The Neuroscience and Law Center presents

The Diagnosis, Treatment, and Prevention of Concussion

Wednesday, October 17, 2018
8:30 a.m. – 5 p.m.
Skadden Conference Center

Lunchtime Keynote Speaker

DeMaurice F. Smith, Executive Director, National Football League Players Association

CLE Course Materials
Part 3
Dr. Butler is a board-certified neurologist with additional clinical subspecialty training in neuropsychiatry and epilepsy. Her clinical work consists of evaluation and treatment of neurologic signs and symptoms in patients with severe psychiatric disease.

Dr. Butler has published over 40 articles in peer-reviewed scientific journals on a wide range of topics in neuroscience and neurology. Her research uses neuroimaging and complementary methods to improve understanding of the brain and the basis of neuropsychiatric disorders such as traumatic brain injury, epilepsy and Alzheimer’s disease as well as normal aging. A recent project funded by the Brain and Behavior Research Foundation aimed to determine whether some military veterans with psychiatric symptoms and a history of multiple concussions might have evidence of the neurodegenerative disease, Chronic Traumatic Encephalopathy. New research interests center on understudied risk factors for neurodegeneration that are more common in women than in men, including hormonal dysregulation and intimate partner violence with repeated brain injury.

She received a B.A. in philosophy from Amherst College and an M.D. from Columbia College of Physicians and Surgeons. She completed neurology residency at Columbia.

**Art C. Cody, J.D.**
Captain USN (Ret.); Deputy Director, Veterans Defense Program, New York State Defenders Association

Captain Art Cody, USN (Retired) is Deputy Director of the Veterans Defense Program of the New York State Defenders Association. Art first served as a U.S. Army helicopter pilot, followed by similar service in the Navy Reserve. In total, his active and reserve military career spans thirty years and he is a veteran of multiple combat zone deployments. He served aboard USS Enterprise (CVN-65) in the initial response to the 9-11 attacks and was most recently deployed to Afghanistan (2011-2012) as the Director of the Rule of Law Section, US Embassy Kabul. As a civilian lawyer, he has represented criminal defendants for over twenty years and chaired the Capital Punishment Committee of the New York City Bar Association. He frequently presents nationally on the defense of veterans, provides counsel to lawyers for veterans, and recently served as lead counsel in a veteran capital clemency hearing. A graduate of West Point, Art has a Master’s Degree from the University of Southern California and graduated magna cum laude from Notre Dame Law School where he was the Executive Editor of the Notre Dame Law Review. His military decorations include the Navy Bronze Star Medal, Meritorious Service Medal, Naval Aviator Badge, Army Aviator Badge and the German Armed Forces Parachutist Badge.

**Kristen Dams-O’Connor, Ph.D.**
Director, Brain Injury Research Center and Associate Professor, Department of Rehabilitation, Icahn School of Medicine at Mount Sinai

Kristen Dams-O’Connor, Ph.D., completed a bachelor’s Degree in Behavioral Neuroscience at Colgate University, a Ph.D. at the University at Albany, doctoral training at the Rusk Institute of Rehabilitation Medicine at New York University Medical Center and a postdoctoral fellowship in Clinical Neuropsychology at Mount Sinai Medical Center. Her work is focused on understanding and improving long-term outcomes after brain injury, and characterizing clinico-pathological signatures of TBI. She leads the Late Effects of TBI (LETBI) brain donor program, and serves as Project Director of the New York Traumatic Brain Injury Model System. Her research is supported by federal grants from the National Institutes of Health, National Institute for Disability Independent Living and Rehabilitation Research, Department of Defense, Centers for Disease Control, and Patient-Reported Outcomes Research Institute. She has published over 70 peer-reviewed manuscripts and chapters on traumatic brain injury treatments and outcomes and has presented her research internationally.

**Deborah W. Denno, Ph.D., J.D.**
Arthur A. McGivney Professor of Law and Founding Director, Neuroscience and Law Center, Fordham University School of Law

Deborah Denno is the Arthur A. McGivney Professor of Law and founding director of the Neuroscience and Law Center at Fordham University School of Law. She received her B.A. from the University of Virginia, her M.A. from the University of Toronto, her Ph.D. in sociology with a specialty in criminology from the University of Pennsylvania, and her J.D. from the University of Pennsylvania Law School, where she was the managing editor of the University of Pennsylvania Law Review. Prior to joining the Fordham Law faculty in 1991, Denno clerked for the Honorable Anthony J. Scirica of the Third Circuit Court of Appeals and worked as an associate at Simpson, Thacher and Bartlett. Denno’s Neuroscience and Law Center provides evidence-based information to academics, lawyers, and the public about legally relevant advances in neuroscience with the goal of fostering legal scholarship and the use of neuroscience in legal circles. Also at Fordham Law, Denno teaches criminal law, criminal procedure, torts, and seminars on topics such as law and neuroscience as well as advanced criminal law and advanced criminal procedure. In 2016, the Fordham Student Bar Association named Denno Teacher of the Year. In 2007, the National Law Journal selected Denno as one of its Fifty Most Influential Women Lawyers in America. Seven of Denno’s articles have been cited by the United States Supreme Court, and the Court has cited four of her articles in the last three years (2015–2017). Denno has published on a broad range of topics relating to criminal law, criminal procedure, social sciences and the law, and the death penalty, including the constitutionality of execution methods. Denno has also initiated cutting-edge examinations of criminal law defenses pertaining to insanity, rape law, gender differences, consciousness, biological and genetic links to crime, drug offenses, jury decision-making, and the impact of lead poisoning. Currently she is working on a book to be published by Oxford University Press analyzing all criminal cases during a two-decade period that have addressed neuroscience evidence. This same study is discussed in her recent article “Concocting Criminal Intent,” 105 Georgetown Law Journal 323 (2017).

**Steven R. Flanagan, M.D.**
Howard A. Rusk Professor of Rehabilitation Medicine, Chair of the Department of Rehabilitation Medicine, NYU Langone Health

Nationally and internationally recognized as one of the leading experts in the area of brain injury rehabilitation, Dr. Steven Flanagan joined NYU Langone Medical Center in 2008 as Professor and Chairman of Rehabilitation Medicine and Medical Director of Rusk Rehabilitation after serving as Vice Chairman of Rehabilitation Medicine at Mount Sinai School of Medicine from 2000-2008. While at Mount Sinai, Dr. Flanagan and his colleagues developed a seamless continuum of care for people with brain injury that was unique in New York State.

He serves on numerous medical advisory boards, including the India Head Injury Foundation, the Brain Trauma Foundation, and the Brain Injury Association of New York State. He is a peer reviewer for several scientific journals, has previously chaired the Central Nervous System Membership Council of the American Academy of Physical Medicine and Rehabilitation Medicine, and currently chairs the Medical Education Committee and sits on its Board of Governors. He authored numerous chapters and peer-reviewed publications and participated in both federally- and industry-sponsored research. He served as Panel Chair for the TBI/Stroke Group for the VA Merit Review from 2007-2013.
He received awards from several organizations, including the Brain Injury Association of New York State, Attending Physician of the Year Award from the Department of Nursing, and Teacher of the Year from the residents in Rehabilitation Medicine at Mount Sinai. He has been continually listed as one of America's Top Doctors by Castle Connolly since 2010.

Michael Flomenhaft, J.D.
Principal, The Flomenhaft Law Firm, PLLC

Michael Flomenhaft concentrates on representing victims of traumatic brain injury and severe chronic pain. He is a graduate of Boston University School of Law and the Trial Lawyers College. He has been a featured speaker to the New York State Bar Association on cases involving traumatic brain injury. In 2008, Columbia University Medical Center designated him director of neurolaw for its Program for Imaging and Cognitive Sciences. In 2009, he was invited to deliver grand rounds on advanced brain imaging applications for traumatic brain injury to the radiology residency program at Columbia University College of Physicians and Surgeons. In 2011, he was a featured speaker at the Second Circuit Conference on "The Legal Brain-scape: Neuroscience & the Law," where he spoke on imaging neuroscience and its assessment of chronic pain and delivered the paper "The Emerging Imaging Science of Chronic Pain: Objectifying the Subjective." In 2014, he chaired and was a key speaker at the all-day CLE at Fordham Law School "Neuroscience in the Courtroom." He has been featured on CUNY Science Television on neuroscience and law. In 2017, he was featured in a webinar by the American Bar Association as the attorney spokesman for its first ever CLE on neuroscience and law, "Neuroscience and the Law: Using Neuroscience in Criminal and Civil Cases." He is a member of the board of advisors to the Neuroscience and Law Center at Fordham Law School. In his trial work, he has pioneered the admission into evidence of various advanced brain imaging applications. These include diffusion tensor imaging (DTI), quantitative volumetric analysis of MRI, and functional MRI (fMRI).

Yelena Goldin, Ph.D.
Staff Neuropsychologist, JFK Johnson Rehabilitation Institute; Clinical Assistant Professor, Rutgers-Robert Wood Johnson Medical School

Dr. Yelena Goldin received her doctorate degree from Ferkauf Graduate School of Psychology at the Albert Einstein Medical School of Yeshiva University in 2009. She completed her fellowship training in clinical neuropsychology and rehabilitation at Mount Sinai School of Medicine.

Dr. Goldin is a clinical and research neuropsychologist in the Cognitive Rehabilitation Department of JFK Johnson Rehabilitation Institute. She is the principal investigator of JFK TBI Model System site specific project and the JFK TBI Model System Coordinator. She is an Assistant Clinical Professor at Rutgers-Robert Wood Johnson Medical School and Adjunct Assistant Professor at Ferkauf Graduate School of Psychology. Her areas of specialization are traumatic brain injury, stroke, aging, and gender issues. She has experience in comprehensive neuropsychological evaluations and cognitive rehabilitation. She has extensive experience in basic and clinical research in the area of traumatic brain injury. Her research has been presented at national and international conferences and earned several prestigious awards.

Dr. Goldin is involved with research training of residents and fellows at JFK Johnson Rehabilitation Institute. She is an active member of the American Congress of Rehabilitation Medicine, where she sits on the Program Committee, chairs the Poster Committee, is actively involved in the Cognitive Rehabilitation Task Force, and is the co-chair of the Brain Injury Special Interest Group task force on Girls and Women with Acquired Brain Injury. She is an advocate for individuals with traumatic brain injury.

Wayne A. Gordon, Ph.D., ABPP-CN
Jack Nash Professor, Icahn School of Medicine at Mount Sinai

Wayne A. Gordon, Ph.D., ABPP-CN, is the Jack Nash Professor of Rehabilitation Medicine at the Icahn School of Medicine at Mount Sinai. He is a board-certified neuropsychologist. His recent research is focused on cognitive rehabilitation, screening for traumatic brain injury (TBI), developing and testing the utility of behavioral interventions to improve the function of individuals with TBI, and examining the long-term secondary conditions associated with TBI. He has received numerous awards from both professional and consumer organizations, including the Jacobi Medallion for distinguished achievements and extraordinary service to the Mount Sinai Medical Center, the Gold Key Award from the American Congress of Rehabilitation Medicine, the William Fields Cavness Award from the Brain Injury Association of America, the Robert L. Moody Prize for Distinguished Initiatives in Brain Injury Research and Rehabilitation and the Champion of Hope award from the Brain Injury Association of New York State. He has published more than 175 articles and book chapters and has presented nationally and internationally on his research. Dr. Gordon has been the project director on many federally funded grants from the National Institutes of Health, Centers for Disease Control and Prevention and National Institute on Disability and Rehabilitation Research involving multiple research projects along with training and outreach. Dr. Gordon’s current research portfolio is funded by grants from NIH, NICHD, CDC and the Brain Injury Association of America.

Clare Huntington, J.D.
Associate Dean for Research, Joseph M. McLaughlin Professor of Law, Fordham University School of Law

Huntington is an expert in the fields of family law and poverty law. Her book Failure to Flourish: How Law Undermines Family Relationships (Oxford 2014) won an Honorable Mention for the Professional and Scholarly Excellence (PROSE) Award in Law and Legal Studies from the Association of American Publishers. Huntington has published widely in leading law journals, exploring the intersection of poverty and families and with a recent focus on non-marital families. Huntington serves as an associate reporter for the American Law Institute's Restatement of the Law, Children and the Law. Huntington's legal experience includes serving as an attorney advisor in the Justice Department's Office of Legal Counsel as well as clerking for Justice Harry A. Blackmun and Justice Stephen Breyer of the Supreme Court of the United States, Judge Merrick B. Garland of the United States Court of Appeals for the District of Columbia Circuit, and Judge Denise Cote of the United States District Court of the Southern District of New York. Prior to joining the Fordham faculty in 2011, Huntington was an associate professor at the University of Colorado Law School. Huntington earned her J.D. from Columbia Law School and her B.A. from Oberlin College.

Samuel Issacharoff, J.D.
Bonnie and Richard Reiss Professor of Constitutional Law, New York University School of Law

Samuel Issacharoff's wide-ranging research deals with issues in civil procedure (especially complex litigation and class actions), law and economics, constitutional law (particularly with regard to voting rights and electoral systems) and employment law. He is one of the pioneers in the law of the political process, where his Law of Democracy casebook (co-authored with Stanford's Pam Karlan and NYU's Rick Pildes) and dozens of articles have helped to create a vibrant new area of constitutional law. He is also a leading figure in the field of procedure, both in the academy and outside. He served as the reporter for the Principles of the Law of Aggregate Litigation of the American Law Institute.
Brad Karp is one of the country’s leading litigators and corporate advisers. Karp has successfully defended financial institutions and other companies in numerous “bet the company” litigations and regulatory matters. Prior to being named chairman of Paul, Weiss in 2008, Brad chaired the firm’s Litigation Department.

Karp has received numerous industry recognitions over the years. Most recently, in January 2018, Karp was named The American Lawyer’s “Litigator of the Year” and Best Lawyers’ “Securities Lawyer of the Year.” In 2017, Karp was selected as a “Litigation Trailblazer” by the National Law Journal and Best Lawyers’ “Banking Lawyer of the Year.”

Karp has been repeatedly named by the National Association of Corporate Directors on its list of most influential people in the boardroom community and selected by Chambers as a “Star” in multiple practice areas.

Karp is active in the community, serving on more than 20 public interest and educational institution boards. Brad is the chairman of the Legal Action Center and a director/trustee of the Riverdale Country School, Mount Sinai Hospital, The Partnership for New York City (Executive Committee), the Harvard Law School Leadership Council, the Lincoln Center Business Advisory Council, the New York City Bar Association (Vice President), the American Constitution Society, Junior Achievement Global, Harvard Law School Center on the Legal Profession, Practicing Attorneys for Law Students Program, Inc., the Leadership Council of the Legal Services Corporation, the Harvard Law School Visiting Committee, the Leadership Council on Legal Diversity, American Friends of Hebrew University, the New York Bar Foundation, the Program Advisory Board of the Brennan Center for Justice, the Mark Messier Foundation, the Best Lawyers Advisory Board, the Economic Club of New York, the Federal Bar Council Second Circuit Inn of Court, the Union College President’s Council, and the United States Supreme Court Historical Society.

Karp graduated from Harvard Law School in 1984 and has spent his entire professional career at Paul, Weiss.

James Kelly, M.A., M.D., F.A.A.N., F.A.N.A.
Executive Director, Marcus Institute for Brain Health, University of Colorado Anschutz Medical Campus; Professor of Neurology, University of Colorado School of Medicine; Fellow, Military Service Initiative, George W. Bush Institute

Dr. James Kelly accepted a Congressional appointment to the US Air Force Academy and later transferred to Western Michigan University where he obtained his B.A. in Psychology in 1974 and MA in Clinical Psychology in 1977. He served his neurology residency and behavioral neurology fellowship at the University of Colorado. He joined the faculty of the University of Colorado School of Medicine in 1989 where he studied brain-behavior relationships and started its first concussion treatment program.

Dr. Kelly is the Senior Fellow at the George W. Bush Institute’s Military Service Initiative, serving as an advisor to the former President on traumatic brain injury (TBI) and psychological health conditions in our military veterans – the “Invisible Wounds” of our current conflicts in Iraq and Afghanistan.

Prior to his current position, Dr. Kelly served as the founding Director of the National Intrepid Center of Excellence (NICOE), where he led the creation of an innovative interdisciplinary team of healthcare professionals who blended high-tech diagnosis and treatment with complementary and alternative medical interventions in a holistic, integrative approach to the care of US military personnel with the complex combination of TBI and psychological conditions such as post-traumatic stress, depression and anxiety. Dr. Kelly has co-authored numerous reports in civilian and concussion care, through funding provided by the U.S. Department of Defense, the Centers for Disease Control, and international sports organizations, including FIFA.

Regina McGlinchey, Ph.D.
Director, VA RR&D TBI Research Center: TRACTS; Associate Director for Research Training; GRECC, VA Boston Healthcare System; Professor in Psychiatry, Harvard Medical School

Regina McGlinchey is Professor of Psychiatry at Harvard Medical School, Supervisory Research Scientist and Associate Director for Research Training for the Geriatric Research, Education and Clinical Center at the VA Boston Healthcare System. Since receiving her Ph.D. in Experimental Psychology from Tufts University, she has been conducting clinical neuropsychological and neuroscience research on cognitive and neural changes associated with aging, stroke, alcoholism, and military-related brain and psychological trauma. Some of her most important contributions to science have come from her role as Principle Investigator and Director of the VA Rehabilitation Research and Development National Network Center for Traumatic Brain Injury called the “Translational Research Center for TBI and Stress Disorders” (TRACTS). Together with a team of researchers at TRACTS, she is developing a multimodal characterization of mild traumatic brain injury and military blast exposure, and demonstrating how associated stress disorders, including PTSD, depression, substance abuse, etc., influence how brain injury is expressed at the psychological, biological and neurobiological levels.

Barclay Morrison III, Ph.D.
Professor of Biomedical Engineering, Vice Dean of Undergraduate Programs, School of Engineering & Applied Sciences, Columbia University

Barclay Morrison, Ph.D., is a professor of Biomedical Engineering, director of the Neurotrauma and Repair Laboratory, and serves as Vice Dean of Undergraduate Programs for the Engineering School at Columbia University. His research focus is on the biomechanics of traumatic brain injury (TBI) at the tissue level to better prevent brain injuries, as well as on the biochemical, genomic, and molecular pathways responsible for post-traumatic cell dysfunction in the search for novel therapies to better treat brain injuries. He has published over 80 peer-reviewed scientific manuscripts, serves as a council member and vice president for the International Research Council on Biomechanics of Injury, is a board member of Football Research Inc., and is associate editor for the Journal of Biomechanical Engineering and the Journal of Neurotrauma. He received his BS in biomedical engineering from Johns Hopkins University, his Ph.D. in bioengineering from the University of Pennsylvania, and continued his academic training as a post-doctoral fellow in the Clinical Neurosciences department at Southampton University in the United Kingdom. Dr. Morrison is past recipient of the Rickard Skalak Best Paper Award given by the American Society for Mechanical Engineers for a publication in the Journal of Biomechanical Engineering and the John Paul Stapp Award for the best paper in the Stapp Car Crash Journal. More recently, he was the keynote speaker at the annual conference of the International Research Council on Biomechanics of Injury.
James M. Noble, M.D., M.S., C.P.H., F.A.A.N.
Assistant Professor of Neurology, Columbia University Irving Medical Center, Taub Institute for Research on Alzheimer’s Disease and the Aging Brain, G.H. Sergievsky Center, Department of Neurology, Columbia University Medical Center

Dr. Noble specializes in behavioral neurology & neuropsychiatry with disorders ranging from concussion to dementia. Since 2011 he has led a concussion care and research initiative at Columbia University, and is involved with the care of athletes at Columbia University, Fordham University, as well as the New York Giants. He works with the 22-school Big 10-Ivy Traumatic Brain Injury collaborative research program, the Brain Injury Association of New York State, and is a member of the New York State Athletic Commission Medical Advisory Board, which sets medical policy for combat sports in New York. His recent concussion-related publications include articles in the American Journal of Sports Medicine, JAMA Neurology, the Journal of the American Academy of Orthopedic Surgeons, and Neurology: Clinical Practice.

