access is preferable. It is possible that one approach—or the two approaches combined—could increase the possibility that a player will review his records and seek appropriate or necessary care. However, without additional information, it is speculative to say the NHL's policy is superior.

Second, the NHL CBA requires clubs to identify an individual responsible for monitoring the club's prescription drug use. The NFL CBA has no such requirement. Nevertheless, the absence of any such provision is mitigated by the NFL's policies concerning medications. NFL clubs do not store controlled substances at their facilities and any prescription medications are filled through a local pharmacy.

Third, while the CFL Standard Player Contract requires players to submit to a pre-season physical by the club's doctors, the CFL CBA also requires that pre-season physicals "to determine the status of any pre-existing condition" be performed by a neutral physician.<sup>243</sup> The stated purpose of this requirement is to help determine "in the future" whether there was "an aggravation of . . . [a] pre-existing condition."<sup>244</sup> Furthermore, the provision is housed within the Injury Grievance article of the CBA,<sup>ah</sup> and thus it appears that the provision is designed to ensure that there is an accurate record of a player's injury history. In contrast, NFL club doctors perform all pre-season physicals and would be the ones to opine about a player's prior injury history. We believe the CFL's approach is preferred, for reasons explained below.

Fourth, the NHL's and MLS' required standards of care appear preferable to that of the NFL, in that they seemingly require club doctors to subjugate their duties to the club to their duties to the player at all times. In contrast, the NFL CBA only explicitly requires that the doctor's first priority be the player when the doctor is "providing medical care." Club doctors have important roles for the club beyond providing medical care, specifically performing fitness-for-play evaluations, the outcomes of which might not be in the player's interests. Consequently, by its specific terms,

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ah Under the CFL Standard Player Contract, clubs are obligated to pay an injured player's medical expenses and salary (provided the player is a veteran) for so long as the player is physically unable to play. CFL Standard Player Contract ¶¶ 20–21. An Injury Grievance would be filed if the player and club disputed the extent of the player's injuries, and thus the club's obligations to pay the player's salary and medical expenses.

the NFL CBA only requires club doctors to consider players as their principal responsibility some of the time. But while the NHL's and MLS' provisions are preferable in their specificity and demands, they still fail to sufficiently protect player health.<sup>ai</sup>

Despite the possible protections provided by the NHL's and MLS' standards of care, they do not—nor do any of the other leagues—address perhaps the most fundamental structural issue concerning player health: the conflicts of interest faced by club medical personnel. In each of the leagues, the club's medical staff treats the players, but is selected by, reports to the club, including providing advice on the players' short-term and long-term usefulness to the club. While the Canadian healthcare system seemingly insulates the Canadian club doctors from payment as a source of conflict, American clubs have financial or other arrangements with their club doctors that can influence doctors' decision-making and care (consciously or unconsciously). While the various player health provisions discussed herein can improve a player's options and empower him to receive better care, there will be concerns about the quality and primacy of player health, and trust in club medical personnel, so long as it is principally clubs that control the medical staff.

For these reasons, in our report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, we recommended that club doctors and medical staff be redefined as “Players’ Doctors” and “Players’ Medical Staff,” to reflect their exclusive responsibility to advance the health of players.<sup>245</sup> Moreover, we recommended that these medical professionals should be chosen and subject to review and termination by a Committee of medical experts selected equally by the NFL and the NFLPA and that their only interaction with clubs should be via the head Players’ Doctor’s written reports on the status of players currently receiving medical treatment. Finally, we recommend that a Players’ Doctor’s determination of a player’s playing status should be controlling. The rationale for this proposed structure is discussed at length in our report but, generally, this arrangement removes the structural conflicts of interest that can and do impede player health. The NHL’s standard of care supports our proposed approach, but does not go far enough. To ensure the best possible and most independent care, a standard of care is insufficient—structural changes are needed.

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ai In our report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, Chapter 3: Club Doctors, we describe in depth doctors legal and ethical obligations in the two different situations: providing medical care; and, performing fitness-for-play evaluations.



## H ) Recommendation

Given the general superiority of NFL policies compared to other leagues, and uncertainty about possible areas where the NFL can learn by comparison, we have only one recommendation related to medical care, generated by comparison to the CFL.

### **Recommendation 1-A: Pre-season physicals for the purpose of evaluating a player's prior injuries should be performed by neutral doctors.**

The CFL requires pre-season physicals for the purpose of evaluating a player's prior injuries to be performed by a neutral doctor. The NFL should adopt the same rule. The use of neutral doctors ensures that players' medical history is being recorded in an accurate manner, *i.e.*, in a manner that correctly details a player's injury history and the ways in which those prior injuries are manifesting themselves today. Clubs—and thus club doctors—have an incentive to minimize players' injuries and declare them fit to play in order to avoid further financial liability. For example, if an NFL player is injured during one season, and fails the pre-season physical the next season, the player is entitled to an Injury Protection benefit, an amount equal to 50% of his Paragraph 5 Salary (*i.e.*, base) for the season following the season of injury, up to a maximum payment of \$1,150,000 (in 2016).<sup>246</sup> If the player is still injured during the next pre-season, he can obtain Extended Injury Protection, a benefit that permits a player to earn 50% of his salary up to \$500,000 for the *second* season after suffering an injury that prevented the player from continuing to play. Additionally, similar to the CFL, if the club doctor finds that a player is healthy enough to play, a player's potential Injury Grievance<sup>aj</sup> is undermined. In these situations, the club doctor, acting in the interests of the club, might be motivated to find that the player is healthy enough to play during the pre-season physical, preventing the player from receiving benefits and compensation to which he is entitled. While we do not know if such practices are common or widespread, in our Report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, we provided examples from players attesting that such situations do occur.<sup>247</sup> Whatever the frequency, a structural conflict still exists and needs to be addressed. A neutral doctor avoids the potential for bias, and ensures players are receiving their just compensation and care.

As discussed in the Introduction, the NFL declined to review this Report. However, MLB did provide comments on the Report which may provide insight into the viewpoints of the other professional leagues. In reviewing a draft of this Report, MLB expressed its disagreement with this recommendation, stating:

The recommendation (1-A) that preseason physical examinations be performed by a neutral doctor misses the point of the PPE [preparticipation physical evaluation]. Continuity of care is an important aspect of player health care and it is the view of our medical experts that having a separate physician for the preseason exam would result in worse care during the season. The recent Consensus Monograph on PPE, which was prepared by several national physician groups and is viewed as the governing document on these types of exams, does **not** include a recommendation for independent physicians.