Kimi Paul-Emile, J.D., Ph.D.
Associate Professor of Law, Associate Director, Center on Race, Law & Justice, Faculty Co-Director, Stein Center for Law & Ethics, Fordham University School of Law

Paul-Emile is an associate professor of law, associate director and head of domestic programs and initiatives at Fordham Law School’s Center on Race, Law & Justice and faculty co-director of the School’s Stein Center for Law & Ethics. Paul-Emile specializes in the areas of law and biomedical ethics, antidiscrimination law, and health law. Her scholarship has been published widely in such journals as the Virginia Law Review, Georgetown Law Journal, UCLA Law Review, George Washington Law Review, and the New England Journal of Medicine. Paul-Emile’s scholarship has appeared in or been covered by over 30 national and international news organizations and other outlets, including The New York Times, National Public Radio, CBS News, MSNBC, CNN, Al Jazeera America, and The Guardian.

In 2017, Paul-Emile was awarded a Making a Difference in Real World Bioethics Dilemmas Grant by the Greenwall Foundation. In 2013, the foundation selected her to receive a Faculty Scholar Award in Bioethics: an award intended to enable outstanding junior faculty members to conduct original research to help resolve important policy and clinical dilemmas at the intersection of ethics and the life sciences. In 2012, she was awarded a public health law research grant from the Robert Wood Johnson Foundation, the nation’s leading philanthropy on health and health care.

Prior to pursuing her doctoral degree, Paul-Emile served as associate counsel at the Brennan Center for Justice at New York University School of Law, and practiced civil rights law at the Center for Constitutional Rights, where she was a National Association for Public Interest Law (now Equal Justice Works) Fellow and later the William Moses Kunstler Fellow for Racial Justice. She also served as senior faculty development consultant at the New York University Center for Teaching Excellence. Paul-Emile holds an A.B. in political science and in American civilization, with honors, from Brown University; a J.D. from Georgetown University Law Center; and a Ph.D. in American studies from New York University.

Amanda L. Sacks-Zimmerman, Ph.D., ABPP-CN
Assistant Professor of Neuropsychology, Department of Neurological Surgery, Weill Cornell Medicine

Amanda L. Sacks-Zimmerman, Ph.D., ABPP-CN, is a board-certified clinical neuropsychologist who has had extensive experience in assessing and treating neurological disorders with cognitive remediation as well as researching the cognitive impact of brain injury. She treats a variety of patients who suffer from cognitive and emotional difficulties that may be the result of epilepsy; radiation or chemotherapy; cardiopulmonary bypass procedures; surgery; cerebrovascular disease; stroke; silent infarcts; brain tumor resection; movement disorders such as multiple sclerosis, Parkinson’s disease, and Huntington’s disease; metabolic disorders; infectious processes such as encephalitis or Lyme disease; chemical toxin exposure; traumatic brain injury; and dementia diagnoses including mild cognitive impairment, Alzheimer’s disease, multi-infarct dementia, and frontal temporal dementia.

Dr. Sacks-Zimmerman received her undergraduate degree in Psychology from The George Washington University and her Ph.D. in Clinical Psychology from Fairleigh Dickinson University. She completed two postdoctoral fellowships, one at University Behavioral Healthcare, UMDNJ, where her research examined cognitive correlates of emotion in dementia, and one at Mount Sinai Medical Center in New York in the Department of Rehabilitation Medicine, where she was trained in assessing, treating, and researching acquired and traumatic brain injury. During that fellowship she assisted in deriving manualized Cognitive Behavioral Treatment for individuals post-TBI for the purpose of researching the efficacy of this treatment. As a faculty member of the Department of Anesthesiology at NYU Langone Medical Center, Dr. Sacks-Zimmerman analyzed and presented data on post-operative cognitive dysfunction as well as derived research studies on cognitive issues post-operatively in cardiac patients and cognitive issues related to compliance in the wound care population. She is currently conducting research to examine the efficacy of cognitive remediation programs on post-operative cognitive difficulties in brain tumor patients.

Christopher A. Seeger, J.D.
Founding Partner, Seeger Weiss LLP

Chris Seeger is a founding partner of Seeger Weiss and one of the nation’s leading attorneys in the areas of complex and mass tort actions. He has earned leadership appointments from state and federal courts throughout the U.S. in many noteworthy multi-district litigations, including pharmaceutical actions involving Vioxx, Zyprexa, Gadolinium, and DePuy ASR, among others. In 2012, the U.S. District Court for the Eastern District of Pennsylvania appointed Chris to lead the multi-district litigation against the National Football League arising out of concussion-related injuries sustained by thousands of former NFL players. In 2016, he was appointed to the Plaintiffs’ Steering Committee for the MDL concerning the Volkswagen diesel emissions controversy, in the U.S. District Court for the Northern District of California. Chris serves on the Settlement Committee and was one of the lead negotiators of a $14.7 billion settlement which includes a massive buyback program for consumers and billions of dollars for environmental remediation. Most recently, he was appointed Plaintiffs’ Co-Lead Counsel for the Proton Pump Inhibitor multidistrict litigation in the U.S. District Court for the District of New Jersey; to the Executive and Settlement Committees for the National Prescription Opiate litigation in U.S. District Court for the Northern District of Ohio; and to the Plaintiffs’ Settlement Committee, serving as Lead Negotiator, for the Syngenta GMO Corn litigation, resulting in a $1.5 billion nationwide settlement. He is an elected member of the American Law Institute; a member of the Board of Advisors to the NYU School of Law, Center on Civil Justice; and serves on an Advisory Council to the Duke Law Center for Judicial Studies.
During his tenure as the Executive Director of the NFL Players Association (NFLPA), DeMaurice Fitzgerald Smith signed a 10-year Collective Bargaining Agreement (CBA) with NFL management, leading the Players through the owners’ 132-day lockout. The new CBA codifies new health and safety protocols for Players, achieved longer off-seasons, significantly reduces the amount of contact during practices, provides for unannounced inspections of training camps, creates the first compliance and accountability structure for NFL medical personnel, and provides the Players’ with their highest share of TV contract revenues in history.

Prior to his post at the NFLPA, Smith was an Assistant United States Attorney in the District of Columbia and was Counsel to then-Deputy Attorney General Eric H. Holder, Jr. After Government service, Smith served as a Partner in the law firms of Latham & Watkins, LLP and Patton Boggs, LLP, in Washington, D.C. where he represented corporations, boards of directors and senior executives in civil and criminal matters.

Smith is a 1989 graduate of the University of Virginia School of Law and a 1985 graduate of Cedarville University. He resides in the Washington D.C. metropolitan area with his wife and two children.

Ryan Surujnath, J.D.
Dean's Fellow, Fordham University School of Law

Ryan Surujnath is a Dean’s Fellow with the Center for Neuroscience and Law, where he works with legal problems facing artificial intelligence. He obtained his J.D. from Fordham Law School in 2017 and his B.A. in history and political science from Rutgers University in 2014. While in law school, he published his Note on the use of blockchain technology in derivatives market infrastructure. His current research continues to focus on uses and regulatory implications of blockchain.

Terri Tanielian, M.A.
Senior Behavioral Scientist, RAND Corporation

Terri Tanielian is a senior behavioral scientist at the RAND Corporation. She is a nationally recognized expert in military and veteran health care policy. Tanielian was co–study director for RAND’s seminal 2008 study Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery and the principal investigator for RAND’s comprehensive study of military and veteran caregivers titled Hidden Heroes: America's Military Caregivers. She has conducted several assessments of issues facing veterans living in the Detroit Metropolitan Area, Massachusetts and in New York State. She has led several other studies including the Deployment Life Study, a study of military families across the deployment cycle, and a study examining community based models for expanding mental health care for veterans and their families under the Welcome Back Veterans Initiative. Tanielian has published numerous peer-reviewed articles, book chapters, and serves on many advisory committees related to veteran mental health policy. Tanielian was recognized with the AcademyHealth Impact Award in 2009 for her work related to the Invisible Wounds of War. Tanielian has a M.A. in psychology from American University.
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**Panel 4: The NFL Concussion Litigation: The Impact of Traumatic Brain Injury on America’s Most Popular Sport**


Deubert, Christopher R., Fernandez Lynch, Holly, Cohen, I. Glenn. Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations. (View Chapters 1-6 in document)
EVALUATING NFL PLAYER HEALTH AND PERFORMANCE: LEGAL AND ETHICAL ISSUES

JESSICA L. ROBERTS, I. GLENN COHEN, CHRISTOPHER R. DEUBERT & HOLLY FERNANDEZ LYNCH†

This Article follows the path of a hypothetical college football player with aspirations to play in the National Football League, explaining from a legal and

† George Butler Research Professor, Director of Health Law & Policy Institute, University of Houston Law Center, 2015–2018 Greenwall Faculty Scholar in Bioethics; Professor, Harvard Law School, Faculty Director of the Petrie–Flom Center for Health Law Policy, Biotechnology, and Bioethics, Co-Lead of the Law and Ethics Initiative, Football Players Health Study at Harvard University; Senior Law and Ethics Associate, Law and Ethics Initiative for the Football Players Health Study at Harvard University; Executive Director, Petrie–Flom Center for Health Law Policy, Biotechnology, and Bioethics, Faculty, Harvard Medical School, Center for Bioethics, Co-Lead, Law and Ethics Initiative, Football Players Health Study at Harvard University, respectively.

Cohen, Deubert, and Lynch received salary support from the Football Players Health Study at Harvard University (FPHS), a transformative research initiative with the goal of improving the health of professional football players. About, FOOTBALL PLAYERS HEALTH STUDY HARV. U., https://footballplayershealth.harvard.edu/about/ [https://perma.cc/UN3R-D82L]. Roberts has also received payment as a consultant for the FPHS. The Football Players Health Study was created pursuant to an agreement between Harvard University and the National Football League Players Association.
ethical perspective the health and performance evaluations he will likely face throughout his career. Some of these evaluations are commonplace and familiar, while others are more futuristic—and potentially of unproven value. How much information about themselves should aspiring and current professional players be expected to provide in the employment context? What are the current legal standards for employers collecting and acting on an individual’s health- and performance-related information? Drawing on disability law, privacy law, and the law governing genetic testing, this Article seeks to answer those questions, as well as to provide recommendations to better protect the health and privacy of professional football players.

The upshot of our analysis is that it appears that some of the existing evaluations of players, both at the NFL Scouting Combine (Combine) and once drafted and playing for a club, seem to violate existing federal employment discrimination laws. Specifically, (1) the medical examinations at the Combine potentially violate the Americans with Disabilities Act’s (ADA) prohibitions on pre-employment medical exams; (2) post-offer medical examinations that are made public potentially violate the ADA’s confidentiality provisions; (3) post-offer medical examinations that reveal a disability and result in discrimination—e.g., the rescission of a contract offer—potentially violate the ADA provided the player can still perform the essential job functions; (4) Combine medical examinations that include a request for a player’s family medical history potentially violate the Genetic Information Nondiscrimination Act (GINA); and (5) the preseason physical’s requirement that a player disclose his family medical history potentially violates GINA.
We believe all employers—including the NFL and its clubs—should comply fully with the current law. To that end, our recommendations center around four “C”s: compliance, clarity, circumvention, and changes to existing statutory schemes as applied to the NFL (and perhaps other professional sports).

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INTRODUCTION

Meet James. He is a twenty-two-year-old male who stands at 6’1” and weighs approximately 203 pounds. James has had a very successful college career as a wide receiver in the Pac-12 and now hopes to join the approximately 2200 men who play professionally for the National Football League (NFL). On any given NFL club, the vast majority of the players are in their twenties while approximately twenty percent are in their thirties. CHRISTOPHER R. DEUBERT, I. GLENN COHEN & HOLLY FERNANDEZ LYNCH, PETRIE–FLOM CTR. FOR HEALTH LAW POLICY, BIOTECHNOLOGY, AND BIOETHICS, PROTECTING AND PROMOTING THE HEALTH OF NFL PLAYERS: LEGAL AND ETHICAL ANALYSIS AND RECOMMENDATIONS 60 (2016). Online Appendix A contains a list of heights and weights by position. Jessica L. Roberts, I. Glenn Cohen, Christopher R. Deubert & Holly Fernandez Lynch, Evaluating NFL Player Health and Performance: Legal and Ethical Issues: Online appendix A (2017), https://www.pennlawreview.com/print/165-U-Pa-L-Rev-Appendix-A.pdf.
League (NFL) each regular season. But before he can realize his dream, James must face a series of health- and performance-based evaluations, designed to test whether he can withstand the rigors of playing professional football. Should James succeed as a professional athlete, any number of individuals will have a great interest in his health and fitness, from those who run the NFL clubs to the eighty-five million fans that will turn on their televisions every week to watch him play. But how much information about his health and his abilities should James be willing to share and, perhaps more importantly, with whom?

Before and during his NFL career, James will be asked to submit to any number of evaluations. Should James agree to an electrocardiogram (EKG) to assess the electrical activity of his heart and to put him (and his club) on notice if he is at risk of cardiac arrest as the result of overexertion? What about a running drill that, while not directly assessing the activity of James’s heart, will nonetheless demonstrate his cardiovascular capacity? What if an NFL club asked James to swallow a pill that would send wireless signals through his body to sensors that translate those signals into data about James’s heart rate, respiration, and skin temperature to share with an athletic trainer? How about a genetic test that assesses cardiac risk? Some of these examples may sound like science fiction but such technologies are currently being deployed by NFL clubs, and trends in this direction are only likely to increase. What about the decidedly low-tech method of just asking James about the history of cardiovascular disease in his family? Should James submit to all of these evaluations? Some of them? None of them? And if he refuses, what are his legal rights?

No one would presumably ever tolerate this degree of invasive inquiry into his or her health status and physical ability when applying for a standard office job. But those jobs do not require full-body collisions with other hulking athletes on a weekly basis. Nor do they promise the potential of multimillion dollar salaries. To be sure, prospective and current NFL players are physically exceptional human beings. Just compare James’s physique to the average American male between the ages of twenty and twenty-nine, who is 5'9" and weighs 183.9 pounds. Because of their extraordinary physiques and abilities, much of what we know about health within the “normal” population may not translate to NFL athletes. Further, the

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2 This figure is derived from official NFL–NFLPA playtime statistics on file with the authors.
average person does not subject himself to the kinds of physical challenges regularly encountered by NFL players.

NFL football is big business. The NFL began play in 1920\(^6\) and since that time has been the premier professional football league in the world and one of the most lucrative of all the sports leagues. The NFL generates about $12 billion in revenue annually\(^7\) and is the most popular sport in America by a variety of measures.\(^8\) Thirty-five percent of Americans consider NFL football their favorite sport, a number that continues to increase.\(^9\) On average, approximately 68,000 people attend every NFL game.\(^10\) Moreover, NFL games are the most watched television programming. More than twenty million people watch the primetime broadcasts, nearly triple the ratings of the major television networks.\(^11\) In 2015, Forbes estimated the average NFL club to be worth $1.97 billion.\(^12\) The average salary of an NFL player is approximately $2 million per year\(^13\) but varies widely based on skill and experience. The National Football League Players Association (NFLPA) estimates that the average player’s career is about three and a half years long, while the NFL asserts that it is nearly six years.\(^14\) All of these features are dramatically different as compared to the employment context of the average office worker, or even to those in more physically demanding jobs.

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\(^8\) See, e.g., Regina Corso, As American As Mom, Apple Pie, and Football?, HARRIS POLL (Jan. 16, 2014), http://www.theharrispoll.com/sports/As_American_as_Mom__Apple_Pie_and_Football__html [http://perma.cc/4VAW-NQME] (explaining that 35% of Americans say that football is their favorite sport while just 14% prefer baseball, the second most popular sport).

\(^9\) Id.


\(^14\) See What Is Average NFL Player’s Career Length? Longer than You Might Think, Commissioner Goodell Says, NFL COMM. (Apr. 18, 2011), http://nflabor.wordpress.com/2011/04/18/what-is-average-nfl-player%26%238211%3Bcareer-length-longer-than-you-might-think-commissioner-goodell-says [http://perma.cc/YG3W-D3S8] (explaining that NFL Commissioner Roger Goodell attributes the difference in the NFL’s estimates to the fact that other estimates include every player who ever signed an NFL contract while the NFL only includes players who made an NFL regular season roster).
Given the revenue and prestige of the sport, and the clear consumer interest, the NFL and its clubs have strong incentives to scout, draft, and retain the highest performing players. As a result, they want to obtain as much information as they can about a player’s current health, athletic abilities, and risks of future injury or disease to facilitate as informed a decision as possible. Moreover, with that kind of fame and money on the line, prospective and current NFL players face substantial pressure to do what they need to do to play professional football, which inevitably includes submitting to numerous health and performance evaluations, even if they would prefer to avoid them, all things being equal.

At present, the NFL and the clubs already collect a significant amount of information about aspiring and current players through medical exams (including physicals) and athletic drills and training. While this existing data is important, it represents only the tip of the iceberg regarding the information NFL clubs would like to have in making decisions related to hiring, firing, trading, and playing.

Not surprisingly then, companies are creating all kinds of new technologies designed to assess health and physical performance. The ingestible pill described above is not science fiction but is based on an actual FDA-approved innovation. Companies are also designing ever-shrinking wearable technologies to measure speed, agility, and strength, as well as genetic tests, which could be used to assess risk or enhance performance. These new evaluative technologies could give stakeholders access to even more data. Consequently, the technologies could also pose a potential concern for players who may fear that the results of those evaluations could cost them their careers. All of this raises a fundamental question: How does the current law apply to these approaches when deployed in employment contexts? This Article, the first to address these issues, seeks to provide an answer.

Focusing on the employment relationship between NFL players, the clubs, and the league, we explore the applicability of two key federal employment discrimination statutes: the Americans with Disabilities Act (ADA) and the Genetic Information Nondiscrimination Act (GINA). Both the ADA and GINA contain provisions limiting an employer’s access to and use of current or prospective employees’ health-related information.

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15 See infra subsection I.B.2.
17 See infra subsection I.B.2.
18 See infra subsection I.B.3.
The ADA, which Congress passed in 1990 and amended in 2008, protects people with disabilities against discrimination across several spheres, including employment, government services, and public accommodations. While it may seem counterintuitive to apply a disability rights law to an elite athlete who is in peak physical condition like James, the ADA's employment provisions nonetheless cover professional sports, and a professional athlete may meet the legal definition of a person with a disability. Most notably, the law restricts employers' ability to seek health-related information about their prospective and current employees through either medical exams or disability-related inquiries. Moreover, the ADA also prohibits employers from discriminating on the basis of disability, unless that discrimination implicates the employee's ability to safely perform the job in question.

GINA provides additional protection, outlawing discrimination on the basis of genetic information in health insurance and in employment. Congress passed GINA in 2008 to assuage people's concerns about genetic privacy and genetic discrimination. Genetic information, as defined by the law, includes a person's genetic test results, the genetic test results of his family members, and his family medical history. Like the ADA, GINA imposes constraints on both an employer's ability to obtain, as well as to act on, the covered information. However, unlike the ADA, GINA does not include health- or safety-related exceptions for discrimination. Consequently, an employer cannot make decisions based on lawfully obtained genetic information, even if the outcome of that choice would be in the interest of job performance or safety.

Given the wide coverage of both the ADA and GINA, we conclude that the NFL and the clubs may already be violating these laws with their current practices. Additionally, as new technologies develop, those entities will be

21 Title I of the ADA applies to employers, employment agencies, labor organizations, and joint labor-management committees. 42 U.S.C. § 12111(2) (2012). The statute, in relevant part, defines an employer as “a person engaged in an industry affecting commerce who has 15 or more employees for each working day in each of 20 or more calendar weeks in the current or preceding calendar year, and any agent of such person.” Id. § 12111(5)(A). The statute provides no explicit exception for professional sports.
22 Id. § 12112(d)(1)–(2), (4); see also infra notes 172–75 and accompanying text.
23 See infra notes 290–300 and accompanying text.
27 See infra note 313 and accompanying text.
28 GINA does, however, include several exceptions for the acquisition of genetic information, including for wellness programs. See infra notes 372–83 and accompanying text.
further tempted to seek and act on even more information about current and prospective players. Some of the new innovations blur the line between evaluations of health and evaluations of performance, pushing the boundaries of which evaluations are medical or genetic—and are thus covered by the ADA or GINA—and which evaluations merely assess athletic ability or potential—and are not. Based on our analysis of the ADA and GINA, we argue that the existing legal safeguards, both as written and as applied, could benefit from additional clarification, as well as certain changes.

First, we assert that the NFL and its clubs should ensure that they are complying with the current law. We are concerned that a number of potential legal violations may be occurring with respect to (1) medical examinations at the NFL Scouting Combine (Combine) (an annual event each February in which approximately 300 of the best college football players are invited to undergo medical examinations, intelligence tests, interviews, and multiple football and other athletic drills and tests in the hopes of demonstrating their prowess and landing a spot in the NFL29); (2) post-offer medical examinations that are made public; (3) post-offer medical examinations that reveal a disability and that result in an adverse employment action; (4) Combine medical examinations that include a request for a player’s family medical history; and (5) the preseason physical’s disclosure requirements. Second, we suggest areas where the ambiguous state of the present legal regulation demands additional clarity. Third, we identify areas of possible legal circumvention and argue against them. Finally, we outline potential changes to the law. To that end, we suggest potential reforms to better strike the balance between the players’ autonomy and privacy and the interests of the NFL and its clubs in avoiding liability, in having the most competitive players, and in protecting players from injury.

This Article is the first in-depth analysis of the law and ethics of health and performance evaluations in the NFL (or any professional sports league). It proceeds in three parts. Part I provides the necessary background for understanding the possible impact of various traditional and cutting edge evaluative technologies on NFL players. It begins by identifying the relevant parties and stakeholders and their relationships. Part I then proceeds to describe both existing and prospective technologies that are either already being used by—or of potential interest to—the NFL and its clubs.30 Building off this foundation, Part II explores the existing law governing the acquisition and use of health, medical, and performance evaluations by the NFL, its clubs, and National Football Scouting—focusing on the ADA and GINA—and applies those laws to the practices and technologies outlined in Part I. Finally, Part III turns to recommendations for the future. We conclude with

30 For more on these technologies, see Online Appendix B, supra note 16.
our four “C”s: compliance, clarification, circumvention, and changes. While our focus is on the NFL, our analysis and recommendations have clear implications for other professional sports leagues, and potentially also for other workplaces that will rely on evaluating technologies.

I. BACKGROUND ON THE NFL AND EVALUATIVE TECHNOLOGIES

Much like its exceptional players, the NFL is not a typical employer. Individuals like James who aspire to play professional football will find themselves interacting with several separate but related legal entities, including the NFLPA, the NFL, the clubs themselves (as well as their medical and training staffs), the entities that organize the Combine, and the private companies seeking to develop and market technologies to these stakeholders. Because of the complexity of these relationships, understanding them is essential to our analysis. To that end, Part I presents the factual and technological background necessary to assess the legal and ethical implications of the use of health- and performance-related evaluations by the NFL and its clubs. It begins by describing the relationships between the various relevant parties before turning to the practices and technologies currently available for measuring NFL players’ health and performance.

A. Interested Parties

The use or potential use of both traditional and cutting edge evaluative technologies in the NFL has major implications for a variety of stakeholders, including most importantly (1) the players and their union, the NFLPA; (2) the NFL and its clubs; (3) the club doctors and athletic trainers; and (4) the private companies responsible for developing the new evaluative technologies. Below we provide background information about these stakeholders to help understand the legal and ethical issues raised by both old and new health and fitness evaluations.

Each season, approximately 2200 players play in the NFL.31 As explained in their Collective Bargaining Agreement (CBA), players are the employees of their respective clubs.32 Their union is the NFLPA. Pursuant to the National Labor Relations Act (NLRA), the NFLPA is “the exclusive representative[ ] of all the employees in [the bargaining] unit for the purposes of collective bargaining in respect to rates of pay, wages, hours of

31 This figure is derived from official NFL–NFLPA playtime statistics (on file with authors).
employment, or other conditions of employment.” The bargaining unit consists of

1. All professional football players employed by a member club of the National Football League;
2. All professional football players who have been previously employed by a member club of the National Football League who are seeking employment with an NFL Club;
3. All rookie players once they are selected in the current year’s NFL College Draft; and
4. All undrafted rookie players once they commence negotiation with an NFL Club concerning employment as a player.

The NLRA requires NFL clubs, acting collectively as the NFL, to bargain collectively with the NFLPA concerning the “wages, hours, and other terms and conditions of employment” for NFL players.

From a legal perspective, the NFL is an unincorporated association of thirty-two member clubs. Each club is a separate and distinct legal entity, with its own legal obligations. However, the NFL also serves as a centralized body for the clubs, including facilitating shared policy and decisionmaking.

The CBA obligates NFL clubs to retain, or hire as consultants, doctors with a variety of specialties, including but not limited to orthopedics, cardiovascular disease, and neurology. Club doctors perform a variety of duties, including

1. providing healthcare to the players;
2. helping players determine when they are ready to return to play;
3. helping clubs determine when players are ready to return to play;
4. examining players the club is considering employing, e.g., at the NFL Combine or as part of free agency; and,
5. helping to clubs determine whether a player’s contract should be terminated.

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34 Collective Bargaining Agreement, supra note 32, pmbl.
37 Cf. Brady v. Nat’l Football League, 640 F.3d 785, 787 (8th Cir. 2011) (per curiam) (providing an example of a case in which each of the thirty-two teams and the NFL were named codefendants).
38 See Const. and Bylaws of the National Football League art. II, § 2.1(A) (stating that the purpose of the NFL is “[t]o promote and foster the primary business of League members, each member being an owner of a professional football club located in the United States”).
39 Collective Bargaining Agreement, supra note 32, art. 39, § 3(a)-(b). Of the thirty-two NFL clubs, only two directly employ any of their club doctors while the other thirty clubs enter into independent contractor arrangements with the doctors. Telephone Interview with Larry Ferazani, Vice President, Labor Litig. & Policy, Nat’l Football League (Oct. 6, 2014).
because of the player’s physical condition, e.g., whether an injury will prevent
the player from playing.\textsuperscript{40}

Each NFL club also employs approximately four athletic trainers, including a
head athletic trainer and three assistants.\textsuperscript{41} Club doctors principally rely on the
athletic trainers to monitor and handle the players’ health during the week.\textsuperscript{42}

National Football Scouting is also relevant when applying the ADA and
GINA to the NFL. National Football Scouting is an organization that provides
scouting services to NFL clubs and that is owned and managed as a joint
endeavor by twenty of the NFL’s thirty-two clubs.\textsuperscript{43} National Football Scouting
also owns and controls National Invitational Camp, the legal entity that is the
Combine.\textsuperscript{44} National Football Scouting, through National Invitational Camp,
runs the Combine.\textsuperscript{45} As will be demonstrated below, we are not concerned with
the application of the ADA and GINA to National Football Scouting directly,
but instead with the application of the ADA and GINA to the NFL and NFL
clubs as a result of their relationship with National Football Scouting.\textsuperscript{46}

NFL club executives, coaches, scouts, doctors and athletic trainers attend
the Combine to evaluate the players for the upcoming NFL Draft.\textsuperscript{47}

According to Jeff Foster, the President of National Football Scouting, all thirty-
two NFL clubs consider the medical exams (and not the athletic drills) to be the
most important part of the Combine.\textsuperscript{48} Since 1987, doctors with IU Health, a
healthcare system affiliated with Indiana University School of Medicine, perform
x-rays, MRIs and other exams at each year’s Combine.\textsuperscript{49} The IU Health doctors

\textsuperscript{40} DEUBERT, COHEN & LYNCH, supra note 1, at 95; see also Collective Bargaining Agreement,
supra note 32, app. A, para. 8 (“If Player fails to establish or maintain his excellent physical condition
to the satisfaction of the Club physician . . . then Club may terminate this contract.”).

\textsuperscript{41} Athletic trainers—unlike most club doctors—are full-time employees of the club and are
with the club and the players at almost all times. DEUBERT, COHEN & LYNCH, supra note 1, at 160.

\textsuperscript{42} See Frequently Asked Questions, NFL PHYSICIANS SOC’Y, http://nflps.org/faqs/how-do-nflps-
CPZ5-JKTE] (“There is a constant source of dialogue between the athletic trainers and the team
physicians in all aspects of the player’s care.”).

\textsuperscript{43} Bill Bradley, Too Much Overlap Caused NFL to Create Annual Scouting Combine, NFL (Feb.
caused-nfl-to-create-annual-scouting-combine [https://perma.cc/Y3FH-X6ZQ].

\textsuperscript{44} Jeff Foster Talks About Challenges of Hosting NFL Scouting Combine, NFL (Feb. 19, 2014, 1:27

\textsuperscript{45} Id.

\textsuperscript{46} See infra subsection III.B.2.

\textsuperscript{47} Home, NFL SCOUTING COMBINE, http://www.nflcombine.net/ [http://perma.cc/7ZSS-YBSP].

\textsuperscript{48} Albert Breer, NFL Scouting Combine’s Evolution Raises Questions About Future, NFL (July 22,
2014, 12:05 PM), http://www.nfl.com/story/nflcombinedraft/20140722/nfl-scouting-combine-

\textsuperscript{49} See id. (‘‘350 MRIs were conducted on 330 players in a four-day period, with IU Health—a
Combine partner for 28 years . . . .’’); Jeff Foster Talks About Challenges of Hosting NFL Scouting
perform examinations on behalf of the Combine, which then provides the results to NFL clubs. 

After the IU Health examinations, club doctors also evaluate the participants. 

The medical examinations at the Combine generally include x-rays, MRIs, echocardiograms, EKGs, and blood analysis. Participants must also take a drug test. Dr. Richard Kovacs, a cardiologist with IU Health, describes the medical exams as "the choke point [because] ... [n]o one goes to [the Combine] until they go through us." These details about the structure of the Combine and the specific individuals who do the examining will prove important for the legal analysis in Part II.

The NFL exercises considerable control over the Combine, including helping to make decisions about the drills players perform, selling public tickets, and broadcasting the event on television. Thus, as we argue below, National Football Scouting may be understood for ADA and GINA purposes as an arm of at least some clubs and of the NFL itself. At a minimum, it provides the NFL and the clubs with the very types of information that the ADA and GINA seek to regulate.

Lastly, many private technology companies both in the U.S. and abroad are creating biological and other health-related products principally geared toward a sports application, making those companies important stakeholders in the conversation about evaluating NFL player health and performance. Biometric companies are working on technologies, with some focusing specifically on genetic tests. For example, several companies are putting cutting-edge technology into wearable devices that generate a variety of biological data. As these technologies get smaller and smaller, robust data

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50 Bradley, supra note 43.
51 Deubert, Cohen & Lynch, supra note 1, at 113.
55 Deubert, Cohen & Lynch, supra note 1, at 112.
56 See infra text accompanying notes 154–56.
57 See infra subsections 1.B.2–3.
generation and collection will increase over time. These companies are responding to market demands, incorporating technologies that can help athletes (professional and amateur) improve their performance and also those that can help athletes be healthier and safer. Given that these demands are principal concerns of the NFL and many other powerful sports leagues, there are powerful economic incentives for the continued creation and expansion of new evaluative technologies.

B. Current and Prospective Technologies

Having identified the relevant stakeholders, here we turn to the kinds of evaluative technologies that are either currently being used or could potentially be used to assess the health and performance of current and aspiring NFL players. Although related, health and performance are not completely synonymous. For example, while detecting a cardiac abnormality speaks to a potential player’s health, he might still be capable of performing at a high level in the present, just with a greater degree of future risk. Thus, when appropriate, we attempt to differentiate measures of health from measures of performance, but we do so cautiously and with the knowledge that these categories frequently overlap. For this reason, we employ the broader rubric of “evaluative” technology, which we intend to include assessments of medical conditions, performance, potential, and risk.

NFL players are subject to a wide variety of assessments of their health, physical condition, and abilities. These evaluations range from athletic drills and traditional medical examinations to cutting-edge wearable technologies and genetic tests. The following sections discuss each of these different types of tests and technologies and their application to professional athletes as groundwork for analyzing the legal implications.

1. Medical Examinations and Athletic Drills

The first category of evaluations is medical examinations and athletic drills. Athletic drills, as used here, refer to skills and performance-based evaluations that are not principally diagnostic. In other words, while medical examinations assess health and wellness, athletic drills are primarily intended to assess skill and performance. This distinction can of course be muddy. For example, both types of assessments could meet a particular legal definition of a medical exam, which we explain in Part II.59

58 Online Appendix B catalogues such technologies in much more exhaustive detail.
59 See infra subsection II.A.1.a.
a. Medical Examinations

As discussed above, players undergo a wide battery of medical examinations during the Combine. Some have labeled the Combine’s medical examinations dehumanizing. One former NFL player, Aaron Collins, described the Combine as follows:

During the physical exams, they pull on every bone in your body, and evaluate everything and X-ray everything. You are like a slab of beef . . . . It’s a meat market. There is not much dignity in it. They are evaluating potential. They check your legs, and pull on you. They check your knees and your ankles, pulling every joint. If you ever had surgery, they X-ray that part of your body a thousand times. They X-ray everybody’s chest, their heart, their this, their that. You take a stress test. You walk on a treadmill. You do everything. At the Combine, every player gets totally evaluated by every team doctor. They stand around you, they slap you on the table, and they evaluate you. This may be one of the first times that you realize that you are no longer Aaron Collins, person—you are Aaron Collins, commodity. It’s a job.

NFL hopefuls who attend the Combine all sign broad authorizations for the release, disclosure, and use of their otherwise private medical and mental health information. In addition, these documents give permission to release and to disclose the entirety of a player’s physical and mental health records (with the exception of psychotherapy notes) and direct a wide range of entities—including both physicians and mental health care professionals, as well as athletic trainers and amateur and professional sports organizations—to provide and to discuss that information with National Football Scouting, the NFL, the clubs and their affiliates, and certain third parties under contract with the NFL. The authorizations are in effect for two years following signing, and a player maintains a limited right to revoke the authorization for information that has not yet been released.

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60 See supra note 52 and accompanying text.
62 Participants in the Combine are asked to sign two documents: (1) an authorization for the use and disclosure of records and information and (2) an authorization for release and disclosure of medical and mental health records. These are reproduced in Online Appendix C. Jessica L. Roberts, I. Glenn Cohen, Christopher R. Deubert & Holly Fernandez Lynch, Evaluating NFL Player Health and Performance: Legal and Ethical Issues: Online app. C (2017), https://www.pennlawreview.com/print/65-U-Pa-L-Rev-Appendix-C.pdf [hereinafter Online Appendix C]. While execution of these waivers is ostensibly voluntary, it is not believed that any players refuse to sign them. DEUBERT, COHEN & LYNCH, supra note 1, at 99 n.k.
63 Online Appendix C, supra note 62.
64 Id. at 4, 7-8.
The medical exams continue after the player has been drafted and joined a club. Every player undergoes a standard minimum preseason physical—conducted by the club doctors—that covers a general medical examination, an orthopedic examination, flexibility testing, an EKG, an echocardiogram, blood testing, baseline neuropsychological testing, urinalysis, vision testing, hearing testing, a dental examination, a chest X-ray, and an X-ray of all previously injured areas. During the season, players often undergo a variety of medical exams if they have been injured or potentially injured. Additionally, the CBA requires players to submit to physicals at their club’s request. And finally, players receive a physical at the conclusion of the season, also conducted by the club doctor.

The results of the medical examinations described above can have a real impact on a player’s career. Take, for example, the case of Star Lotulelei who, during the 2013 Combine, dropped from being one of the top projected draft picks to number fourteen after an irregular echocardiogram. While a subsequent MRI showed no evidence of a heart abnormality, the damage was already done. That result arguably cost Lotulelei millions of dollars, as he was drafted lower than expected. Similarly, in the 2016 NFL Draft, Notre Dame linebacker Jaylon Smith, UCLA linebacker Myles Jack, and Alabama linebacker Reggie Ragland all went from projected first-round draft picks to second-round draft picks because of suspected medical issues: Smith and Jack had knee injuries, while Ragland was diagnosed with an enlarged aorta during pre-draft medical exams.
b. Drills

In addition to the medical examinations, the players participate in multiple athletic drills at the Combine, including the forty-yard dash, bench press, vertical jump, broad jump, three-cone drill, twenty-yard shuttle, and sixty-yard shuttle.72 While these drills demonstrate a player’s speed, agility, and athleticism, they can also serve a medical purpose by exposing physical limitations the player might have due to past or current injuries. Clubs certainly have an interest in testing players with injury histories at the Combine to see if they have fully healed from a particular injury or surgery and to judge whether the player will ever be able to be in the same condition he was prior to the injury.