While we generally agree with MLB that continuity of care is important, we disagree with MLB's comment for several reasons.

First, it is important to understand we believe there is a structural conflict of interest whereby NFL club doctors provide care to players while also providing services for the club.<sup>ak</sup> As a result, players have business reasons to be concerned about the outcome of the pre-season physical. As explained above, club doctors may not accurately record a player's condition, which can negatively affect his contract status and benefits to which he is entitled.

aj An Injury Grievance is "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 NFL CBA, Art. 45, § 1.

ak In our Report *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations* we set forth a comprehensive recommendation to address this issue. We propose restructuring NFL club medical staff in such a way that the doctor treating the players has as his or her only concern the well-being of the player-patient and has no advisory role to the club.

**Recommendation Concerning Club Medical Personnel – continued**

Second, our recommendation would not affect continuity of care as MLB’s comment seems to suggest. Assuming doctors working for the club continue to treat players (which is not what we recommend as explained in footnote ak), the club doctor would have full access to the results of the pre-season physical and is also permitted to re-examine the player at any time, including during the pre-season. However, a physical performed by a neutral doctor should be used to establish the player’s pre-existing conditions in order to better protect the player’s business interests.

Third, MLB’s reference to the consensus monograph<sup>al</sup> is misplaced. The monograph specifically states that it “is intended to provide a state-of-the-art, practical, and effective screening tool for physicians who perform PPEs for athletes in *middle school, high school, and college*.”<sup>248</sup> Thus, the monograph does not apply to *professional sports*, and does not speak to the issues raised above.

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al See Am. Acad. Pediatrics, *Preparticipation Physical Evaluation* (4th ed. 2010). This monograph was created through the coordination of the American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.



## Endnotes

- 1 The AMA's Code of Medical Ethics can be found on its website at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 22, 2016), *archived at* <http://perma.cc/8JJ4-MYJX>.
- 2 FIMS' Code of Ethics is available from its website at <http://www.fims.org/en/general/code-of-ethics>. FIMS also published a Team Physician Manual which is one of the preeminent manuals for sports injuries and also covers the same ethical considerations espoused in its Code of Ethics.
- 3 See *NATA Code of Ethics*, Nat'l Athletic Trainers Ass'n, Sept. 28, 2005, <http://www.nata.org/codeofethics>, *archived at* <http://perma.cc/7ZXQ-KP5U>.
- 4 See, e.g., John Lantos, Ann Marie Matlock, David Wendler, *Clinician Integrity and Limits to Patient Autonomy*, 305 J. Am. Med. Ass'n 495–9 (Feb. 2, 2011) ("Respect for patient autonomy plays a central role in modern clinical ethics"); Simon N. Whitney, Amy L. McGuire, Laurence B. McCullough, *A Typology of Shared Decision Making, Informed Consent, and Simple Consent*, 140 Ann. Intern. Med 54–59 (2003) ("Enhancing patient choice is a central theme of medical ethics and law."); Cathy Charles, Amiram Gafni, Tim Whelan, *Decision-making in the physician-patient encounter: revisiting the shared treatment decision-making model*, 49 Social Science & Medicine 651–61 (1999) (emphasizing the need to respect differences in patient preferences). See also Stedman's Medical Dictionary (28th ed. 2006) (defining "autonomy" as "[t]he condition or state of being autonomous, able to make decisions unaided by others."); Black's Law Dictionary (9th ed. 2009) (defining "autonomy" as: "the right of self-government"; "an individual's capacity for self-determination.")
- 5 See Mark A. Hall, et al., *Health Care Law and Ethics* 168–69 (2003) (collecting cases and statutes discussing doctors' obligations to keep patient information confidential); AMA Code, Fourth Principle ("A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.")
- 6 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 Co-employee 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).
- 7 See *Lotysz v. Montgomery*, 309 A.D.2d 628 (N.Y.App. 2003) (NFL player's medical malpractice claim against club doctor barred by state workers' compensation statute); *Daniels v. Seattle Seahawks*, 92 Wash.App. 576 (Wash.App. 1998) (same); *Hendy v. Losse*, 54 Cal.3d 723 (Cal. 1991) (same); *Rivers v. New York Jets*, 460 F.Supp. 1233 (E.D.Mo. 1978) (NFL player's claim that club wrongfully concealed the true nature of player's condition barred by workers' compensation statute); *Brinkman v. Buffalo Bills Football Club Division of Highwood Service, Inc.*, 433 F.Supp. 699 (W.D.N.Y. 1977) (NFL player's claim that club failed to provide adequate medical care barred by workers' compensation law). See also *Bryant v. Fox*, 162 Ill.App.3d 46 (Ill.App. 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); Pam Louwagie and Kevin Seifert, *Stringer claims against Vikings dismissed*, Newspaper of the Twin Cities (Minneapolis, MN), Apr. 26, 2003, available at 2003 WLNR 14250471 (medical malpractice claims against club doctors barred by workers' compensation statute). *Martin v. Casagrande*, 159 A.D.2d 26 (N.Y.App. 1990) (NHL player's claim that club doctor and general manager conspired to withhold information about player's medical condition barred by workers' compensation statute); *Bayless v. Philadelphia National League Club*, 472 F.Supp. 625 (E.D.Pa. 1979) (former MLB player's claim that club negligently administered pain-killing drugs barred by workers' compensation statute).
- 8 See *Stringer v. Minnesota Vikings Football Club, LLC*, 705 N.W.2d 746 (Minn. 2005) (estate of former NFL player against athletic trainers barred by workers' compensation statute); *McLeod v. Blase*, 290 Ga.App. 337 (Ga.App. 2008) (former NBA player's claim against athletic trainer for alleged negligent treated barred by workers' compensation statute).
- 9 See Memorandum and Order, *Stringer v. Minnesota Vikings Football Club, LLC*, No. 02-415, at 11-14 (Minn. Dist. Ct. Apr. 25, 2003) (denying club doctor's motion to dismiss certain claims on ground that doctor was independent contractor); *Bryant v. Fox*, 162 Ill.App.3d 46 (Ill.App. 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).
- 10 Lawsuits against clubs are difficult to pursue. The CBAs present the biggest obstacle against any such claim. Common law claims such as negligence are generally preempted by the Labor Management Relations Act ("LMRA"). 29 U.S.C. § 185. The LMRA bars or "preempts" state law claims 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. *Allis-Chambers Corp. v. Lueck*, 471 U.S. 202, 213, 220 (1985). In order to assess a club's health-related duties to a player—an essential element of a negligence claim—a Court would likely have to refer to and analyze the terms of the CBA, resulting in the claim's preemption. 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).
- 11 Jon R. Johnson, *Session 8: Canada and U.S. Approaches to Health Care: How the Canadian and U.S. Political, Regulatory, and Legal Systems Impact Health Care*, 31 Can.-U.S. L.J. 251, 254 (2005).
- 12 *Id.* at 257.
- 13 *Id.* Under the 1966 Medicare Act, the federal government covered one half of the cost of eligible provincial plans covering physician services, but the government has since shifted to a "block-funding system" where it pays the provinces a lump sum for healthcare that covers about 15–20% of the cost of the plans. *Id.* at 257, 262–63.
- 14 *Id.* at 258–59.
- 15 *Id.* at 255, 260.
- 16 *Id.* at 264. See also Roy Romanow, *Directions in Canadian Health Care After the Romanow Report*, 67 Sask. L. Rev. 1, 3 (2004) ("And most doctors [in Canada] are effectively independent contractors paid according to fee schedules."); Colleen M. Flood & Bryan Thomas, *Canadian Medical Malpractice Law in 2011: Missing the Mark on Patient Safety*, 86 Chi. Kent L. Rev. 1053, 1056–57 (2011) ("In general, the provinces supply publicly funded health services by contracting with physicians—who are private, for-profit contractors—through provincial medical associations. The dominant method of payment for these private physicians has been a fee-for-service system, although this is slowly changing."); Daniel W. Srsic, *Collective Bargaining by Physicians in the United States and Canada*, 15 Comp. Lab. L.J. 89, 9192 (1993) ("In Canada, doctors continue to work almost exclusively in private practice, while in the United States an increasing number of doctors are working as employees of hospitals and HMOs."). Most hospitals, meanwhile, are non-profit and publicly funded, although they are not government owned. Johnson, *supra* note 11 at 263. Also, for-profit clinics may contract with a province to provide "insured services" to patients without violating the Canada Health Act, so long as patients do not have to pay for those services. *Id.* at 264 n.62.
- 17 *Id.* at 264.