Like the medical exams, this kind of testing does not end at the Combine. Players are often subjected to more of the same athletic drills leading up to the NFL Draft in private meetings and workouts with clubs.73 Athletic drills are also a central part of the player’s employment once he is with an NFL club. Training camps and practices consist of all kinds of athletic drills and football-related activities. While football is the primary focus of these drills, they can also have a medical component. The drills will constantly demonstrate the player’s current physical health and ability, including whether he has any injuries or has not fully recovered from previous injuries.

The evaluations might be even more intensive if the player is not yet a member of the club. Typically every Tuesday during the regular season (which is the players’ normal rest day following a Sunday game), clubs will hold tryouts for unemployed players that play positions where either the club

(footnotes)

has recently suffered an injury or where the club is looking to upgrade. The tryouts typically consist of a variety of football drills, sometimes against other prospective players. While these assessments are focused on the player’s skill level, like the other athletic drills, they also reveal a player’s physical condition, including recovery from prior injuries. As part of the tryout, the club also generally subjects the player to a basic physical and, assuming that goes well, signs the player to a contract.

Although the Tuesday tryouts are generally for the players fighting to get back into the NFL, star players are also occasionally subjected to similar evaluations. Beginning in March of every year, unrestricted free agents are able to offer their services to any and all clubs but first must pass a physical. If the player does not pass the physical, any contract offer will be revoked and the player is once again a free agent, but now with the black mark of a failed physical as reported by the media.

In sum, both before they are hired to play NFL football and throughout their playing careers, players are constantly subjected to medical examinations and athletic drills. These are high stakes events, with careers and significant sums of money on the line each time. These examinations and drills—particularly those conducted at the pre-employment stage—are not primarily aimed at protecting player health, but instead are done with the business purpose of evaluating a player’s ability to perform successfully on the field and enable the club to win. In other words, while they may have some benefit to the


76 An unrestricted free agent is “any player with four or more Accrued Seasons . . . at the expiration of his Player Contract.” He is “completely free to negotiate and sign a Player Contract with any Club, and any Club shall be completely free to negotiate and sign a Player Contract with such player, without penalty or restriction.” Collective Bargaining Agreement, supra note 32, art. 9, § i(a).

players, the primary interest of the NFL and its clubs in the medical evaluations and athletic drills is to obtain as much information as possible about a player’s current and future ability to help the club. For example, before offering a long-term contract to a player, a club would want to examine the player’s injury history to evaluate the likelihood of future injury.

2. Nongenetic Technologies

Medical examinations and athletic drills are traditional forms of health surveillance by NFL clubs. In the last several years many technology companies have been creating new products to measure player health. We focus our analysis here on products that NFL clubs are already using or are likely to use in the future, including at the Combine. While no categorization is perfect, the products these companies produce generally fall into eight categories: (1) player tracking, (2) heart rate, (3) sleep, (4) readiness, (5) body temperature, (6) force, (7) hydration, and (8) head impact sensors. Clubs may use these technologies for evaluating and improving performance, as well as for preventing or minimizing injury. For example, in 2015, the Philadelphia Eagles held their star running back out of practice because his hydration level was too low.

In what follows, we provide summaries of four examples of technologies we believe are the most relevant to the legal and ethical issues discussed in this Article, though many others are detailed in Online Appendix B: (1) Catapult Sports (Catapult) / Zebra Technologies (Zebra); (2) Fatigue Science; (3) BioForce HRV; and (4) X2 Biosystems.

First, tracking technologies are of interest to the NFL. Catapult is an Australian company that provides matchbook-sized GPS devices, known as the OptimEye system, that can be worn on a player’s uniform. The devices contain sensors capable of measuring and collecting data about the player’s performance, including agility, force, and acceleration. The data is transmitted by radio to

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78 Online Appendix B includes detailed information about thirteen companies that have developed such technologies for use in professional or elite-level sports and their effects on players.

79 See Tom Pelissero, NFL Ponders Changes to Tests Given at Annual Scouting Combine, USA TODAY (Feb. 22, 2016, 12:13 AM), http://www.usatoday.com/story/sports/nfl/2016/02/21/scouting-combine-changes/80700052/ (describing the steps the NFL is taking to integrate new technology into the Combine).

80 See Josh Alper, Chip Kelly: DeMarco Murray Was Held Out of Practice Because of Hydration Issue, NBC SPORTS: PRO FOOTBALL TALK (Aug. 4, 2015, 1:15 PM), http://profootballtalk.nbcsports.com/2015/08/04/chip-kelly-demarco-murray-held-out-of-practice-because-of-hydration-issue/ (explaining the team’s decision and highlighting the coach’s comment that “[i]t’s not just for [Murray], we treat every player on a daily basis” (alteration in original) (internal quotation marks omitted)).


82 Id.
cloud-based software for analysis.\textsuperscript{83} Similarly, San Diego–based Zebra produces a wearable Real Time Locating System (RTLS) sensor for a player’s shoulder pads.\textsuperscript{84} Zebra’s technology collects data such as position, speed, and distance that are registered and compiled into a database.\textsuperscript{85} Unlike Catapult’s devices, the Zebra technology does not measure force, so it does not help players avoid injury.\textsuperscript{86}

As of November 2016, seventeen NFL clubs use Catapult’s devices.\textsuperscript{87} Clubs are principally focused on using the technology to prevent injuries.\textsuperscript{88} The device enables the club to identify which players have exerted high amounts of force and, as a result, have them participate less or at a lower intensity in future practices.\textsuperscript{89} It also enables the club to design practices that are more efficient and less strenuous for the players, as well as create practice regimens that suit the needs of each position.\textsuperscript{90} Some players will suffer because of the technology: it will identify which players are moving slower and less forcefully than others, which could cause a club to terminate those players’ contracts.\textsuperscript{91}

By contrast, Zebra is “The Official On-Field Player Tracking Provider” of the NFL.\textsuperscript{92} In July 2014, the NFL announced that it would install Zebra’s technology in seventeen stadiums during the 2014 NFL season.\textsuperscript{93} Specifically, the NFL installed the technology in the fifteen stadiums that hosted Thursday Night Football games that season.\textsuperscript{94} In a 2015 New York Times article, an official with the company that distributes Zebra’s data described the technology as “the future of sports” given the amount of data that is currently available.\textsuperscript{95} Coaches and trainers certainly seem interested in putting that newly available information to

\textsuperscript{83} Id.
\textsuperscript{85} Id.
\textsuperscript{86} See id. (noting that the technology “capture[s] precise location measurements”).
\textsuperscript{88} Id.
\textsuperscript{89} Id.
\textsuperscript{90} Id.
\textsuperscript{91} See supra note 40 and accompanying text.
\textsuperscript{93} NFL Commc’ns, supra note 84.
\textsuperscript{94} Id.
use. The Seahawks’ director of player health and performance, Sam Ramsden,
explained that Zebra’s technology could help him assess whether his players are
injured or tired based on their speed and other factors. Ramsden noted, “I look
at it more as segue to have a conversation with the player . . . . The data is
basically saying, ‘Looks like you weren’t cutting as hard today—is there
something going on?’” Thus, technologies like those produced by Catapult and
Zebra can empower players by giving them more information, which could in
turn enhance performance or prevent injury. However, that same data could
result in their being benched, traded, or terminated.

Second, Fatigue Science is a Canadian company that offers a wrist-worn
device called a Readiband that is worn while sleeping to collect data about an
athlete’s sleep, including quality, quantity, and timing. The Readiband captures
actigraphy data by taking sixteen 3D measurements of the tiny movements in the
wearers’ wrist per second and uses the acquired data to determine when a person
is sleeping. The data is then analyzed using a web-based application. The
Seattle Seahawks and the New York Giants currently use the Readiband, and
news reports indicate that other NFL clubs may be using similar technology.

Fatigue Science’s technology could both benefit and harm players. The
importance of sleep from a medical and scientific viewpoint is well-established.

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96 Id.
97 Id. (internal quotation marks omitted).
99 See C.A. RUSSELL ET AL., ARCHINOETICS, LLC, VALIDATION OF THE FATIGUE SCIENCE
READIBAND™ ACTIGRAPH AND ASSOCIATED SLEEP/WAKE CLASSIFICATION ALGORITHMS 7
(undated), https://fatigue-science.squarespace.com/s/Readiband_Validation.pdf [https://perma.cc/R8W8-GBHC] (describing how actigraphy can be used to monitor sleep).
100 Team Platform, supra note 98 (discussing coaches’ access to data from the Readiband via coaching dashboards).
102 See Cheri D. Mah et al., The Effects of Sleep Extension on the Athletic Performance of Collegiate Basketball Players, 34 SLEEP 943, 943 (2011) (“Several studies have also demonstrated the negative impact of sleep restriction on physical performance . . . .”).
Studies link better sleep with improved athletic performance. Unfortunately, a 2003 study found that 34% of offensive linemen (the biggest players on each club) suffered from sleep apnea. Yet one possible downside is that clubs may learn that a player is failing to get good sleep because of off-the-field behaviors, such as staying out late. Such data might also lead the club to reconsider the player's short-term or long-term employment.

Third, BioForce HRV (BioForce), a Washington-based company founded by the Seahawks’ former strength and conditioning coach, offers an online and smartphone application that collects data to measure heart rate variability (HRV). BioForce claims that HRV is a measure of an athlete’s “readiness and fatigue.” The software is designed to work with other heart rate monitors.

BioForce’s technology, which it claims is used by NFL clubs, could help both players and their clubs. Heart rate can be a useful measure of an athlete’s exertion levels. By knowing his heart rate, the player (or his coach) can either increase or decrease the intensity of the workout as appropriate. Moreover, as with Fatigue Science’s Readiband, the player may learn of a medical condition that he should take steps to address. However, the club might learn medical information about the player, such as an irregular heartbeat, that could cause the club to reconsider the player’s employment in the short or long term.

Fourth, X2 Biosystems (X2), another Washington-based company, offers two types of sensors designed to measure the force of hits sustained by players and to transmit that data wirelessly to a mobile device. The first sensor is embedded into the player’s mouthguard, and the second is worn as a patch.

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103 See id. at 946 (describing how several members of the Stanford University men’s basketball team demonstrated an improvement in performance after sleep extension over five to seven weeks); Roger S. Smith et al., The Impact of Circadian Misalignment on Athletic Performance in Professional Football Players, 36 SLEEP 1999, 2000 (2013) (“Sleep deprivation can impair performance in athletes and can increase the risks of accidents and morbidity/mortality in the general public.”).


107 Id.


behind the player’s ear.\textsuperscript{111} X2 also offers software that can gather data to help diagnose concussions.\textsuperscript{112}

Since the 2013 season, the NFL has required all clubs to use X2’s software to evaluate possible concussions.\textsuperscript{113} If these products are accurate, they may protect the health of players. However, players and the NFLPA have expressed resistance to the sensors.\textsuperscript{114} Specifically, players are concerned that the data might not be reliable and will result in players being removed from games unnecessarily.\textsuperscript{115} Additionally, players are concerned that clubs will use the data to avoid employing players with a history of concussions.\textsuperscript{116}

The NFLPA is aware of these shifts in technology. NFLPA Vice President of Business and Legal Affairs, Sean Sansiveri, has expressed an interest in monetizing new technologies, noting that the NFLPA’s licensing arm has followed emerging technologies, such as wearable technologies, with great interest.\textsuperscript{117} Not surprisingly, the CBA specifically addresses wearable technologies:

The NFL may require all NFL players to wear during games and practices equipment that contains sensors or other nonobtrusive tracking devices for purposes of collecting information regarding the performance of NFL games, including players’ performances and movements, as well as medical and other player safety-related data. Sensors shall not be placed on helmets without the NFLPA’s consent. Before using sensors for health or medical purposes, the NFL shall obtain the NFLPA’s consent.\textsuperscript{118}

As mentioned, the line between a technology being used for “performance” purposes, as opposed to “health or medical” purposes is not clear.\textsuperscript{119} Relatedly, the

\textsuperscript{111} Id.
\textsuperscript{112} See X2 Head-Trax Head Impact Management Solution, X2 BIOSYSTEMS, http://x2biosystems.com/x2_integrated_concussion/ [https://perma.cc/F7HX-8DRM] (describing X2’s Head-Trax head impact management solution and X2’s Integrated Concussion Evaluation (ICE) app).
\textsuperscript{115} Id.
\textsuperscript{116} See, e.g., id. (“[F]ormer Steeler Hines Ward [said] that . . . sensors would open up a ‘Pandora’s box’ by providing data that could be used to remove players from games or even in contract negotiations.”).
\textsuperscript{118} Collective Bargaining Agreement, supra note 32, art. 51, § 13(c).
\textsuperscript{119} See supra Section I.B.
NFLPA has recently filed a grievance over the use of sleep monitors, alleging that clubs must obtain NFLPA approval before employing such devices.\footnote[120]{Michael David Smith, \textit{As Teams Monitor Players' Sleeping Habits, NFLPA Cries Foul}, NBC SPORTS: PROFOOTBALLTALK (Oct. 22, 2015, 4:28 PM), http://profootballtalk.nbcSports.com/2015/10/22/as-teams-monitor-players-sleeping-habits-nflpa-cries-foul/ [https://perma.cc/R4Z9-EL4E].} Next, we turn to genetic tests, another area of technology that presents both opportunities and concerns for NFL players.

3. Genetic Tests

It is undeniable that genes have a major influence in the biological processes required for athletic success, including but not limited to muscle and cartilage formation, metabolism, and blood oxygenation.\footnote[121]{See Mario Kambouris et al., \textit{Predictive Genomics DNA Profiling for Athletic Performance}, 6 \textit{RECENT PATENTS ON DNA & GENE SEQUENCES} 229, 229 (2012).} Thus, genetic testing may detect both genetic advantages and barriers to successful athletic performance.\footnote[122]{Id.} The genetic technologies available at present can be divided into two major categories: (1) those associated with performance and (2) those associated with risk of injury.

Of course, genetic potential does not ensure athletic success, or vice versa—it is well known that genotype does not always express itself in phenotype—and the science to test relevant genotypes for sports is still in its infancy. Thus, currently available testing can merely help to predict who will be more successful on the playing field.\footnote[123]{See Reeves Wiedeman, \textit{Searching for the Perfect Athlete}, \textit{NEW YORKER: SPORTING SCENE} (July 31, 2013), http://www.newyorker.com/the-sporting-scene/searching-for-the-perfect-athlete [https://perma.cc/L2JJ-ZWMU] ("[P]rofessional teams, which rise and fall on their ability to judge which athletes are worth spending time and money on, are starting to take genetics seriously.")}. A 2013 article summed up the state of research: "[F]ew genes are consistently associated with elite athletic performance, and none are linked strongly enough to warrant their use in predicting athletic success."\footnote[124]{Lisa M. Guth & Stephen M. Roth, \textit{Genetic Influence on Athletic Performance}, 25 \textit{CURRENT OPINION IN PEDIATRICS} 653, 653 (2013).} A 2013 \textit{British Journal of Sports Medicine} article went even further: "Current genetic testing has zero predictive power on talent identification and should not be used by athletes, coaches or parents."\footnote[125]{Yannis Pitsiladis et al., \textit{Genomics of Elite Sporting Performance: What Little We Know and Necessary Advances}, 47 \textit{BR. J. SPORTS MED.}, Apr. 2013, at 1, 5.} Whatever their prognostic accuracy or lack thereof, such technologies continue to attract the attention of sports stakeholders who will try almost anything to find an edge.

Several companies have already begun to commercialize the potential connection between genetics and athleticism. A 2011 study in the \textit{Journal of...}
Personalized Medicine found that thirteen companies were providing sports-related DNA tests or analyses to consumers. The tests were given names such as “Sports DNA Test,” “Sports X Factor Standard Panel,” “Athletic Gene Test,” “Sports Gene Test,” and “Athletics Profile Test” and ranged in price from $79 to about $1100.

Things changed in November 2013 when the FDA ordered one of the leading companies offering sports-specific DNA tests, 23andMe, to stop advertising its health-related genetic tests without FDA authorization. At that time, the FDA had not developed any rules for direct-to-consumer (DTC) genetic testing. Thus, the FDA was concerned about whether the tests were clinically validated and how consumers would interpret their results. Shortly thereafter, 23andMe ceased offering the DTC health-related genetic tests. However, in February 2015, the FDA approved 23andMe’s DTC test for Bloom Syndrome—a rare genetic condition—leading to speculation that the Agency might approve other DTC genetic tests related to health. Indeed, by the end of the year, the FDA had permitted 23andMe to offer carrier tests for thirty-five other conditions.

While the future of DTC genetic testing in United States remains uncertain, several foreign companies have continued to offer sports-specific genetic tests. In 2005, an Australian professional rugby club tested eighteen
of its twenty-four players for eleven exercise-related genes. In 2011, an unidentified Premier League (one of the world’s leading professional soccer leagues) club was reported to have tested its athletes for genes related to injury risk. In March 2014, the British company DNAFit announced that it was conducting genetic testing of two Premier League soccer clubs and one “leading” European club, although the names of the clubs remained confidential. DNAFit’s testing would reportedly “disclose the players’ balance of speed and endurance genes, whether they have injury-prone genes, and the best nutrition to fit their DNA.” DNAFit has also provided genetic testing to British track athlete Jenny Meadows. Finally, in 2015, Uzbekistan’s Academy of Sciences began testing children for fifty genes to measure their athletic potential.

At present, genetic testing in elite or professional American sports has been more limited than abroad. For example, Major League Baseball (MLB), following prior incidents of fraud, now uses DNA testing in rare cases—and only with the player’s permission—to prove the identity and age of certain Latin American prospects. The National Collegiate Athletic Association (NCAA) currently requires that all Division I student-athletes be tested for the sickle cell gene trait or sign a waiver exempting the school and the NCAA from liability should he or she be harmed as a result of the trait. Sickle cell trait can cause problems for athletes during periods of intense exercise, and while a student-athlete will not be disqualified because of a positive test, he or she will be made aware of the possible complications and taught how to best avoid such complications. NFL clubs test for sickle cell as part of the standard preseason physical if the player has not previously been tested.

137 Id.
138 Id.
142 Id.; see also DAVID EPSTEIN, THE SPORTS GENE 177-78 (2013) (explaining that athletes who carry the sickle cell trait gene are “genetically disadvantaged for long-distance sports”).
143 Collective Bargaining Agreement, supra note 32, app. K.
Genetic testing for certain conditions has been most controversial in the National Basketball Association (NBA), particularly regarding heart abnormalities. The Chicago Bulls refused to re-sign Eddy Curry based on the possibility that he had hypertrophic cardiomyopathy (HCM), a heart ailment responsible for the death of NBA star Reggie Lewis in 1993. Similarly, following a positive HCM test, the New York Knicks declared Cuttino Mobley unfit to play, leading him to retire. Mobley sued the Knicks for allegedly violating state antidiscrimination laws. After a federal court denied the Knicks’ motion to dismiss an amended complaint in March 2013, the parties settled the case on undisclosed terms in August 2013. Similarly, in 2014, NBA prospect Isaiah Austin withdrew from the draft and gave up his NBA dreams when a pre-draft physical revealed that he suffered from Marfan syndrome, a rare genetic disorder that can weaken the heart and cause it to rupture during strenuous activity.

Despite these public controversies, interest in genetic testing in sports remains extremely high. In 2012, ESPN, in collaboration with 23andMe, tested the DNA of 100 former and current NFL offensive linemen. The results did not indicate that the players had a higher number of genes thought to be associated with athletic performance than the general population. However, researchers have claimed that there are more than 200 genes associated with physical performance and that at least twenty of them might be tied to elite athletic performance. The purpose of this discussion is not to identify the genes that are (or might be) tied to athletic performance, but rather to point out that the possibility of linking genetics with athletic performance remains an area of interest for players and companies.

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144 See Andrew E. Rice, Eddy Curry and the Case for Genetic Privacy in Professional Sports, 6 VA. SPORTS & ENT. L.J. 1, 2-3 (2006) (noting that the Chicago Bulls would not re-sign Curry until he received a genetic test to rule out HCM); see also EPSTEIN, supra note 142, at 242-51 (discussing the problems that HCM poses for athletes and listing examples of professional athletes with HCM).
145 See Mobley v. Madison Square Garden LP, No. 11-8290, 2012 WL 2339270, at *2 (S.D.N.Y. June 14, 2012) (alleging that the Knicks forced him to retire so that insurance would pay the remainder of his contract and to avoid having to pay the NBA's luxury tax, which is imposed on teams that maintain a payroll of more than a certain threshold).
150 See id. (“Our theory that NFL linemen might be genetic outliers was all at-out [sic] wrong. Every way that 23andMe looked at it, the pros were just like the [average] Joes.”).
151 Pitsiladis et al., supra note 125, at 1.
Analyzing how the NFL and its clubs evaluate player health and ability requires background on the various stakeholders in the NFL, as well as the types of evaluative technologies that are currently available. Having laid this groundwork, in Part II, we turn to the ways in which existing federal employment discrimination protections might regulate the ability of the NFL and its clubs to evaluate their current and aspiring players.

II. WHAT LAWS REGULATE THE USE OF HEALTH AND PERFORMANCE EVALUATIONS BY EMPLOYERS?

As explained above, NFL players are employees of their clubs. As employers, the clubs must comply with relevant state and federal employment laws. Additionally, at least one state trial court has found that the NFL (and not just the clubs) exercises the requisite control to be considered an employer of players pursuant to a state drug testing statute, though the decision is controversial. Thus, it is possible that courts may treat the NFL as an employer under certain circumstances as well. However, whether the league has an employment relationship with the players is an issue that courts likely decide on a case-by-case basis.

Furthermore, National Football Scouting, which runs the Combine, may also have to abide by certain employment-related laws. As noted in Part I, two-thirds of the NFL’s clubs jointly own and manage National Football Scouting. Thus, the Combine appears to be under substantial NFL control, and all of the league’s clubs significantly benefit from the medical exams conducted. While National Football Scouting is technically a separate corporate entity, it too might have to comply with employment discrimination legislation to the extent that it operates as an extension of the NFL and its clubs. In any event, the clubs use information obtained from the Combine to

152 Collective Bargaining Agreement, supra note 32, pmbl.
153 See Williams v. The Nat’l Football League, No. 27-CV-08-29778, slip op. at 16 (Dist. Ct. Minn. May 6, 2010) (finding that, for purposes of Minnesota’s Drug and Alcohol Testing in the Workplace Act (DATWA), an employment relationship exists between the players and the NFL). This case was appealed in 2011, and the appellate court agreed with the lower court’s conclusion on the issue, explaining, “The district court’s findings in this regard are not clearly erroneous, and we agree that the NFL is an employer, and appellants its employees, within the meaning of DATWA.” Williams v. The Nat’l Football League, 794 N.W.2d 391, 396 (Minn. Ct. App. 2011). But see Brown v. Nat’l Football League, 239 F. Supp. 2d 372, 383 (S.D.N.Y. 2002) (explaining that plaintiff, a former NFL player, was an employee of his specific club—and not the league—for the purpose of determining whether the mandatory arbitration provision of the Collective Bargaining Agreement applied).
154 See supra notes 43–45 and accompanying text.
155 See supra note 49 and accompanying text.
156 See Wilson v. MVM, Inc., 475 F.3d 166, 172-73 (3d Cir. 2007) (outlining multiple tests courts use to determine whether an employer that contracts with another employer exercises sufficient
make hiring decisions. Thus, regardless of National Football Scouting's potential status as an arm of the clubs or the NFL, the clubs and the NFL cannot use the Combine as a mechanism to violate employment discrimination laws.

This Part outlines the existing law that applies to inquiring about, obtaining, and acting on information about employee health, with a particular focus on NFL players and the evaluative technologies described in Part I. Specifically, this Part explores the protections and the applicability of the employment portions of the ADA and GINA, which govern the ability of employers to collect and to consider applicants' and employees' health-related and genetic information. Given the players' employment relationship with the clubs, as well as possibly with the NFL itself, these laws would apply when those entities evaluate players as described in Part I. While many individual states have their own legislation governing disability and genetic-information discrimination in employment, we focus on the federal protections for simplicity.

A. Americans with Disabilities Act

The first relevant federal employment discrimination provision is Title I of the ADA. With respect to NFL players, the most significant protections relate to discrimination and to medical examinations and inquiries. Importantly, the ADA also prevents employers and unions from engaging in collective bargaining that discriminates against individuals protected by the ADA.157

Title I prohibits covered entities from discriminating against qualified individuals on the basis of disability.158 Significantly, the ADA does not cover all employment-related relationships. Covered entities only include employment control over the latter's employees so as to qualify as their employer as well). For example, in deciding whether the Rehabilitation Act, a law governing federal employees with disabilities, should apply to the employees of private security firms that contract with the federal government, some courts have applied the “joint employment test,” asking whether “one employer while contracting in good faith with an otherwise independent company, has retained for itself sufficient control of the terms and conditions of employment of the employees who are employed by the other employer.” Id. at 173 (internal quotation marks omitted) (quoting NLRB v. Browning-Ferris Indus. of Pa., Inc., 691 F.2d 1117, 1123 (3d Cir. 1982)). Others use a multifactor balancing test to determine if the federal agency controls the “means and manner” of the employee's performance. Id. (internal quotation marks omitted) (quoting Cmty. for Creative Non-Violence v. Reid, 490 U.S. 730, 751 (1989)).

157 See Condon A. McGlothlen & Gary N. Savi ne, Eckles v. Consolidated Rail Corp.: Reconciling the ADA with Collective Bargaining Agreements: Is This the Correct Approach?, 46 DEPAUL L. REV. 1043, 1044 (1997) (claiming that the ADA “obviously prohibits an employer and union from entering into a collective bargaining agreement which, for instance, restricts the hiring of persons with AIDS” or members of other protected classes).

158 See 42 U.S.C. § 12112(a) (2012) (“No covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.”).
agencies, labor organizations, joint labor-management committees, and employers with fifteen or more employees. While establishing that the defendant is a covered entity is usually rather straightforward, demonstrating that the plaintiff has eligibility to sue can be more complex.

While some ADA provisions apply to all individuals regardless of disability status, in other cases, a plaintiff must first show that he has a “disability” as defined by the statute and second, that he meets the legal definition of a “qualified individual.” The ADA defines disability as “(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment.” An individual is qualified if he can perform the essential job functions with or without reasonable accommodation. We discuss both the disability and qualified requirements at greater length later in this Part.

To sue for a violation of Title I, a plaintiff must have filed a complaint with the Equal Employment Opportunity Commission (EEOC) or the relevant state employment agency. A plaintiff can proceed to court only after exhausting these administrative remedies. Because the ADA largely relies on individual claimants filing complaints for enforcement, an employer can theoretically discriminate without consequence, as long as none of its applicants or employees take action. This reality is particularly salient in the hyper-competitive environment of the NFL and other professional sports, where players are likely to be extremely hesitant to do anything that would jeopardize their already slim chances of success. Hence, the ADA’s private enforcement mechanism, which requires self-selection, might explain why so few professional athletes have filed cases despite the presence of widespread potential violations.

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159 Id. § 12111(2).
160 Id.; id. § 12111(g)(A)–(B).
161 Id. § 12102(1).
162 Id. § 12111(8).
163 Id. § 12102(1).
164 Id. § 12111(8).
165 See infra subsections II.A.2.a.i–ii.
166 THE BUREAU OF NAT’L AFFAIRS, INC., FAIR EMPLOYMENT PRACTICES MANUAL § 431:5 (2016). The ADA adopts the same pre-lawsuit procedures as Title VII of the Civil Rights Act with respect to its employment discrimination provisions. See Filing a Lawsuit in Federal Court, U.S. EQUAL EMP. OPPORTUNITY COMMISSION, https://www.eeoc.gov/federal/fed_employees/lawsuit.cfm (explaining that the “law requires that you first try to settle your discrimination complaint by going through the administrative complaint process” and noting that the same applies for Title VII claims).
To be clear, employees—including NFL players—cannot prospectively waive their legal rights under the ADA or GINA. For example, while the CBA and the players’ contracts contain clauses requiring arbitration of employment-related disputes, the EEOC will accept and process charges regardless of whether the complainant is bound by an arbitration clause. Indeed the EEOC “may pursue injunctive relief and seek any other relief not available in the arbitral forum even on behalf of a party that signed a pre-dispute arbitration agreement.”

We now turn to the types of claims available under Title I: (1) claims for unlawful disability-related inquiries and medical examinations and (2) claims for discrimination on the basis of actual, past, or perceived disability.

1. Medical Exams and Disability-Related Inquiries

The statute includes a section specifically governing “medical examinations and inquiries.” It prohibits employers from asking questions or ordering a medical examination to determine whether an applicant or an employee is a person with a disability. Importantly, Title I’s medical examination provisions

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168 See EEOC, EEOC ENFORCEMENT GUIDANCE 915.002 (Apr. 10, 1997), https://www.eeoc.gov/policy/docs/waiver.html [https://perma.cc/J2NX-33KW] (noting that the ADA allows individuals to waive personal claims that have already arisen but does not permit individuals to waive their rights under the statute in advance). In other words, an employer cannot ask an employee to give the employer the right to act in a discriminatory way.

169 See infra note 344.

170 Collective Bargaining Agreement, supra note 32, art. 43; id. app. A, para. 19. The law distinguishes between arbitrating and waiving claims. While antidiscrimination claims cannot be waived, agreements to arbitrate antidiscrimination claims are generally enforceable unless the statute specifically states otherwise. Compare 14 Penn Plaza LLC v. Pyett, 556 U.S. 247, 274 (2009) (“We hold that a collective-bargaining agreement that clearly and unmistakably requires union members to arbitrate ADEA claims is enforceable as a matter of federal law.”), with id. at 265 (“The decision to resolve ADA claims by way of arbitration instead of litigation does not waive the statutory right to be free from workplace age discrimination.”). However, because no provision of the Collective Bargaining Agreement explicitly requires the arbitration of GINA claims, it is unlikely that players would be required to arbitrate them. Jennifer K. Wagner, Sidelining GINA: The Impact of Personal Genomics and Collective Bargaining in Professional Sports, 12 VA. SPORTS & ENT. L. J. 81, 114-15 (2012). Moreover, even if the Collective Bargaining Agreement did lawfully require the arbitration of GINA claims, such a requirement would only apply to current players and not players participating at the NFL Combine, as they are not yet part of the bargaining unit covered by the Collective Bargaining Agreement. See Collective Bargaining Agreement, supra note 32, pmbl. (defining the bargaining unit as players currently and previously employed by an NFL club, rookie players who have already been selected in the NFL draft, and undrafted rookie players who have commenced contract negotiations with an NFL club).


172 See 42 U.S.C. § 12112(d)(1) (2012) (“The prohibition against discrimination as referred to in subsection (a) of this section shall include medical examinations and inquiries.”).

173 Id. § 12112(d)(2), (4). The statute does, however, allow employers to require a medical exam or make an inquiry when doing so is “shown to be job-related and consistent with business necessity.” Id. § 12112(d)(4).
apply with equal force to applicants and employees both with and without disabilities. As a result, an individual does not have to establish a statutorily defined disability or show that he is a qualified individual when suing for an improper exam or inquiry.

At the end of this Part, Table 1 summarizes the ADA provisions concerning medical examinations and disability-related inquiries.

a. Claims

While the statute and its accompanying regulations do not contain a clear definition of a disability-related inquiry or medical examination, the EEOC has offered some guidance. According to the EEOC, a disability-related inquiry is a “question (or series of questions) that is likely to elicit information about a disability.” Disability-related inquiries include asking about information that would clearly be of interest to NFL clubs, such as whether an individual takes medication or if he has ever been disabled. Likewise, the EEOC guidance defines a “medical examination” as a “procedure or test that seeks information about an individual’s physical or mental impairments or health.”

The EEOC lists seven criteria for determining whether a particular evaluation constitutes a medical exam:

1. whether the test is administered by a health care professional;
2. whether the test is interpreted by a health care professional;
3. whether the test is designed to reveal an impairment or physical or mental health;
4. whether the test is invasive;
5. whether the test measures an employee’s performance of a task or measures his/her physiological responses to performing the task;
6. whether the test normally is given in a medical setting; and,
7. whether medical equipment is used.

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174 See Michelle A. Travis, Lashing Back at the ADA Backlash: How the Americans with Disabilities Act Benefits Americans Without Disabilities, 76 TENN. L. REV. 311, 337 (2009) (highlighting that the pre-offer medical examination provisions of the ADA refer to all “job applicant[s],” rather than just to qualified individuals with a disability, as found in other ADA sections) (quoting 42 U.S.C. § 1211(d)(2)(A)).

175 See LEX K. LARSON, EMPLOYMENT DISCRIMINATION § 154.07(4)(a) (2d ed. 2011) (“Questions have arisen as to who has standing to enforce the ADA provisions governing the employer’s access to and the use of medical information. The few circuits addressing these questions have determined that to have standing under these provisions, a plaintiff need not establish that he or she is a qualified individual with a disability.” (citations omitted)). Larson specifically cites the Eighth, Ninth, Tenth, and Eleventh Circuits, and several district courts, as examples of courts without any such requirement. Id.


177 Id.

178 Id. (emphasis omitted).

179 Id.
Examples include a wide range of familiar medical screenings and procedures like vision tests, blood pressure and cholesterol evaluations, range-of-motion tests designed to measure strength and motor function, psychological tests, and diagnostic procedures like MRIs and CAT scans.180

Because the ADA covers both physical and mental disabilities, its medical inquiry and examination provisions apply with equal force to assessments of psychological health.181 The ADA, therefore, covers a wide range of evaluations, including many examinations and inquiries that are currently part of the Combine, as well as the NFL physicals described in Part I.182 Moreover, as mentioned, collective bargaining agreements cannot prospectively waive substantive antidiscrimination rights.183

To summarize, to the extent that the CBA—or the common practices of the NFL, the clubs, and National Football Scouting—require players or prospective players to submit to medical examinations or answer questions that might reveal an impairment, those entities could be in violation of the ADA. Whether or not those evaluations are lawful will depend at least in part on the timing of the examination or inquiry because the law has different legal standards for similar practices: (1) pre-employment, (2) post-offer, and (3) during employment.

i. Pre-Employment

Title I forbids pre-employment medical exams or inquiries regarding whether an applicant is “an individual with a disability or as to the nature or severity of such disability.”184 However, the law explicitly allows “preemployment inquiries [but not medical exams] into the ability of an applicant to perform job-related functions.”185 For example, an employer might explain the physical rigors of the job to the prospective employee and then ask the applicant whether he or she could perform those functions, with or without reasonable accommodation. In addition to inquiring about specific job-related functions, an employer could also make a general inquiry regarding whether the individual has a physical or mental impairment that would prevent him or her from performing essential job

180 Id.
181 NFL clubs are very concerned about the psychological health of prospects. See, e.g., Mike Florio, Confusing Reports Emerge About Randy Gregory, NBC SPORTS: PROFOOTBALLTALK (Apr. 29, 2015, 2:43 PM), http://profootballtalk.nbcspor...gregory/ [http://perma.cc/P9UE-443U] (reporting that prospect Randy Gregory’s draft status was falling due to “concern about [his] ability to handle the mental rigors of professional football” (internal quotation marks omitted)).
182 See supra subsection I.B.1.
183 See supra note 168 and accompanying text.
185 Id. § 12112(d)(2)(B). Unfortunately, the ADA does not explicitly define applicant, leaving some question about whether a participant at the Combine qualifies as an applicant for employment by the NFL or NFL clubs. We assume that the participant does.
Thus, an employer might ask whether there is anything the applicant thinks could impede his or her ability to perform the job in question. Again, these provisions apply to all job applicants, not just qualified individuals with disabilities.\textsuperscript{187}

As will be discussed at greater length below, these provisions are particularly relevant to the activities of the NFL and its clubs at the Combine, which include a number of medical examinations before clubs draft or actually offer any of the prospects employment.\textsuperscript{188} The Combine is an invite-only recruiting event: approximately 300 of the best college players are invited to participate.\textsuperscript{189} Additionally, the authorizations the players sign before the Combine authorize parties to use the released information only in relation to the players “actual or potential employment in the National Football League.”\textsuperscript{190} Given the targeted and elite nature of the Combine, the screenings that take place are reasonably likely to be deemed pre-employment exams (in contrast to a step even before that), although the issue has never been litigated.\textsuperscript{191}

\section*{ii. Post-Offer (Employee Entrance Examination)}

The ADA permits post-offer medical examinations when (1) they are imposed on all entering employees regardless of disability; (2) their results are kept confidential, meaning the information is collected and maintained in a medical file separate from the employee’s personnel file and not shared except for accommodation, first aid and safety, or compliance reasons; and (3) the information obtained is used only in accordance with the statute (i.e., \textit{not} to screen out individuals with disabilities or otherwise discriminate unless related to job performance).\textsuperscript{192} While the results of the post-offer exam are confidential, an employer can require that an employee sign an authorization disclosing all of her health records as a condition of employment\textsuperscript{193} (with the exception of genetic

\begin{flushleft}
\textsuperscript{187} See supra note 174 and accompanying text.
\textsuperscript{188} See infra subsection II.A.1.b.i.
\textsuperscript{189} See supra note 29 and accompanying text.
\textsuperscript{190} Online Appendix C, supra note 62, at 3, 7.
\textsuperscript{191} While Title I of the ADA applies to stages of review that are potentially earlier than pre-employment, such as open casting calls, remains unclear. Some, however, have advanced such an argument. \textit{See}, e.g., Carley G. Mak, \textit{Fame, Fortune, and . . . Fourteen-Hour Days? Open Casting Calls for Reality TV Contestants Are Pre-Employment Tests and Public Accommodations Under the Americans with Disabilities Act}, 26 \textit{LOY. L.A. ENT. L. REV.} 523, 544 (2006) (arguing that the ADA’s pre-employment provisions apply to open casting calls for reality television programs).
\textsuperscript{193} Rothstein, supra note 186, at 41-42.
\end{flushleft}
information pursuant to GINA, as discussed below\textsuperscript{194}). Put simply, an employer can condition an offer of employment on releasing otherwise private personal health information.