- 18 See, e.g., Lonny Balbi, *The Liability of Professional Team Sports Physicians*, 22 Alberta L. Rev. 247, 249 (1984); *Wilson v. Vancouver Hockey Club*, (1983) 5 D.L.R. 4th 282, para. 7 (Can. B.C.S.C.) (“He explained that the reference to ‘bill 0113’ was a general practitioner billing code number that would have to be sent to the Medical Services Plan in order that Dr. Peers would be paid.”); *Robitaille*, 19 B.C.L.R. at para. 57 (“The doctors rendered accounts to the medical services association for the account of the player for office consultations and other ‘non-dressing room’ services.”).
- 19 See Roy Romanow, *Directions in Canadian Health Care After the Romanow Report*, 67 Saskatchewan L. Rev. 1, 3–4 (2004). Physicians providing these services include, for example, dentists, dental surgeons, ophthalmologists, psychologists, chiropractors, physiotherapists, osteopaths, and naturopaths. *Id.*
- 20 The CBA does not define “retain” or otherwise dictate the requisite scope of involvement by the various doctors.
- 21 NFL CBA, Art. 39, § 1.
- 22 NFL CBA, Art. 39, § 1(e).
- 23 *NFL Physicians Society Mission Statement*, Nat’l Football League Physicians Soc’y, <http://nflps.org/about/> (last visited Aug. 7, 2015), archived at <http://perma.cc/928Z-LVZ4>.
- 24 See Dave Siebert, *What Is Medical Care Like on an NFL Sideline?*, Bleacher Report (Nov. 15, 2013), <http://bleacherreport.com/articles/1850732-what-is-medical-care-like-on-an-nfl-sideline>, archived at <http://perma.cc/7JR4-HR3G> (quoting then-NFLPS President Matthew Matava describing the “about 177 NFL team physicians”); *Team Physicians*, Nat’l Football League Physicians Society, <http://nflps.org/team-physicians/> (last visited Feb. 24, 2016), archived at <https://perma.cc/HK8A-QJ9L> (listing 153 club doctors as members of the NFLPS).
- 25 See *Frequently Asked Questions—How Often Do All NFLPS Members Meet?*, Nat’l Football League Physician’s Soc’y, <http://nflps.org/faqs/how-often-do-all-nflps-members-meet/> (last visited Aug. 7, 2015), archived at <http://perma.cc/76P5-DRQX>; *Frequently Asked Questions—What Are Typical Topics at Members Meetings?*, Nat’l Football League Physician’s Soc’y, <http://nflps.org/faqs/what-are-typical-topics-at-members-meetings/> (last visited Aug. 7, 2015), archived at <http://perma.cc/LR79-9AN3> (“The topics at these meetings vary and address any or all of the potential injuries that an NFL player may experience. This can include orthopaedic injuries such as ACL tears, meniscus tears, cartilage injuries to the knee, multiligamentous injuries to the knee, high ankle sprains, fractures, dislocations, foot injuries, surgical techniques, rehabilitation, hip injuries, arthroscopy of the hip, sports hernia challenges, shoulder injuries such as dislocations or labral tears, rotator cuff problems, elbow dislocation, biceps or triceps injuries, wrist injuries, and hand and finger injuries or dislocations. From a medical standpoint, there has been a recent emphasis on heat-related illnesses, cardiac conditions, MRSA infections, sickle cell traits, concussions and the management of acute blunt trauma to the chest or abdomen.”).
- 26 This information was provided by NFLPS.
- 27 This information was provided by PFATS.
- 28 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/P62S-C2KH>.
- 29 *Mission*, Prof. Football Athletic Trainers Soc’y, <http://www.pfats.com/about/mission> (last visited May 31, 2016), <https://perma.cc/SV92-L2FC>.
- 30 *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>.
- 31 *Mission*, Prof. Football Athletic Trainers Soc’y, *supra* note 29.
- 32 See Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, Ch. 3 (2016).
- 33 NFL CBA, Art. 39, § 3(e).
- 34 NFL CBA, Art. 39, § 1(c).
- 35 This information was provided by the NFLPA.
- 36 NFL Comments and Corrections (June 24, 2016).
- 37 NFL CBA, Art. 39, § 1(c).
- 38 NFL CBA, Art. 40, § 2(a).
- 39 NFL CBA, Art. 39, § 6.
- 40 NFL CBA, App. A, § 8.
- 41 NFL CBA, Art. 42, § 1(a)(iii).
- 42 NFL CBA, Art. 39, §§ 4–5.
- 43 NFL CBA, Art. 39, § 4.
- 44 *How does a physician become an NFL team physician?* NFL Physicians Soc’y, <http://nflps.org/faqs/how-does-a-physician-become-an-nfl-team-physician/> (last visited Aug. 25, 2015), archived at <http://perma.cc/72XA-N2KW>.
- 45 see *Synernet Staff Visits NFL Headquarters*, Synernet (Feb. 11, 2015), <http://www.synernet.net/news/news.aspx>, archived at <https://perma.cc/E4UC-WNWP>.
- 46 Telephone Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).
- 47 NFL Comments and Corrections (June 24, 2016).
- 48 See Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 3(D) (2016).
- 49 Telephone Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).
- 50 *Id.*
- 51 *Id.*
- 52 Bill Pennington, *Sports Turnaround: The Team Doctors Now Pay the Team*, The New York Times, May 18, 2004, <http://www.nytimes.com/2004/05/18/sports/sports-medicine-sports-turnaround-the-team-doctors-now-pay-the-team.html?pagewanted=1>, archived at <https://perma.cc/BDU2-ETSM>.
- 53 See Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 2(A) (2016).
- 54 NFL Comments and Corrections (June 24, 2016).
- 55 Memorandum from Dan Halem to All Major League Clubs (Dec. 1, 2015).
- 56 *Id.*
- 57 Memorandum from Dan Halem to MLB General Managers and Medical Personnel (Nov. 7, 2012).
- 58 *Id.*
- 59 Memorandum from Dan Halem to All Major League Clubs (Dec. 1, 2015).
- 60 See 2012 MLB CBA, Art. XIII, Attachments 5, 6, 18, 35 and 36, and Schedule A.
- 61 NFL CBA, Art. 39, § 1.
- 62 *Home*, Major League Baseball Team Physicians Ass’n, <http://mlbtpa.org/> (last visited Aug. 25, 2015), archived at <http://perma.cc/2JTM-XMJ5>.
- 63 *MLBPA, MLB Announce Details of New Labor Agreement*, MLBPA (Dec. 2, 2016), [http://www.mlplayers.com/ViewArticle.dbml?DB\\_OEM\\_ID=34000&ATCLID=211336390](http://www.mlplayers.com/ViewArticle.dbml?DB_OEM_ID=34000&ATCLID=211336390), archived at <https://perma.cc/4XUA-2DAW> (announcing replacement of 15-day DL with 10-day DL).
- 64 *Id.*
- 65 MLB CBA, Art. XIII, § E.
- 66 *About*, Professional Baseball Athletic Trainers Soc’y, <http://pbats.com/about/> (last visited Aug. 25, 2015), archived at <http://perma.cc/G9FP-42CS>.
- 67 MLB CBA, Art. XIII, § G.
- 68 See AMA Code Opinion 3.1.5—Professionalism in Relationships with Media: To safeguard patient interests when working with representatives of the media, all physicians should: (a) Obtain consent from the patient or the patient’s authorized representative before releasing information; (b) Release only information specifically authorized by the