Technically, post-offer exams need not be job-related as long as they meet the three criteria above. However, if the employer revokes the offer of employment because an employee fails to fulfill a particular qualification standard, it must show that the exclusionary qualification standard is job-related and consistent with business necessity.\textsuperscript{195} For instance, a truck driving company might condition job offers on the candidate having 20/20 vision. As long as all employees have to pass a vision test, the results of the exam are confidential, and the company does not use them to violate the ADA, the examination is lawful under the ADA’s medical exam provisions. But if an employee who fails the vision test sues, the employer would have to demonstrate that the standards for passing that exam are job-related and consistent with business necessity. In other words, the truck driving company would have to prove that 20/20 vision relates to driving trucks and that the vision test serves a legitimate business purpose in assuring that the company runs safely and efficiently. During litigation, the employee may be able to establish that 20/40 vision—not 20/20 vision—is sufficient for driving a truck. Thus, while the vision test might not be an unlawful medical exam, the underlying qualification standard could violate the ADA. Ironically then, the law technically allows employers to obtain information during preplacement examinations that cannot ultimately be used to make decisions.\textsuperscript{196}

iii. During Employment

Title I also regulates medical exams and inquiries after the employment relationship has been established. With respect to current employees, it provides,

A covered entity shall not require a medical examination and shall not make inquiries of an employee as to whether such employee is an individual

\textsuperscript{194} See infra notes 341–42 and accompanying text.

\textsuperscript{195} See 29 C.F.R. § 1630.14(b)(3) (2015) (“Medical examinations conducted in accordance with this section do not have to be job-related and consistent with business necessity. However, if certain criteria are used to screen out an employee or employees with disabilities as a result of such an examination or inquiry, the exclusionary criteria must be job-related and consistent with business necessity, and performance of the essential job functions cannot be accomplished with reasonable accommodation as required in this part.”); see also EEOC, supra note 176 (stating these conditions to answer the question of whether “an employer [may] ask an employee for documentation when s/he requires a reasonable accommodation” (emphasis omitted)).

\textsuperscript{196} See Mark A. Rothstein et al., Limiting Occupational Medical Evaluations Under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, 41 AM. J.L. & MED. 523, 541 (2015) (“The preplacement rules established by the ADA lead to the anomalous result that employers are legally permitted to obtain health information that they are not legally permitted to use in the decision-making process.”).
with a disability or as to the nature or severity of the disability, unless such examination or inquiry is shown to be job-related and consistent with business necessity.197

Generally, an employer-mandated medical inquiry is both "job-related" and "consistent with business necessity" if the employer "has a reasonable belief, based on objective evidence, that: (1) an employee's ability to perform essential job functions will be impaired by a medical condition; or (2) an employee will pose a direct threat due to a medical condition."198 Thus, job-relatedness requires that the inquiry pertain to the specific job in question, whereas business necessity speaks to whether the particular examination is necessary to achieve a legitimate business purpose.

The statute's implementing regulations include certain exceptions, allowing "voluntary medical examinations and activities, including voluntary medical histories,"199 in conjunction with employee health programs200 such as employer-provided wellness initiatives and "inquiries into the ability of an employee to perform job-related functions."201 Yet for reasons discussed below, we do not think this exception is especially relevant to our context.202

b. Specific NFL Evaluative Technologies

The ADA’s disability-related inquiry and medical exam provisions apply to several of the kinds of evaluations described in Part I, including traditional medical examinations and athletic drills, as well as burgeoning nongenetic and genetic technologies.

i. Medical Examinations and Athletic Drills

The ADA could apply to many of the traditional medical examinations and athletic drills conducted by the NFL, the clubs, and National Football Scouting, both before and during a player’s employment. As discussed, pursuant to the EEOC’s guidance, medical examinations include vision, blood pressure, and range-of-motion tests.203 The statute covers most mental and physical

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198 EEOC, supra note 176, at n.40 (footnotes omitted) (internal quotation marks omitted).
199 29 C.F.R. § 1630.14(d).
200 Information obtained from these voluntary exams is subject to the same confidentiality requirements and exceptions as the results of the employee entrance exams described above. 42 U.S.C. § 12112(d)(4)(C). See supra note 192 and accompanying text for the requirements.
202 See infra text accompanying notes 231–32.
203 See supra note 180 and accompanying text. For a detailed description of the various types of medical screenings covered by the ADA, see supra subsection II.A.1.a.
Moreover, questions related to a current or prospective player’s health and fitness could constitute disability-related inquiries as they are “likely to elicit information about a disability.” It is more likely that the ADA will apply to medical examinations and physicals, which assess health and fitness, as opposed to athletic drills, which principally assess skills and performance. However, given the EEOC’s broad construction of medical examinations and inquiries, the ADA might cover an athletic drill that reveals or could reveal information about a potential disability. Whether an athletic drill could be construed as a disability-related inquiry or a medical examination would have to be evaluated on a case-by-case basis.

Of course, the ADA does not create an outright ban on these kinds of evaluations. It simply requires that they meet certain standards. For example, the NFL or a club could ask a prospective player about his health, as it pertains to his ability to play football—i.e., to perform “job-related functions.” Similarly, the club may make disability-related inquiries and require medical examinations after making a conditional offer of employment, as long as it requires all entering employees to undergo the same evaluations and the results are kept confidential and are not used to discriminate. Finally, once a player begins employment, the NFL or a club can make disability-related inquiries and impose medical examinations that are job-related and consistent with business necessity.

The upshot of this analysis is that at present, various parts of the NFL scouting process may violate the ADA. As mentioned, the Combine includes pre-employment medical examinations, such as x-rays, MRIs, EKGs, and blood tests. Additionally, players may be asked sensitive questions during Combine interviews, including queries that relate to current or previous disabilities. Indeed, one of the principal purposes of the Combine is to determine whether a player is “injury prone.” In reviewing other work from the Football Players Health Study, the NFL stated that the comprehensive medical examination at the

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204 See supra note 178 and accompanying text.
205 EEOC, supra note 176; see also supra text accompanying note 176.
206 See supra note 185 and accompanying text.
207 See supra note 192 and accompanying text. Recall that an employer can lawfully condition an offer on passing a medical exam. Consequently, if a club has complied with ADA’s employee entrance exam provisions but withdraws its employment offer after a prospective player fails a post-offer medical examination, that action would not violate the statute.
209 See supra note 52 and accompanying text.
211 Hunsinger Benbow, supra note 54.
Combine is “a traditional employer ‘fit-for-service’ examination, common across numerous industries.” While job-related inquiries are permissible, however, any pre-employment medical examinations violate the ADA.

It might be argued that National Football Scouting’s status as a legally distinct entity could insulate it (and the NFL) from liability, as National Football Scouting itself does not employ players. Yet if a court determined that National Football Scouting is under the control of the NFL or some or all of its clubs (or—if short of actual control—its activities are legally imputed to those entities under the ADA), the evaluations conducted at the Combine would seem to constitute clear violations of the ADA’s ban on pre-employment medical exams. Moreover, even if National Football Scouting is not acting as an arm of the NFL or of the clubs, it nonetheless provides the venue for the NFL and the clubs to conduct activities that violate the ADA. The Combine allows the NFL and the clubs to obtain exactly the type of health-related information that the ADA is designed to regulate. It would defeat the purpose of the ADA’s medical exam and inquiry provisions if an employer could claim it did not violate the law because, instead of conducting the exam directly, it contracted with a third-party medical professional. Similarly, it would defeat the purpose of the ADA’s medical exam and inquiry provisions if the NFL and its clubs could place themselves outside the scope of the ADA by contracting with National Football Scouting to perform evaluations. While this particular issue has not yet been litigated—and may reflect a statutory gap—our view is that pre-employment exams conducted at the Combine likely violate the ADA.

Furthermore, the clubs’ post-offer customs might also violate the ADA in that they are not universal and confidential. Specifically, the clubs may violate the ADA to the extent that the post-offer medical examinations are not administered uniformly. Thus, any special screening of an individual player would be highly suspect. Moreover, the widely publicized nature of the results calls their confidentiality into question.

212 Comments and Corrections from the Nat’l Football League, to I. Glenn Cohen & Holly Fernandez Lynch Concerning the Report, Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations (June 24, 2016) (on file with authors).
213 See supra note 185 and accompanying text.
214 See supra notes 43–45 and accompanying text.
215 A federal district court rejected the National Hockey League’s argument that player health information is not discoverable due to the ADA’s confidentiality provisions and implied that the league itself may be violating the ADA. See In re Nat’l Hockey League Players’ Concussion Injury Litig., 120 F. Supp. 3d 942, 951 (D. Minn. 2015) ("[T]he U.S. Clubs disclose players’ medical information to parties other than simply supervisors and managers, whether those parties are retained by the U.S. Clubs or are true third parties, such as the media. This redisclosure of players’ medical information by the U.S. Clubs themselves could arguably be violative of the ADA’s confidentiality provisions, applying the U.S. Clubs’ reading of the statute." (citation omitted)).
ii. Nongenetic Technologies

The ADA’s limitations on medical examinations may also apply to some of the innovative, nongenetic technologies described in Part I.216 As a threshold matter, one must first determine if those evaluations constitute medical examinations within the meaning of the statute. Again, courts would likely assess these cases individually by assessing whether a particular technology meets the relevant criteria outlined by the EEOC.217

Insofar as technology relies on traditional medical assessments, like blood testing or imaging techniques, they would appear to have at least some of the defining characteristics of ADA-covered medical examinations.218 However, with regard to wearable technologies like Catapult’s GPS device, Fatigue Science’s wristband, BioForce’s app, and X2’s sensors, the ADA’s applicability is less clear. This ambiguity revolves around the question of whether these sensors are medical devices (or are collecting medical or health-related data) when they monitor speed, force, movement, sleep, and heart rate.

Perhaps not surprisingly, the NFL and the NFLPA are currently in negotiations concerning whether the information collected by wearable sensors merely measures performance or is for “health and medical purposes.”219 Specifically, collecting data on “performance” is permissible under the CBA, whereas collecting data for “health or medical purposes” requires NFLPA consent.220

Whether wearable technologies are deemed medical devices or found to collect health or medical information will determine if the ADA applies. Using these new technologies does not clearly meet the definition of a medical examination. They do not require the expertise of a healthcare professional and do not need to be employed in a medical setting. With some exceptions (such as the pill described earlier221), many of the technologies are not invasive, nor are they obviously medical equipment. While some wearable technologies could reveal an impairment, devices that measure speed or heart rate are not designed for this purpose. Of the seven defining characteristics of ADA-regulated medical exams, wearable technology appears to consistently meet only one: it “measures an employee’s performance of a task or measures his/her physiological responses to performing the task.”222 Although the EEOC’s criteria

216 See supra subsection I.B.2.
217 See supra notes 178–80 and accompanying text.
218 For example, they could be administered and interpreted by healthcare professionals, capable of revealing impairments or measuring performance, and involve medical equipment.
219 This information was confidentially provided by the NFLPA on June 28, 2016.
220 Collective Bargaining Agreement, supra note 32, art. 51, § 13(c).
221 See supra subsection I.B.2.
222 EEOC, supra note 176.
weigh against designating these technologies as medical examinations, this area lacks robust precedent leading to a clear resolution.

In theory, assessing performance could detect the presence of an impairment, even if the technique being used is *not* considered medical. For example, having a player wear a monitor while sleeping could detect signs of previously undiagnosed sleep apnea. Additionally, collecting performance-related data over time could also lead to the discovery of an impairment if the player experiences subtle declines in ability that would have otherwise gone unnoticed. Thus, whether the ADA applies to the kinds of innovative technologies described in Part I would depend on how broadly courts apply the term “medical examination.”

iii. Genetic Tests

Although some genetic testing, such as paternity, ancestry, or forensic tests, do not relate to health, the varieties that would be of most interest to the NFL and its clubs include tests designed either to predict or enhance performance or to determine the propensity for injury. By revealing a player's susceptibility to injury or disease, they arguably constitute medical examinations, thereby triggering the ADA's restrictions on medical examinations and inquiries. As with other kinds of medical examinations, the ADA prohibits pre-employment genetic tests. Thus, a club that administers a pre-offer genetic test for the sickle cell disease or trait violates the law. Genetic testing would be ADA-permissible post-offer if everyone is tested, the tests are confidential, and the results are used in accordance with the statute.223 Finally, genetic testing during employment would need to be job-related and consistent with business necessity.224 However, as will be discussed below, GINA regulates genetic testing in employment far more strictly.225

c. Possible Responses and Defenses

While the ADA's protections appear robust at first blush, various exceptions and defenses may allow the NFL, the clubs, and National Football Scouting to lawfully obtain health-related information about current and prospective players. To illustrate, let us return to our hypothetical player, James, introduced at the beginning of this Article. Suppose that, as a prospective player, he went to the Combine and was asked to provide his family medical history, to agree to an EKG, to perform a running drill, to swallow a sensory pill, and to take a genetic test. Whether any—or perhaps all—of these kinds of evaluations would violate the ADA's prohibition on pre-

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224 See id. § 12112(d)(4)(A).
225 See infra Section II.B.
employment disability-related inquiries and medical examinations depends on how the EEOC and the courts interpret the scope of the statute.

To start, if the court determines that National Football Scouting is completely distinct from the NFL and the clubs, National Football Scouting would not be a covered entity under Title I because it is not an employer of NFL players, an employment agency, a labor organization, or a joint-management committee. However, if a court determines that Title I of the ADA covers National Football Scouting, the statute would prohibit any pre-employment medical examinations at the Combine. Perhaps, National Football Scouting, the NFL, and the clubs could defend the request for family medical history as a job-related inquiry; however, the EKG and the genetic test would be strictly forbidden as medical examinations. Whether the running drills or the pill violate the ADA would depend on how expansively the court in question interpreted the meaning of a medical examination. The NFL and the clubs could, of course, argue that these measures indicate performance, not health, putting them outside the reach of the statute.

Given the level of fitness required to play professional football, a wide-range of health-related questions could potentially be related to a prospective player’s ability to perform job-related functions. Thus, the NFL and the clubs likely do not violate the ADA by asking interview questions that might reveal disability-related information before the individual has an employment offer; put differently, the NFL and its clubs could very likely defend most inquiries by establishing their relevance to an individual’s ability to play football. These inquiries could range from specific (e.g., the average wide receiver runs a forty-yard post route in under five seconds: is that something you would be able to do?) or general (e.g., is there anything that would impede your ability to perform the essential functions of an NFL football player?). If challenged, the NFL or the clubs could assert that the inquiries speak to the individual’s ability to play professional football. Recall, however, that this exception is for job-related inquiries, not medical exams. Pre-offer medical examinations are forbidden regardless of job-relatedness.

That said, pursuant to the ADA, the NFL and the clubs could conduct medical examinations of prospective players after those individuals receive employment offers from the clubs (since the Combine is pre-hiring, its medical examinations would always be pre-offer). Importantly, to comply with the law, the NFL and the clubs would have to ensure that the results of the post-offer medical examinations are kept confidential, that the post-offer medical examinations are universal, and that the results are only used in accordance with the ADA. However, news stories about medical examinations conducted during NFL free agency indicate that the results of at least some

players' medical examinations are currently released to the press.\textsuperscript{227} As mentioned in Part I, players sign broad authorizations before participating in the Combine.\textsuperscript{228} While it is possible that the players are waiving their legally protected confidentiality right in the hopes of signing a particular contract, they cannot consent to violations of the law.\textsuperscript{229} Thus, to avoid running afoul of the ADA, the clubs likely need to institute more robust confidentiality protections for the results of post-offer medical examinations.

Thus, depending on how expansively the court interprets the meaning of a medical examination, the NFL or the clubs could perform those same five evaluations described above post-offer. (Of course if the drill and the pill are not considered "disability-related" or "medical," the ADA would not apply and the NFL and the clubs could administer them at any time.) In fact, the NFL and the clubs could condition an individual's offer on a prospective player's passing a particular evaluation, as well as on releasing his medical records. However, insofar as the evaluations are not universal or confidential, the ADA would forbid them. Thus, should James be singled out for an EKG or have the results from the EKG released to the press, he could sue and the NFL and the clubs would not have a clear defense.

Finally, should the NFL or the clubs decide to evaluate players throughout their employment—which given the physical nature of the sport, they certainly will want to do so—they may conduct medical examinations that are job-related and consistent with business necessity. In other words, a wide variety of evaluations could relate to playing football. Because health and athletic performance are linked, those entities could easily argue that medical examinations of the players serve the legitimate business purpose of ensuring safe and effective play. This exception is broad enough to cover medical examinations following an injury because an injury could affect an individual's ability to play (job-related), and treating the current injury, as well as preventing re-injury, are legitimate concerns for the player's health and safety (business necessity). For example, a club could authorize an MRI of a player who suffered a knee injury. Thus, most medical examinations of current NFL players would most likely be allowed under the ADA, as they would tend to be both job-related and consistent with business necessity.

\textsuperscript{227} See, e.g., Stapleton, supra note 77.

\textsuperscript{228} See supra note 62 and accompanying text. For copies of these waivers, see Online Appendix C, supra note 62.

\textsuperscript{229} A player himself could certainly disclose his results to the press. See 1 GARY S. MARX WITH DEBORAH ROSS, DISABILITY LAW COMPLIANCE MANUAL § 3:40 (2d ed. 2016) ("The ADA does not prohibit an individual with a disability from voluntarily disclosing his or her own medical information to persons beyond those to whom an employer can disclose such information."). However, his employer cannot pressure him to do so. Id.
As noted, applicants and employees cannot consent to violations of the law. While the statute does allow employees and applicants to volunteer health and medical information under certain circumstances, such as wellness programs designed to lower health insurance costs, none of the exceptions look like fertile ground for an argument that otherwise unlawful evaluations are voluntary. However, it is worth noting that a player could voluntarily offer medical information, for example to assuage the concerns of a club. Yet even if a prospective player voluntarily provides the NFL or the clubs with information regulated by the ADA, the voluntariness of the disclosure does not immunize the NFL or the clubs from the statute’s antidiscrimination provisions: they still could not use that information to discriminate on the basis of an actual, past, or perceived disability.

It is true that upon joining an NFL club (post-offer, and actually employed), players are required to make certain health-related disclosures pursuant to their contracts and the CBA. The standard NFL player contract contains a disclosure provision stating,

Player represents to Club that he is and will maintain himself in excellent physical condition. Player will 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 under this contract and to respond fully and in good faith when questioned by the Club physician about such condition. If Player fails to establish or maintain his excellent physical condition to the satisfaction of the Club physician, or make the required full and complete disclosure and good faith responses to the Club physician, then Club may terminate this contract.

Further, the collectively bargained Notice of Termination lists “fail[ing] to make full and complete disclosure of your physical or mental condition during a physical examination” as an accepted ground for termination.

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230 See LARSON, supra note 175, § 157.06 (“Since the ADA enforcement procedures are taken from Title VII, and it is well-settled that under Title VII there can be no prospective waiver of an individual’s claims, there can be no prospective waiver of an individual’s ADA claims. However, the waiver of an ADA claim as part of a settlement or severance agreement will be considered valid provided that the waiver is knowing and voluntary, as evidenced by the totality of the circumstances.” (footnotes omitted)).

231 See supra note 200 and accompanying text.

232 See supra note 200.


234 Id. app. H (“You are hereby notified that effective immediately your NFL Player Contract(s) with the Club covering the football season(s) has (have) been terminated for the reason(s) checked below: . . . You have failed to make full and complete disclosure of your physical or mental condition during a physical examination.”).
These provisions put players in a difficult position, as they create an incentive to avoid being formally diagnosed with a condition to avoid triggering the obligation to disclose. But avoiding diagnostic tests and medical exams could delay treatment and lead to further harm as the illness or injury worsens over time. Additionally, the collectively bargained nature of these disclosures and releases creates additional pressure on the players, further undermining their purported voluntariness.

Moreover, a failure to adequately disclose can undermine a player’s potential injury grievance. Because of the players’ disclosure obligations, the CBA presumes that any player who passed the club physical is fit to play. Consequently, alleging that “the player failed to make full and complete disclosure of his known physical or mental condition when questioned during a physical examination by the Club” is a special defense that a club can raise in its answer to a player’s injury grievance.

From a practical perspective, given the physical nature of the job, insofar as the ADA allows employers to make job-related inquiries (both before and during employment) and conduct medical exams post-offer and during employment, the NFL and its clubs would have a robust defense to demanding such inquiries and exams at the permissible times. That is not to say, however, that the NFL and its clubs can simply require any and all medical inquiries and examinations. While assessing the range of motion of a quarterback’s arm quite clearly pertains to his ability to perform his job, conducting a dental exam appears less relevant. Courts would likely make these determinations on a case-by-case basis.

2. Discrimination

In addition to its medical examination and disability-related inquiry provisions, the ADA also forbids adverse employment actions against qualified individuals on the basis of a disability. At the end of this Section, Table 2 summarizes the ADA provisions concerning discrimination against qualified individuals with disabilities.

235 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.” *Id.* art. 44, § 1.

236 *See id.* art. 44, § 12 (“If the player passes the physical examination of the Club prior to the preseason training camp for the year in question, having made full and complete disclosure of his known physical and mental condition when questioned by the Club physician during the physical examination, it will be presumed that such player was physically fit to play football on the date of such examination.”).

237 *Id.* art. 44, § 3(a)(2).
a. Claims

Title I contains a rather lengthy description of what constitutes discrimination. Section 12112(a) states, “No covered entity shall discriminate against a qualified individual on the basis of disability in regard to job application procedures, the hiring, advancement, or discharge of employees, employee compensation, job training, and other terms, conditions, and privileges of employment.” The statute includes several subsections explaining how to construe its antidiscrimination mandate. Section 12112(b) explains that discrimination against a qualified individual with a disability covers a wide range of employer actions that both intentionally and unintentionally have an adverse effect on people with disabilities, including classifying individuals on the basis of disability; participating in discriminatory contracts or other agreements with employment-related entities; and adopting qualification standards that tend to screen out individuals with disabilities, unless those standards are job-related and consistent with business necessity.

i. Disability

Unlike the medical examination provisions, the ADA’s discrimination sections require litigants to establish that they are qualified individuals with disabilities. Recall that the ADA defines disability as "(A) a physical or mental impairment that substantially limits one or more major life activities of such individual; (B) a record of such an impairment; or (C) being regarded as having such an impairment." It goes on to explain that

[a]n individual meets the requirement of "being regarded as having such an impairment" if the individual establishes that he or she has been subjected to an action prohibited under this chapter because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.

Consequently, to be a person “with a disability” pursuant to the ADA, an individual does not have to be currently experiencing a substantially limiting impairment if she has previously had such an impairment (record of) or is

238 42 U.S.C. § 12112(a). At present, courts are split on the question of whether claimants must establish that the disability was simply a motivating factor or whether it must be a but-for cause of the discrimination. See LARSON, supra note 175, § 156.02 (citing the Second, Ninth, and Eleventh Circuits as examples of courts that have adopted the "widely recognized [view] that . . . it is not necessary . . . to demonstrate that the disability was the sole cause of the adverse employment decision" but noting that the Sixth and Tenth Circuits follow the sole cause standard).

239 42 U.S.C. § 12112(b).

240 See supra notes 174–75 and accompanying text.

241 42 U.S.C. § 12102(1).

242 Id. § 12102(3)(A).
perceived by her employer to be impaired (regarded as). Impairments cover a wide range of both physical and mental conditions, including addiction.

With respect to major life activities, in the ADA Amendments Act of 2008 (ADAAA), Congress added a nonexhaustive list to the statute. Accordingly, “major life activities include, but are not limited to, caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working,” as well as “major bodily function[s].” Major bodily functions “include[e] but [are] not limited to, functions of the immune system, normal cell growth, digestive, bowel, bladder, neurological, brain, respiratory, circulatory, endocrine, and reproductive functions.” These additions to the law were intended to counteract previously restrictive court interpretations of “major life activity.” Lastly, the “regarded as” prong, as defined by the ADAAA, could potentially capture a wide range of conduct. This definition of disability is intentionally broad.

At first blush, it may seem counterintuitive that NFL players—elite athletes in peak physical condition—might meet the legal definition of “individuals with disabilities.” However, Congress used “disability” as a term of art in the statute with a specific meaning. In addition to players with chronic conditions like heart problems or diabetes, the ADA could potentially cover injured players, depending on the degree of the injury (actual impairment), the history of injuries (record of),

243 See 29 C.F.R. § 1630.2(h)(1)–(2) (2012) (providing examples of physical and mental impairments).
244 See JOHN F. BUCKLEY, EQUAL EMPLOYMENT OPPORTUNITY: 2016 COMPLIANCE GUIDE § 7.08[A][3] (2016) (“Persons addicted to drugs, but who are no longer using drugs illegally and are receiving treatment for drug addiction...are protected by the ADA...on the basis of past drug addiction.”).
247 Id. § 12102(a)(B).
248 Id.
249 See Jessica L. Roberts, Healthism and the Law of Employment Discrimination, 99 IOWA L. REV. 571, 596 n.163, 597 (2014) (citing Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184, 200-01 (2002), superseded by statute, § 2(b)(4)–(5), 122 Stat. at 3554—which restricted the scope of major life activities to those “central to most people’s daily lives,” as opposed to “merely a task, or class of tasks, that are required for the claimant’s job,” as an example of the kind of restrictive Supreme Court interpretation of disability that the ADAAA was meant to counteract).
251 See id. § 2(a)(4), 122 Stat. at 3557 (“The holdings of the Supreme Court in Sutton v. United Air Lines, Inc., 527 U.S. 471 (1999) and its companion cases have narrowed the broad scope of protection intended to be afforded by the ADA.”).
or the player’s risk of injury (regarded as). As a result, a player does not have to be experiencing an actual impairment to be considered an individual with a disability.

For example, imagine a player injures himself seriously but not permanently. Short-term impairments constitute disabilities when they are “sufficiently severe.” Hence, under existing law, he might be able to assert that his temporary injury is severe enough to qualify as a disability. However, courts will make these determinations on a case-by-case basis. For example, while the inability to walk for seven months could constitute a disability for ADA purposes, a torn ACL might not. Likewise, if a prospective or current player at some point had a substantially limiting impairment and subsequently healed, the history of injury would qualify as a disability under the “record of” prong.

Finally, the breadth of the “regarded as” provision means it could be particularly useful to NFL players. While “regarded as” may not apply to temporary disabilities, it would cover instances in which individuals are perceived as having disabilities, regardless of whether they are actually impaired or actually limited in a major life activity.

For example, Star Lotulelei, discussed above, was arguably “regarded as” being disabled after an echocardiogram detected a cardiovascular abnormality. A player who experiences a limitation in a major bodily function that might not directly affect his current ability to play, such as a congenital heart problem, diabetes, or cancer, could also qualify as an individual with a disability. For instance, a federal court found that professional golfer Stephen Barron had established a strong likelihood of success on his claim that he was disabled under the ADA based on low testosterone production. Consequently, the “regarded as” prong might be the most powerful avenue of relief for NFL

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252 If the injury is severe enough, he might acquire a permanent impairment.
254 Following the 2008 amendments, the ADA applies to some temporary impairments. See Summers v. Altarum Inst. Corp., 740 F.3d 325, 333 (4th Cir. 2014) (holding that an accident which left a plaintiff unable to walk for seven months was sufficiently severe to qualify as a disability following the ADAAA expansions).
255 See Koller v. Riley Riper Hollin & Colagreco, 850 F. Supp. 2d 502, 514 (E.D. Pa. 2012) (holding that the plaintiff failed to establish that his torn ACL, which required surgery, rose to the level of a disability under the statute).
256 See 42 U.S.C. § 12102(3)(B) (2012) (stating that the regarded as prong “shall not apply to impairments that are transitory and minor” and that “[a] transitory impairment is an impairment with an actual or expected duration of 6 months or less”).
257 Id. § 12102(3)(A).
258 Newton, supra note 68.
259 Barron v. PGA Tour, Inc., 670 F. Supp. 2d 674, 685 (W.D. Tenn. 2009). However, the court ultimately denied his request for a temporary restraining order to require the PGA tour to allow him to compete. Id. at 691.
players under the ADA. Even players who are completely free of impairments both past and present may be considered people with disabilities if they can establish that the NFL or the clubs treated them in a discriminatory manner. The regarded as prong may also be the most comfortable fit, as the players themselves loathe portraying themselves as impaired.

Still, it is not sufficient to show that one has a “disability” to proceed with a claim under the ADA’s antidiscrimination provisions.

ii. Qualified

Under Title I of the ADA, a “qualified individual” is “an individual who, with or without reasonable accommodation, can perform the essential functions of the employment position that such individual holds or desires.”\textsuperscript{260} In determining which job functions are essential, the statute gives deference to the employer.\textsuperscript{261} EEOC regulations define essential job functions as “the fundamental job duties of the employment position the individual with a disability holds or desires,” not including marginal functions.\textsuperscript{262} For example, the essential functions of an administrative assistant might include printing, filing, scanning, delivering mail, and moderate lifting.

The regulations go on to indicate that a job function could be “essential” for purposes of the ADA for at least three reasons:

(i) The function may be essential because the reason the position exists is to perform that function;

(ii) The function may be essential because of the limited number of employees available among whom the performance of that job function can be distributed; and/or

(iii) The function may be highly specialized so that the incumbent in the position is hired for his or her expertise or ability to perform the particular function.\textsuperscript{263}

Hence, whether a job function is essential depends on its importance and not its frequency.

Of course, in addition to establishing a disability, an individual who wishes to pursue an ADA claim must also establish that he is qualified. The “qualified individual” inquiry is especially challenging in the context of professional sports

\textsuperscript{260} 42 U.S.C. § 12111(8).

\textsuperscript{261} See \textit{id.} (“For the purposes of this subchapter, consideration shall be given to the employer’s judgment as to what functions of a job are essential, and if an employer has prepared a written description before advertising or interviewing applicants for the job, this description shall be considered evidence of the essential functions of the job.”).

\textsuperscript{262} 29 C.F.R. § 1630.2(n)(1) (2015).

\textsuperscript{263} \textit{Id.} § 1630.2(n)(2).
where excellence, not mere competence, is the necessary standard. There is very little guidance or case law on this issue. The applicable regulations allow courts to look to written job descriptions and collective bargaining agreements when assessing which job functions are essential.\textsuperscript{264} The standard NFL player contract states that the “Club employs Player as a skilled football player.”\textsuperscript{265} It goes on to explain that “Player represents that he has special, exceptional and unique knowledge, skill, ability, and experience as a football player, the loss of which cannot be estimated with any certainty and cannot be fairly or adequately compensated by damages.”\textsuperscript{266} Additionally, the contract states,  

Player understands that he is competing with other players for a position on Club’s roster within the applicable player limits. If at any time, in the sole judgment of Club, Player’s skill or performance has been unsatisfactory as compared with that of other players competing for positions on Club’s roster, or if Player has engaged in personal conduct reasonably judged by Club to adversely affect or reflect on Club, then Club may terminate this contract.\textsuperscript{267}  

Thus, according to the standard contract, whether an individual is qualified to play NFL football is a relative—not an absolute—inquiry. Thus, the qualified individual inquiry likely is more of a moving target in the case of an elite athlete than it is in the case of an administrative assistant.  

In terms of relevant case law, two cases potentially address how to determine essential job functions of professional athletes. First, in 2006, Roy Tarpley, a former basketball player whom the NBA banned for violating its drug and alcohol policies, filed an ADA claim with the EEOC after the NBA denied his request to reenter the league.\textsuperscript{268} The EEOC found reasonable cause that the NBA had violated his rights under the ADA and issued a right to sue letter, placing Tarpley “in an advantaged position, particularly [for] settlement talks.”\textsuperscript{269} Tarpley sued the league in a Texas federal court, but the case settled before the court made any substantive rulings.\textsuperscript{270} Nevertheless, documents indicate that Tarpley would have argued that the essential job functions of an NBA player include “not only the ability to play NBA

\textsuperscript{264} Id. § 1630.2(n)(3).  
\textsuperscript{266} Id. para. 3 (emphasis added).  
\textsuperscript{267} Id. para. 11 (emphasis added).  
\textsuperscript{268} Michael A. McCann, Do You Believe He Can Fly? Royce White and Reasonable Accommodations Under the Americans with Disabilities Act for NBA Players with Anxiety Disorder and Fear of Flying, 41 PEPP. L. REV. 397, 419 (2014).  
\textsuperscript{269} Id. at 420.  
\textsuperscript{270} Id.
basketball, but also the capability of being a role model.”

Given the language of the standard NFL player contract, there would be a strong argument that the essential functions of being an NFL player include exceptional skills and performance, as well as a behavioral element off of the field akin to being a role model.

The other potentially relevant case, *PGA Tour, Inc. v. Martin*, is actually a Title III (public accommodations) case, not a Title I (employment) case. Still, the Supreme Court analyzed the essential aspects of golf to determine whether the plaintiff’s request for a modification—that he be allowed to drive a golf cart during play—would “fundamentally alter the nature” of PGA Tour tournaments. In so doing, the Court looked to the “Rules of Golf” that govern both amateur and professional golf, the “Conditions of Competition and Local Rules” that govern the PGA's professional tournaments, and the “Notices to Competitors” that issued for specific tournaments.

Thus, a court asked to assess whether an individual is qualified to play professional football would likely look to analogous sources like a player’s contract, the CBA, official NFL rules and regulations, and the descriptions of the player’s position from the NFL and its clubs. “Qualified” in these circumstances would necessarily mean performing at an elite, superior level. To be sure, the qualified inquiry for professional athletes is more complex than for traditional jobs. However, NFL clubs’ need to seek out the best available players does not necessarily mean that anyone less than the best must be unqualified per se. If that were true, the qualification standard would be meaningless given that every employer seeks the best available candidate. Again, whether a player is elite is a relative question—not an absolute one. For example, an individual whose level of skill and performance might have been elite in the past may no longer be qualified relative to the current group of players. Thus, NFL players challenging clubs or the league under the ADA may have difficulty establishing both the aspects of play that constitute “essential functions” of professional football and whether they can perform those essential functions with comparative excellence.

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271 Id. However, it is questionable whether Tarpley would have been able to meet the first function because he had not played in the NBA for eight years and would have been—if reinstated—the second oldest player in the league. Moreover, he also had a history of serious knee problems. Id. at 420–21.

272 See 532 U.S. 661, 675–76 (2001) (“At issue now, as a threshold matter, is the applicability of Title III [of the ADA] to petitioner’s golf tours . . . .”).

273 Id. at 682 (internal quotation marks omitted). The Court ultimately explained that the use of carts to play golf is not inconsistent with the fundamental characteristic of the game and that the essence of golf is shotmaking. Id. at 683. Additionally, the Court explained that the PGAs walking requirement for professional tournaments is likewise not an “indispensable feature” of tournament golf since the rule’s purpose is to fatigue players and Martin already tired more easily than his able-bodied opponents Id. at 685, 690.

274 Id. at 666–67.
b. Specific NFL Evaluative Technologies

We now apply these principles of the ADA to the various types of traditional NFL examinations and drills, as well as to the cutting edge evaluative technologies described in Part I.

i. Medical Examinations and Athletic Drills

The ADA prohibits adverse employment actions on the basis of an actual or perceived disability if the employee can still perform his or her essential job functions.\(^{275}\) If the person can no longer perform those essential job functions, he or she is not qualified and, therefore, cannot sue for discrimination. Thus, if the NFL or a club chooses not to hire, not to renew, or to otherwise disadvantage a player who can perform the essential job functions of playing football on the basis of medical or health-related information, they could be liable for discrimination.

For example, imagine that our hypothetical player, James, has diabetes but can still play at an elite level (i.e., the diagnosis does not affect his performance in any negative way).\(^{276}\) Pursuant to the ADA, it is unlikely that National Football Scouting could reject him from the Combine—or could the NFL or the club fail to hire him on the basis of his diabetes—unless it could show some threat to his health and safety or to the health and safety of others. The same would be true for a player with a congenital heart defect, a player with a record of a severely limiting injuries, or a player, like Star Lotulelei,\(^{277}\) who had been perceived as having an impairment.\(^{278}\) Thus, for their qualification standards to be lawful, the NFL and the clubs must establish that their selection criteria are both “job-related” and “consistent with business

\(^{275}\) See 42 U.S.C. § 12102(3)(A) (2012) (noting that the ADA applies to both actual and perceived impairments); id. § 12111(8) (defining a qualified individual under the ADA as one who can still perform the essential functions of the job).


\(^{277}\) See supra text accompanying note 258.

\(^{278}\) In 2015, a somewhat similar situation unfolded with wide receiver Bud Sasser. The St. Louis Rams drafted Sasser in the sixth round of the NFL Draft before learning that he had a heart condition. Since Sasser had not been invited to the Combine, his condition was not discovered until after he was drafted. The Rams’ doctors recommended that Sasser not play while Sasser’s agent declared that another doctor had cleared him. The Rams still signed Sasser to a contract commensurate with his draft position (including a $113,737 signing bonus) even though they were under no such obligation. Nevertheless, the club ultimately terminated the contract, leaving Sasser’s NFL future in doubt. Mike Florio, Agent Says Bud Sasser Has Been Cleared to Play, NBC SPORTS: PROFootballTalk (June 5, 2015, 7:44 AM), http://profootballtalk.nbcsports.com/2015/06/05/agent-says-bud-sasser-has-been-cleared-to-play/ [http://perma.cc/YFR9-LJzW].
necessity.” Even assuming that the NFL, the club, and National Football Scouting are performing medical examinations and athletic drills in accordance with the ADA’s restrictions on disability-related inquiries and medical exams (e.g., not conducting pre-offer examinations), they must still take care to not engage in illegal discrimination upon receipt of post-offer examination information.