- patient or patient's representative or that is part of the public record; (c) Ensure that no statement regarding diagnosis or prognosis is made except by or on behalf of the attending physician; and, (d) Refer any questions regarding criminal activities or other police matters to the proper authorities. *Opinion 3.1.5—Professionalism in Relationships with Media*, Am. Med. Ass'n, available at <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics.page> (last visited Aug. 1, 2016), archived at <https://perma.cc/ZR8K-FC93>.
- 69 MLB CBA, Art. XIII, § G(6).
- 70 MLB CBA, Art. XIII, § G(7)(a).
- 71 MLB CBA, Art. XIII, § I.
- 72 MLB CBA, Art. XIII, § C.
- 73 MLB CBA, Attachment 36.
- 74 *Id.*
- 75 *Id.*
- 76 *Id.* at Concussion Return to Play Form.
- 77 Memorandum from Dan Halem to MLB General Managers and Medical Personnel (Nov. 7, 2012).
- 78 MLB Uniform Player Contract, at REGULATIONS ¶ 2.
- 79 MLB CBA, Art. XIII, § D.
- 80 MLB CBA, Art. XIII, § D.
- 81 MLB CBA, Art. XIII, § G.
- 82 *Id.*
- 83 *Id.*
- 84 Email from Jon Coyles, MLB Labor Counsel, to Chris Deubert (Oct. 6, 2014, 15:13 EST) (on file with author).
- 85 *Id.* MLB is not aware of any field managers that have the authority to hire or terminate medical personnel. *Id.*
- 86 *Id.*
- 87 Bill King, *Team Doctors Rattled by Threat of Malpractice Suits*, SportsBusinessDaily.com (June 21, 2004), <http://www.sportsbusinessdaily.com/Journal/Issues/2004/06/20040621/SBJ-In-Depth/Team-Doctors-Rattled-By-Threat-Of-Malpractice-Suits.aspx>, archived at <http://perma.cc/5E7V-QMXX>; See generally Dennis Durao, *An Endangered Species: Professional Sports Team Physicians*, 15 *Quinnipiac Health L.J.* 33 (2011) (detailing increases in insurance premiums for physicians treating professional athletes).
- 88 Email from Jon Coyles, *supra* note 84.
- 89 MLB CBA, Attachment 35.
- 90 MLB CBA, Attachment 18 at ¶¶ 2–3.
- 91 *Id.* at ¶ 8.
- 92 MLB Uniform Player Contract, ¶ 6(b)(1), included as Schedule A to the 2012 MLB CBA.
- 93 *Id.* at ¶ 6(b)(2). The receiving club must return all of the records within 30 days. *Id.*
- 94 Tom Haudricourt, *Milwaukee Journal Sentinel Tom Haudricourt column*, Milwaukee J. Sentinel, Apr. 6, 2008, available at 2008 WLNR 6507711; Alyson Footer, *Clearing up the term 'athletic trainer'*, MLB News, Mar. 25, 2008, <http://m.mlb.com/news/article/2444052/>, archived at <http://perma.cc/S2CD-RXDE>; see also Alison Gardiner-Shires, Scott C. Marley, John C. Barnes, Mark E. Shires, *Professional baseball athletic trainers' perceptions of preparation for job-specific duties*, 47 *J. of Athletic Training* 704 (2012).
- 95 Tim Johnson and Dr. Eric Berkson, *Life As a Red Sox Team Physician*, Mass. Gen. Hospital (Apr. 13, 2010), <http://www.massgeneral.org/about/newsarticle.aspx?id=2165>, archived at <http://perma.cc/DAG9-X9AZ>.
- 96 *Id.*
- 97 Memorandum from Dan Halem to MLB General Managers and Medical Personnel (Nov. 7, 2012).
- 98 Memorandum from MLB Commissioner Selig to All Major League Owners, President and General Managers re: Medical Service Provider Sponsorships (Nov. 17, 2004) (on file with author). Before this policy, some sponsorship arrangements involved payments from the sponsoring provider to the club, coupled with agreements to provide free health-care to players and their families in exchange for advertising space in the club's stadium. *Healthy: Rangers Ink Deal With Medical Center of Arlington*, SportsBusinessDaily.com (Feb. 25, 2004), <http://www.sportsbusinessdaily.com/Daily/Issues/2004/02/Issue-108/Sponsorships-Advertising-Marketing/Healthy-Rangers-Ink-Deal-With-Medical-Center-Of-Arlington.aspx>, archived at <http://perma.cc/3MQK-4DKP>.
- 99 Memorandum from Daniel R. Halem to All Major League Club Presidents, General Managers, Assistant General Managers, Club Counsel, Team Physicians and Certified Athletic Trainers re: Medical Service Provider Sponsorships (Feb. 18, 2014) (on file with author).
- 100 Email from Jon Coyles, MLB Labor Counsel, to Chris Deubert (Oct. 6, 2014, 15:13 EST) (on file with author).
- 101 *Id.*
- 102 Memorandum from Daniel R. Halem to All Major League Club Presidents, General Managers, Assistant General Managers, Club Counsel, Team Physicians, and Certified Athletic Trainers re: Medical Service Provider Sponsorships (Feb. 18, 2014) (on file with author).
- 103 See, e.g., Oliver Millerchip, *Kaiser Permanente Backs MLB's Nationals*, SportsProMedia.com (May 7, 2014), [http://www.sportspromedia.com/news/kaiser\\_permanente\\_backs\\_mlbs\\_nationals](http://www.sportspromedia.com/news/kaiser_permanente_backs_mlbs_nationals), archived at <http://perma.cc/XMQ3-TG2X> (noting a managed care consortium's sponsorship of the Washington Nationals); *Pirates Announce Affiliation Renewals With Team Partners*, MLB.com (May 6, 2013, 9:23 am), <http://m.mlb.com/news/article/46753608/pirates-announce-affiliation-renewals-with-team-partners>, archived at <https://perma.cc/U358-X9KR> (noting a multiyear agreement for Highmark to be the "Official Healthcare Provider of the Pittsburgh Pirates").
- 104 NBA CBA, Art. XXII, § 1(a).
- 105 NBA CBA, Art. XXII, § 6.
- 106 NBA CBA, Art. XXII, § 3.
- 107 NBA CBA, Art. XXII, § 1(b).
- 108 *About*, Nat'l Basketball Athletic Trainers Ass'n, <http://nbata.com/about-us/> (last visited Aug. 25, 2015), archived at <https://perma.cc/AT3Z-N7TT>.
- 109 *Id.*
- 110 See Travis Tate, *A Day in the Life of—Athletic Trainer*, NBA.com, [http://www.nba.com/jazz/news/day\\_in\\_the\\_life\\_athletic\\_trainer.html](http://www.nba.com/jazz/news/day_in_the_life_athletic_trainer.html) (last visited Aug. 25, 2015), archived at <http://perma.cc/N7CV-SFVW> (describing duties of Utah Jazz athletic trainer); Jaimie Siegle, *Behind the Scenes at Philips Arena with NBA Head AT Wally Blase*, Nat'l Athletic Trainers Ass'n (May 22, 2014), <http://www.nata.org/nata-news-blog/behind-scenes-philips-arena-nba-head-wally-blase>, archived at <http://perma.cc/BBF2-TE4G> (describing duties of Atlanta Hawks athletic trainer); Fred Kerber, *Train of Thought—Walsh Keeps Nets in Working Order*, N.Y. Post, Nov. 15, 2008, available at 2008 WLNR 21933024 (describing duties of New Jersey Nets athletic trainer).
- 111 NBA CBA, Art. XXII, § 2.
- 112 NBA CBA, Art. XXII, § 4(f).
- 113 NFL CBA, Art. 40, § 2(a).
- 114 NBA CBA, Art. XXII, § 11(c).
- 115 NBA CBA, Art. XXII, § 11(b).
- 116 NBA CBA, Art. XXII, § 11(a).
- 117 NBA CBA, Art. XXII, § 11(d)(2).
- 118 NBA CBA, Art. XXII, § 11(d)(3).
- 119 NBA CBA, Art. XXII, § 11(d)(3).
- 120 NBA CBA, Art. XXII, § 11(g).
- 121 *Id.* The contract amendment possibility existed in CBAs prior to 2017 and thus is not limited to the Fitness-to-Play determinations. When a club doctor believes a player is not sufficiently fit to play (which would include general fitness as well as medical determinations), a player's contract can be amended to provide that the club can suspend the player for successive one-week periods until the club believes the player can play. See *id.*; 2017 NBA CBA, Art. II, § 3(l); NBA Uniform



Player Contract, Ex. 7. After each one-week suspension, the player has the right to be examined by a doctor selected by the President or a Vice President of the American Society of Orthopedic Surgeons (the “Reviewing Physician”). NBA Uniform Player Contract, Ex. 7. The Reviewing Physician’s determination “concerning the physical condition of the Player to play skilled basketball” is binding on the club and the player. *Id.* If the Reviewing Physician determines that the player “is in physical condition sufficient to play skilled basketball,” then the club can no longer suspend the player. *Id.* At this point, as a practical matter, the player would be allowed to suit up and presumably practice, but the club would still have the discretion not to play the player. Nevertheless, if the club is unwilling to play the player, the player is of no value to the club. Consequently, the club would likely play the player, trade him to another club, or release him. According to the NBA, this provision generally concerns players’ physical fitness at the beginning of each season. Nevertheless, it has the potential to be applied to the Fitness-to-Play determinations as well.

- 122 *Chris Bosh fails Heat physical with blood clotting, no timetable for return*, Sports Illustrated (Sep. 23, 2016), <http://www.si.com/nba/2016/09/23/chris-bosh-miami-heat-blood-clotting>, archived at <https://perma.cc/25X4-UYU3>.
- 123 *Id.*
- 124 Howard Beck, *Stuck in Standoff Over Chris Bosh’s Future, NBA to Create New Medical Panels*, Bleacher Rep. (Dec. 21, 2016), [http://bleacherreport.com/articles/2683133-stuck-in-standoff-over-chris-bosh-future-nba-to-create-new-medical-panels?utm\\_source=facebook.com&utm\\_medium=share&utm\\_campaign=web-des-art-top-188](http://bleacherreport.com/articles/2683133-stuck-in-standoff-over-chris-bosh-future-nba-to-create-new-medical-panels?utm_source=facebook.com&utm_medium=share&utm_campaign=web-des-art-top-188), archived at <https://perma.cc/GB52-PBHY>.
- 125 *Id.*
- 126 NBA CBA, Art. XXII, § 10(b).
- 127 NBA CBA, Art. XXII, § 10(c).
- 128 NBA CBA, Art. XXII, § 10(g).
- 129 NBA Uniform Player Contract, § 7(a).
- 130 NBA Uniform Player Contract, § 7(d).
- 131 NBA Uniform Player Contract, § 7(e).
- 132 NBA Uniform Player Contract, § 7(f).
- 133 NBA CBA, Art. XXII, § 7.
- 134 NBA Uniform Player Contract, § 7(f).
- 135 NBA Uniform Player Contract, § 7(g).
- 136 NBA CBA, Art. II, § 13(i).
- 137 NBA Uniform Player Contract, § 7(h)(i).
- 138 NBA Uniform Player Contract, § 7(h)(ii).
- 139 NBA Uniform Player Contract, § 7(i).
- 140 Email from David Weiss, Associate Vice President and Assistant General Counsel, NBA, to author (Sept. 30, 2014).
- 141 NBA CBA, Art. XXII, § 4(a). However, a “player or his immediate family (where appropriate) shall have the right to approve the terms and timing of any public release of medical information relating to any injuries or illnesses suffered by that player that are potentially life- or career-threatening, or that do not arise from the player’s participation in NBA games or practices.” 2017 NBA CBA, Art. XXII, § 4(e).
- 142 NBA CBA, Art. XXII, § 4(b).
- 143 NBA CBA, Art. XXII, § 6.
- 144 *See, e.g., Sacramento Kings Announce Kaiser Permanente as Team’s New Medical Provider*, Nat’l Basketball Ass’n, Oct. 3, 2013, <http://www.nba.com/kings/news/sacramento-kings-announce-kaiser-permanente-teams-new-medical-provider>, archived at <http://perma.cc/FB55-RK6F>; *DMC Sports Medicine — New Home*, Detroit Med. Center, <http://www.dmc.org/detroit-medical-center-sports-medicine-new-home.html> (last visited Aug. 25, 2015), archived at <http://perma.cc/DEU3-G74H>.
- 145 NHL CBA, § 34.2(a).
- 146 NHL CBA, § 34.2(b)(i).
- 147 *Mission Statement*, Prof. Hockey Athletic Trainers Soc’y, <http://www.phats-sphem.com/mission> (last visited Aug. 26, 2015), archived at <http://perma.cc/74ZD-J2Z7>.
- 148 *See FrankD, An interview with Tampa Bay Lightning Head Athletic Trainer Tommy Mulligan*, SB Nation (Feb. 9, 2010, 6:00 AM), <http://fromtherink.sbnprivate.com/2010/2/9/1299657/an-interview-with-tampa-bay> archived at <http://perma.cc/BRC2-6A86> (discussing duties of Tampa Bay Lightning athletic trainer).
- 149 NHL CBA, § 34.1(a).
- 150 NHL CBA, § 34.1(b).
- 151 NHL CBA, § 34.3(b)(ii).
- 152 NHL CBA, § 34.8.
- 153 Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 2(l) (2016).
- 154 NHL CBA, § 34.4(a).
- 155 Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 4(D) (2016).
- 156 NHL CBA, § 23.10.
- 157 Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 3(A) (2016).
- 158 NHL CBA, § 34.4(c)(i).
- 159 NHL CBA, § 34.4(c)(ii).
- 160 NHL CBA, § 34.4(c)(iii).
- 161 NHL CBA, § 34.4(d).
- 162 NHL CBA, § 34.4(e).
- 163 NHL CBA, § 34.5(a).
- 164 Standard Player Contract, § 2, included as Exhibit 1 to the 2013 NHL CBA.
- 165 NHL CBA, § 34.5(a).
- 166 NHL CBA, § 34.5(b).
- 167 NHL CBA, § 34.6.
- 168 NHL CBA, § 34.6(d).
- 169 In a pair of cases from the early 1980s, Canadian courts were split about whether club doctors are employees or independent contractors. *See Robitaille v. Vancouver Hockey Club, Ltd.*, (1981) 124 D.L.R. 3d 228 (Can. B.C.C.A.), available at <https://www.canlii.org/en/bc/bcca/doc/1981/1981canlii532/1981canlii532.html>, archived at <https://perma.cc/Q4N9-HGP4> (finding that the three club doctors were employees of the defendant club and holding the club vicariously liable); *Wilson v. Vancouver Hockey Club*, (1983) 5 D.L.R. 4th 282 (Can. B.C.S.C.), available at <https://www.canlii.org/en/bc/bcsc/doc/1983/1983canlii340/1983canlii340.html>, archived at <https://perma.cc/JNG5-X593> (finding that the club doctor was an independent contractor and the defendant club was not vicariously liable for his negligence). *See also Martin v. Casagrande*, 559 N.Y.S.2d 68, 69 (N.Y.App.Div. 1990) (NHL player’s recovery under workers’ compensation laws barred player’s lawsuit against club and club doctor); Frank Fitzpatrick, *Jury Starts Deliberations in Babych’s Lawsuit*, Philly.com (Oct. 31, 2002), [http://articles.philly.com/2002-10-31/sports/25352880\\_1\\_dave-babych-flyers-physician-deliberations](http://articles.philly.com/2002-10-31/sports/25352880_1_dave-babych-flyers-physician-deliberations), archived at <http://perma.cc/5TE5-7TUU>; *Dave Babych Wins Injury Lawsuit*, CBCSports (Nov. 1, 2002, 1:31 a.m.), <http://www.cbc.ca/sports/hockey/dave-babych-wins-injury-lawsuit-1.304723>, archived at <http://perma.cc/C29K-ZK5T> (former player awarded \$1.37 million in damages against club doctor for alleged improper treatment of broken foot after court determined that club doctor was an independent contractor).
- 170 NHL CBA, § 34.3(a).
- 171 NHL CBA, § 34.3(c)(x).
- 172 NHL CBA, § 34.3(c).
- 173 Sean Gordon & David Shoalts, *Diagnosing Sports Injuries Never an Exact Science*, Globe & Mail, Feb. 7, 2012, <http://www.theglobeandmail.com>



- /sports/hockey/diagnosing-sports-injuries-never-an-exact-science/article544490/, archived at <http://perma.cc/N26D-Q7WL>. NHL spokespersons have been cagey about the number of teams with such deals in the past. See Tom Farrey, *A Snapshot of Sports' Medical Dilemma*, ESPN, Sept. 12, 2002, <http://espn.go.com/gen/s/2002/0912/1430969.html>, archived at <http://perma.cc/N26D-Q7WL> ("Spokespersons for the NHL and Major League Baseball say they don't know how many of their teams have such deals.").
- 174 Gordon & Shoalts, *supra* note 173. Accepting payment from medical groups is "frowned upon" in Canada. *Id.*
- 175 See Bill King, *Team Doctors Rattled by Threat of Malpractice Suits*, SportsBusinessDaily.com (June 21, 2004), <http://www.sportsbusinessdaily.com/Journal/Issues/2004/06/20040621/SBJ-In-Depth/Team-Doctors-Rattled-By-Threat-Of-Malpractice-Suits.aspx>, archived at <http://perma.cc/5E7V-QMXX>.
- 176 CFL CBA, § 34.18.
- 177 See Administration, Edmonton Eskimos, <http://www.esks.com/page/administration> (last visited Aug. 26, 2016), archived at <https://perma.cc/6JNY-Y6U8> (listing nine doctors affiliated with Edmonton); *Football Op*, Montreal Alouettes, <http://en.montrealalouettes.com/football-operations/> (last visited Aug. 26, 2016), archived at <https://perma.cc/DC3G-LMAJ> (listing nine doctors affiliated with Montreal Alouettes); *Front Office & Football Operations*, Toronto Argonauts, <http://www.argonauts.ca/coaching-staff-football-operations/> (last visited Aug. 22, 2016), archived at <https://perma.cc/P3C8-HDT7> (listing seven doctors affiliated with Toronto Argonauts).
- 178 *Id.*
- 179 *Id.*
- 180 CFL CBA, § 34.03.
- 181 CFL Standard Player Contract, ¶ 6.
- 182 NFL CBA, App. A, § 8.
- 183 Telephone interview by Chris Deubert with Michael Copeland, President and Chief Operating Officer, CFL (July 24, 2014).
- 184 See *Robitaille v. Vancouver Hockey Club, Ltd.*, (1981) 124 D.L.R. 3d 228 (Can. B.C.C.A.), available at <https://www.canlii.org/en/bc/bcca/doc/1981/1981canlii532/1981canlii532.html>, archived at <https://perma.cc/Q4N9-HGP4> (finding that the three club doctors were employees of the defendant club and holding the club vicariously liable); *Wilson v. Vancouver Hockey Club*, (1983) 5 D.L.R. 4th 282 (Can. B.C.S.C.), available at <https://www.canlii.org/en/bc/bcsc/doc/1983/1983canlii340/1983canlii340.html>, archived at <https://perma.cc/JNG5-X593> (finding that the club doctor was an independent contractor and the defendant club was not vicariously liable for his negligence).
- 185 CFL CBA, § 24.09.
- 186 CFL CBA, § 24.08.
- 187 *Dr. Robert McDougall and the Saskatchewan Roughriders*, 17 J. Can. Rheumatology Ass'n (2007), [http://www.stacommunications.com/customcomm/Back-issue\\_pages/CRAJ/crajPDFs/2007/fall2007/english/04.pdf](http://www.stacommunications.com/customcomm/Back-issue_pages/CRAJ/crajPDFs/2007/fall2007/english/04.pdf), archived at <http://perma.cc/VAP5-8P59>.
- 188 *An Athlete's Perspective: An Interview with CFL All-star Chris Walby*, 17 J. Can. Rheumatology Ass'n (2007), [http://www.stacommunications.com/customcomm/Back-issue\\_pages/CRAJ/crajPDFs/2007/fall2007/english/04.pdf](http://www.stacommunications.com/customcomm/Back-issue_pages/CRAJ/crajPDFs/2007/fall2007/english/04.pdf), archived at <http://perma.cc/VAP5-8P59>.
- 189 *Id.*
- 190 Telephone interview by Chris Deubert with Michael Copeland, President and Chief Operating Officer, Can. Football League (July 24, 2014).
- 191 Sean Gordon and David Shoalts, *Diagnosing Sports Injuries Never an Exact Science*, Globe & Mail, Feb. 7, 2012, <http://www.theglobeandmail.com/sports/hockey/diagnosing-sports-injuries-never-an-exact-science/article544490/>, archived at <http://perma.cc/N26D-Q7WL>.
- 192 The MLS Medical Manual states that "Club Physicians and Athletic Trainers are required to comply with the policies and procedures set forth in this manual." MLS Medical Policies & Procedures Manual § I (2015).
- 193 MLS Medical Policies & Procedures Manual § III.5 (2015).
- 194 MLS CBA, § 9.8.
- 195 MLS Medical Policies & Procedures Manual Introduction (2015).
- 196 *Home*, MLS Team Physician Soc'y, <http://www.mlsteamdocs.com/> (last visited Aug. 26, 2015), archived at <http://perma.cc/QJ7E-82SN>.
- 197 *About*, Prof. Soccer Athletic Trainers' Soc'y, <http://www.psats.net/#!psats-members-/cigi> (last visited Aug. 26, 2015), archived at <http://perma.cc/D22U-5SP7>.
- 198 MLS Medical Policies & Procedures Manual § V.2 (2015).
- 199 Interview with MaryBeth Horodyski, Vice President, NATA, and Jim Thornton, President, NATA (Aug. 20, 2014).
- 200 See *BOC Vision & Mission*, Board of Cert. for Athletic Trainers, <http://bocac.org/about-us/boc-vision-mission> (last visited Aug. 7, 2015), archived at <http://perma.cc/3J98-WU2T>.
- 201 See *An In Depth Look with an Athletic Trainer in Major League Soccer*, Board of Cert. for the Athletic Trainer, <http://www.bocac.org/blog/uncategorized/an-in-depth-look-with-an-athletic-trainer-in-major-league-soccer/> (last visited Aug. 26, 2015), archived at <http://perma.cc/W86J-FAHW> (interview with Houston Dynamo athletic trainer describing his duties); Luke Lohr, *Plight of the MLS Athletic Trainer*, The MLS Reserves, Apr. 4, 2012, [www.mlsreserves.com/2012/04/plight-of-mls-athletic-trainer.html](http://www.mlsreserves.com/2012/04/plight-of-mls-athletic-trainer.html), archived at <http://perma.cc/PZ6S-Z89R> (interview with FC Dallas athletic trainer describing his duties).
- 202 *Id.*
- 203 *Id.*
- 204 MLS CBA, § 9.7.
- 205 *Id.*
- 206 MLS Medical Policies & Procedures Manual § I (2015). See also *id.* § IV.5 ("Club Physicians will always provide medical services based on their best medical judgment."); *id.* § X.A ("Club Physicians and Athletic Trainers will at all times comply with the highest standard of care when treating any injury or other medical problem.")
- 207 MLS CBA, § 9.1(v).
- 208 MLS Standard Player Agreement, ¶ 7(g).
- 209 NFL CBA, App. A, ¶ 8.
- 210 MLS Standard Player Agreement, ¶ 4(b).
- 211 NFL CBA, App. A, ¶ 8.
- 212 MLS CBA, § 9.5.
- 213 MLS CBA, § 9.1(i).
- 214 MLS CBA, § 9.1(iii).
- 215 MLS CBA, § 9.1(iv).
- 216 MLS CBA, § 9.3(i)(a).
- 217 MLS CBA, § 9.3(i).
- 218 MLS CBA, § 9.4.
- 219 *Id.*
- 220 NFL Player Contract, § 8, included as Appendix A to the 2011 NFL CBA.
- 221 MLS Medical Policies & Procedures Manual § III.1, § V.2 (2015).
- 222 MLS Medical Policies & Procedures Manual § V.3 (2015).
- 223 Email from Bob Foose, Executive Director, MLS Players Union, to author (Aug. 29, 2014).
- 224 See Docket, *D.C. Soccer LLC, et al. v. Commonwealth Orthopaedics & Rehabilitation, P.C., et al.*, 2012-CA-007050 (D.C. Sup. Ct.), available by searching the District of Columbia courts website at <https://www.dccourts.gov/cco/maincase.jsf>.
- 225 See Complaint, *Namoff v. D.C. Soccer LLC* (D.C. Sup. Ct. Aug. 29, 2012).
- 226 Order, *Namoff v. D.C. Soccer LLC*, No. 2012-CA-7050 (D.C. Sup. Ct. May 8, 2014); Steven Goff, *Namoff's lawsuit was dismissed*, Wash. Post, Jan 14, 2015, <https://www.washingtonpost.com/news/soccer-insider/wp/2015/01/14/namoffs-lawsuit-was-dismissed/>, archived at <https://perma.cc/5JEK-EZCE>.
- 227 Order, *Namoff v. D.C. Soccer LLC*, No. 2012-CA-7050, \*2 (D.C. Sup. Ct. May 8, 2014).

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- 228 *Id.* at 8.
- 229 See Order, *Namoff v. Annunziata*, No. 2012-CA-008981 (D.C. Sup. Ct. Aug. 12, 2014).
- 230 *Id.* at 7.
- 231 *Id.* at 9.
- 232 *Id.* at 6.
- 233 *Id.*
- 234 MLS CBA, Ex. 2.
- 235 *New York Red Bulls and Hospital for Special Surgery Announce Partnership*, Hospital for Special Surgery (Mar. 21, 2007), [http://www.hss.edu/newsroom\\_hss-partnership-new-york-red-bulls-soccer-team-sports-medicine.asp](http://www.hss.edu/newsroom_hss-partnership-new-york-red-bulls-soccer-team-sports-medicine.asp), archived at <http://perma.cc/UR8C-JAFC>.
- 236 See *Technical Staff*, N.Y. Red Bulls, <http://www.newyorkredbulls.com/technicalstaff> (last visited Aug. 26, 2015), archived at <http://perma.cc/88X2-LF4A>.
- 237 *Orlando City SC and Orlando Health Unveil Inaugural MLS Home Jersey*, Orlando City Soccer Club (Nov. 5, 2014), available at <http://www.orlandocitysc.com/post/2014/11/05/orlando-city-sc-and-orlando-health-unveil-inaugural-mls-home-jersey>, archived at <http://perma.cc/RL3N-6VJY>.
- 238 See *Daryl Christopher Oshbar*, Orlando Health, <http://www.orlandohealth.com/physician-finder/daryl-christopher-osbahr-md?hcmacid=a0bi000000HyCQ3AAN> (last visited Aug. 22, 2016), archived at <https://perma.cc/66C5-6U7X>.
- 239 MLS Medical Policies & Procedures Manual § X.B.2.d (2015).
- 240 NHL CBA, § 34.5(a).
- 241 NHL CBA, § 34.4(f).
- 242 NFL CBA, Art. 40, § 2(a).
- 243 CFL CBA, § 24.08.
- 244 *Id.*
- 245 See Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, § 2(H) (2016).
- 246 NFL CBA, Art. 45, § 2.
- 247 See Christopher R. Deubert, I. Glenn Cohen, Holly Fernandez Lynch, *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, Recommendation 1:1-F (2016).
- 248 Am. Acad. Pediatrics, *Preparticipation Physical Evaluation 3* (4th ed. 2010).