It is worth pausing to emphasize that if a medical examination (post-offer or during employment) or inquiry (at any time) reveals that a person cannot perform the essential job functions of a professional football player, the NFL or the club can refuse to hire him or can terminate him lawfully since he is not “qualified” as required by the statute.

ii. Nongenetic Technologies

Should wearable technology reveal a disability, Title I’s antidiscrimination provision would prevent discrimination on the basis of that disability. That said, if a player’s performance declines so substantially that he can no longer meet the rigorous standards of professional football, he would no longer be qualified to play and would thus be outside the scope of Title I’s protection. If the technology only measures performance—without detecting impairment—the ADA offers no meaningful protection. An adverse employment action based on performance data alone would not constitute discrimination on the basis of disability. To the contrary, it would most likely be justifiable if the performance data indicated that the individual was no longer capable of performing the essential functions of NFL football. Put another way, anything less than peak performance could be taken as an indication of the person’s relative inferiority as a player, making it an acceptable ground for an adverse employment action.

That said, given the often extensive injury history of NFL players, the line between performance data and impairment detection is a murky one. For example, a sensor that measures the amount of force a player creates might typically be construed as a performance metric, but if the player has a history of knee injuries, a reduction in force might be indicative of the player’s level of impairment. Courts will likely struggle to distinguish the two should these issues be litigated.

279 42 U.S.C. § 12112(b)(6).
280 See supra notes 274–75 and accompanying text.
281 See supra subsection II.A.1.b.i. for a discussion of the importance of the difference.
iii. Genetic Tests

The ADA’s antidiscrimination provisions might also apply to genetic tests. Arguably, to discriminate against an individual on the basis of genetic information is to regard that person as disabled. Moreover, recall that being regarded as disabled requires only that an individual face discrimination “because of an actual or perceived physical or mental impairment whether or not the impairment limits or is perceived to limit a major life activity.” Hence, a plaintiff could argue that in addition to discrimination on the basis of genetic information under GINA, he or she also faces discrimination on the basis of a perceived disability.

While the ADA may technically apply to scenarios related to genetic testing and genetic-information discrimination, GINA will likely be the primary legal tool for such circumstances. While GINA does not preempt the ADA—and claimants can and do assert violations of both statutes—it specifically includes genetic test results and excludes the type of manifested conditions that the ADA covers, thereby implying complementary protections.

c. Possible Responses and Defenses

In cases of alleged discrimination, the NFL or a club could use a multitude of defense strategies, such as arguing that the player is not qualified, that an exclusionary qualification standard is job-related and consistent with a business necessity, or that the player poses a direct threat to the health or safety of himself or others. One response to a discrimination claim is to assert that the plaintiff is not a qualified individual with a disability. Thus, the NFL or the club could challenge James regarding how much his alleged impairment currently limits him (substantially limiting impairment), has limited him in the past (record of), or whether he has ever been perceived as being disabled (regarded as). Although the ADAAA’s broader definition of disability makes it harder for employers to establish the absence of a disability, they can still assert that the person cannot perform essential job functions—even with reasonable accommodations—and is therefore not “qualified.” Since elite athletic ability is essential to playing professional football, this defense could be strong for the NFL or the clubs. The NFL or the club might then argue that while James is at an absolute level of excellence with respect to playing football, he still

284 See infra notes 325–36.
285 See supra notes 245–50 and accompanying text.
falls comparatively short compared to other aspiring professional players competing for the position.

Challenging whether an individual is disabled or qualified are responses that cut across the various definitions of discrimination in Title I. Yet, some of the specific constructions of discrimination found in § 12112(b) have their own separate statutory exceptions or defenses.286 Suppose James has established that he is qualified to play football at the elite level (as well as to conform to the necessary behavioral norms) and also that he is a person with a disability as defined by the ADA. In response to his claim for failing to accommodate a qualified individual with a disability, James’s employer could argue that the requested accommodation is not reasonable,287 or that even if the requested accommodation were reasonable, it would create an undue hardship.288 Say James has a learning disability and requests extra time than is normally provided for taking the Wonderlic test at the Combine.289 James would have to demonstrate that his request for additional time is reasonable; then the NFL or the clubs (through National Football Scouting) could argue his request would impose some kind of unacceptable burden.

The ADA includes specific statutory defenses to allegations that a qualification standard disproportionately screens out individuals with disabilities.290 Importantly, essential job functions (the touchstone for the qualified individual inquiry) are distinct from qualification standards. As noted, essential job functions are the fundamental duties of the job,291 while qualification standards are the selection criteria the employer uses to assess whether an individual is qualified. Thus, a person who could perform the essential functions of the job (i.e., is qualified) might be screened out by discriminatory qualification standards.292 For example, playing elite football is an essential job function for an NFL player. In

286 42 U.S.C. § 12112(b).
287 See id. § 12111(8) (defining a qualified individual as one who, “with or without reasonable accommodation, can perform the essential functions” of the job (emphasis added)). To demonstrate that an accommodation is reasonable, a plaintiff “need only show that an ‘accommodation’ seems reasonable on its face, i.e., ordinarily or in the run of cases.” US Airways, Inc. v. Barnett, 535 U.S. 391, 401 (2002).
288 Illegal discrimination includes “not making reasonable accommodations” for “an otherwise qualified individual . . . unless [the employer] can demonstrate that the accommodation would impose an undue hardship on the operation of [its] business.” 42 U.S.C. § (b)(5)(A) (emphasis added). An “undue hardship” is “an action requiring significant difficulty or expense.” Id. § 12111(10)(A).
289 Prospective players with learning disabilities have not been given extra time to take the Wonderlic test at the Combine, as would be required by the ADA. See, e.g., Lowell Cohn, NFL Fails to Protect Player with Learning Disability, PRESS DEMOCRAT (Apr. 9, 2012), http://www.pressdemocrat.com/news/2310726-181/nfl-fails-to-protect-player [https://perma.cc/26EY-HK9X] (explaining that Morris Claiborne was not afforded any testing accommodations during his Wonderlic examination despite having a documented learning disability).
290 42 U.S.C. § 12113(a).
291 See supra note 262 and accompanying text.
292 See 42 U.S.C. § 12112 (b)(6) (noting that illegal discrimination includes using qualification standards that “screen out or tend to screen out an individual with a disability”).
screening for the most elite football players, the NFL or its clubs could theoretically adopt a hearing requirement due to a belief that the best football players need to be able to hear one another in a huddle, hear the officials’ whistles, and respond to verbal signals from the coach. While there might be some correlation between hearing and football playing, a hearing requirement could nonetheless screen out qualified players, such as former Seattle Seahawk Derrick Coleman, who is deaf.  

An employer can potentially defend a qualification standard that screens out individuals with disabilities by showing it is (1) job-related, (2) consistent with a business necessity, and (3) that the job cannot be accomplished with reasonable accommodation. Thus, the NFL or its clubs can adopt qualification standards that disparately impact people with disabilities as long as those standards relate to the job of playing football, further a legitimate business purpose, and have no viable reasonable accommodation. For example, if James failed a hearing test at the Combine and was not hired as a result of a hearing policy, the club would have to assert that a certain degree of hearing is job-related and consistent with business necessity and that James could not be adequately accommodated, say through hearing aids or by using sign language or some other visual means of communication.

Additionally, the ADA allows employers to adopt qualification standards that require that “an individual shall not pose a direct threat to the health or safety of other individuals in the workplace.” The ADA defines a “direct threat” as “a significant risk to the health or safety of others that cannot be eliminated by reasonable accommodation.” According to the Supreme Court, the presence or absence “of a significant risk must be determined from the standpoint of the [discriminator], and the risk assessment must be based on medical or other objective evidence.” Thus, employers cannot invent hypothetical risks to invoke the defense.

While, on its face, the statute only provides a defense when employing an individual with a disability that could harm others, the Supreme Court has

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293 See Tom Friend, Derrick Coleman Misses Nothing, ESPN (Jan. 31, 2014), http://espn.go.com/nfl/playoffs/2013/story/_/id/10372203/super-bowl-xlviii-deafness-deter-seattle-derrick-coleman [http://perma.cc/PF3Z-75EL] (explaining that Coleman was the third deaf player in NFL history and the first to play offense, which requires more quick and last-minute communication with teammates than defense).


295 The NHL actually excludes players who are blind in one eye. See Bill Littlefield, David-Alexandre Beauregard: One Eye, 20 Years, 540 Goals, ONLY GAME (Dec. 21, 2013), http://onlyagame.wbur.org/2013/12/21/david-alexandre-beauregard-blind-hockey-player [http://perma.cc/TFQ3-3F4P] (discussing the twenty-year career of minor hockey player David-Alexandre Beauregard, who has never reached the NHL, in part due to a league rule prohibiting players who are blind in one eye).

296 42 U.S.C. § 12113(b).

297 Id. § 12111(3).

extended Title I’s direct threat defense to the employees themselves. In other words, employers can screen out individuals with disabilities to avoid putting those individuals at significant risk. In the leading Supreme Court case in this area, *Chevron U.S.A. Inc. v. Echazabal*, the Court held that Chevron could lawfully refuse to hire respondent Echazabal due to a medical exam that revealed liver damage, which Chevron’s doctors believed could be exacerbated by exposure to toxins while working in the refinery. Thus, one possible defense for the NFL and the clubs would be to argue that making decisions based on players’ actual, past, or perceived disabilities would in fact benefit the players themselves by keeping them out of harm’s way.

Imagine that James’s Combine EKG has revealed abnormal heart function, he is forced to leave the Combine, and—as a result—is not ultimately drafted or signed. James could allege discrimination based on an actual or a perceived cardiac impairment. However, the clubs could raise the direct threat defense, arguing that to employ an individual with compromised heart function as a professional football player would place him at a significant health risk and, given the nature of the sport, that the risk cannot be eliminated by a reasonable accommodation. Therefore, the direct threat defense is potentially powerful for these defendants with respect to health-related screenings because they can argue that adopting health-related qualification standards is necessary to avoid putting players at serious risk. But to succeed, they would have to demonstrate that the risk in question is “significant”—based on objective evidence—and that it cannot be eliminated through reasonable accommodation.

Spinal stenosis, a narrowing of the spinal canal, provides another useful hypothetical for the direct threat defense. David Wilson, a running back for the New York Giants, was advised by team doctors to retire based on his spinal stenosis. Ostensibly, the doctors based their advice on the belief that Wilson was endangering himself by continuing to play. However, while they may face greater risk of discomfort and ultimately decide that continuing to play is not worth it, at least one article reports “research shows that players with spinal stenosis are at no greater risk of devastating spinal cord injury.” Nonetheless, many players with that condition are encouraged to stop playing football. While perhaps well-meaning, recommendations to leave professional football because of...
spinal stenosis are therefore based on perceived—not actual—risk. Thus, should a club dismiss a player on the basis of spinal stenosis, a direct threat defense would mostly likely fail due to the absence of an actual risk of heightened injury. Thus, the direct threat defense may be available in the context of professional football, but there are limits to its applicability.

3. ADA Summary

Navigating the goals of the ADA and its application to the NFL context is no easy feat, so we summarize it: Title I of the ADA could apply to the clubs or the NFL (1) by prohibiting certain medical examinations or inquiries and (2) by forbidding both intentional and unintentional adverse employment actions on the basis of an actual, past, or perceived disability. The NFL and its clubs could assert a variety of defenses. For example, they could assert that qualification standards or medical inquiries and exams for current employees are job-related and consistent with business necessity. For certain actions, they could challenge whether the individual is qualified or has a disability. Lastly, if a player is endangering himself or others, the club or the NFL may be able to use the direct threat defense.

304 While the NFL and the clubs might have multiple defenses, National Football Scouting’s activities are exclusively pre-employment and only related to medical examinations and inquiries, not employment-related actions. See supra notes 43–45, 47–54 and accompanying text. This means that the only statutory exception available to it would be for pre-employment, job-related inquiries.
Table 1: Medical Examinations and Inquiries

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Types of Screening</th>
<th>Defenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicants</td>
<td>Pre-employment medical examinations</td>
<td>None</td>
</tr>
<tr>
<td>Applicants</td>
<td>Pre-employment inquiries</td>
<td>Inquiry is job-related</td>
</tr>
<tr>
<td>Applicants (post-offer)</td>
<td>Employee entrance exam</td>
<td>Exams must be (1) universal (all entering employees are subject); (2) confidential; and (3) used only in accordance with ADA</td>
</tr>
<tr>
<td>Current employees</td>
<td>Medical examinations and inquiries</td>
<td>Exams and inquiries must be (1) job-related and (2) consistent with business necessity</td>
</tr>
</tbody>
</table>

Table 2: Discrimination Against Qualified Individuals with Disabilities

<table>
<thead>
<tr>
<th>Violations</th>
<th>Defenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limit, segregate, or classify on the basis of disability</td>
<td>• No disability</td>
</tr>
<tr>
<td></td>
<td>• Not qualified</td>
</tr>
<tr>
<td></td>
<td>• Did not discriminate / adversely affect</td>
</tr>
<tr>
<td>Failure to accommodate</td>
<td>• No disability</td>
</tr>
<tr>
<td></td>
<td>• Not qualified</td>
</tr>
<tr>
<td></td>
<td>• Accommodation not reasonable</td>
</tr>
<tr>
<td></td>
<td>• Undue hardship</td>
</tr>
<tr>
<td>Discriminatory qualification standards</td>
<td>• No Disability</td>
</tr>
<tr>
<td></td>
<td>• Not Qualified</td>
</tr>
<tr>
<td></td>
<td>• (1) Job-related; (2) consistent with business necessity; and (3) cannot be eliminated with reasonable accommodation</td>
</tr>
<tr>
<td></td>
<td>• Direct threat</td>
</tr>
</tbody>
</table>


306 Unless otherwise noted, the statutory support for the defenses included in the table corresponds with the provision describing the violation. These provisions apply to all qualified individuals with disabilities at all stages of employment. 42 U.S.C. § 12112(a).

307 Id. § 12112(b)(1).
308 Id. § 12112(b)(5).
309 Id. § 12112(b)(6).
310 Id. § 12113(a).
311 Id. § 12113(b).
B. Genetic Information Nondiscrimination Act

Apart from the ADA, the Genetic Information Nondiscrimination Act is another federal statute that could apply to the collection and use of players’ health-related information.

Title II of GINA prohibits both acquiring and acting on genetic information in employment. The law applies to various types of employers covered by other federal statutes such as Title VII, as well as employment agencies, labor organizations, and training programs. The sections most relevant to NFL players are the employer and labor organization provisions. Like the ADA, GINA does not exempt sports-related employers. To the contrary, proponents of the law cited Eddy Curry’s story as evidence of the need for legal regulation. Both GINA’s prohibitions on genetic discrimination and its restrictions on requests for genetic information could apply to efforts of the NFL or its clubs to evaluate and monitor player health. As is the case under the ADA, plaintiffs must exhaust their administrative remedies before pursuing a lawsuit, and they cannot prospectively waive their claims.

The statute adopts a fairly expansive definition of genetic information. GINA defines an individual’s “genetic information” as “information about—(i) such individual’s genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members

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313 See § 202(a)–(b), 122 Stat. at 907-08 (codified at 42 U.S.C. § 2000ff-1(a)–(b)) (prohibiting discrimination in employment based on the employee's genetic information and prohibiting employer requests for such information except under certain conditions).
314 See 42 U.S.C. § 2000ff-2(B) (incorporating the definition of employer from 42 U.S.C. § 2000e (Title VII)—among other statutes—into the definition of employer under GINA).
315 Id. § 2000ff-2.
316 Id. § 2000ff-3.
317 Id. § 2000ff-4.
318 See Wagner, supra note 170, at 94 (“GINA defines covered entities broadly enough to include the clubs and teams (as employers) as well as the players’ associations (as labor organizations).”).
319 See supra note 21 and accompanying text.
320 Wagner, supra note 170, at 93.
321 Id. For more about Eddy Curry’s story, see supra note 144 and accompanying text.
322 See supra note 167 and accompanying text.
323 GINA’s process and remedies are modeled on those of Title VII. See 42 U.S.C. § 2000ff-6(a)(1) (applying the “powers, procedures, and remedies” of Title VII to GINA claimants). As explained above, the ADA also adopts the same pre-lawsuit procedures as Title VII, which includes an administrative remedy exhaustion requirement. See supra note 166.
324 Given that the precedent for Title VII applies to the ADA and that GINA adopts the same process and remedies as Title VII, it follows that individuals cannot prospectively waive their GINA claims. See EEOC, supra 168 (noting that the ADA does not permit advance waiver of the rights it guarantees).
of such individual.” The statute focuses exclusively on genetic testing, not other health-related tests. Although the statute does not explicitly state that family medical history constitutes genetic information, the inclusion of manifested conditions of family members has been read to extend the statute to family medical history, a rather common type of health-related information.

Regarding the family member provision, the plain language of neither the statute nor the regulations restrict the scope to conditions with specific hereditary components. Nonetheless, some courts have read this provision more restrictively, finding that GINA does not cover family medical history lacking a genetic component. Regardless, family medical history—and not genetic test results—have been the most frequent basis for GINA claims to date.

Importantly, while the statute covers the manifested conditions of a person’s relatives, GINA does not cover an individual’s own manifested genetic conditions. The law’s primary focus is therefore pre-symptomatic or asymptomatic individuals. The EEOC regulations define the terms “manifestation” or “manifested” to mean “that an individual has been or could reasonably be diagnosed with the disease, disorder, or pathological condition by a health care professional with appropriate training and expertise in the field of medicine involved” and specifies that “a disease, disorder, or pathological

326 Rothstein et al., supra note 196, at 526-27.
327 The EEOC regulations define “family member” to include dependents through marriage—including spouses and stepchildren—and adoption. 29 C.F.R. § 1635.3(a)(1) (2015). Moreover, in issuing its final rule on employer-provided wellness programs, the EEOC clarified that a spouse “is a ‘family member’ under GINA.” Genetic Information Nondiscrimination Act, 81 Fed. Reg. 31,143, 31,144 (May 17, 2016) (quoting 42 U.S.C. 2000ff(4)(a)(ii)). The regulations themselves explain that “[a] program is not reasonably designed to promote health or prevent disease if it imposes a penalty or disadvantage on an individual because a spouse’s manifestation of disease or disorder prevents or inhibits the spouse from participating or from achieving a certain health outcome,” which indicates that a spouse’s manifested condition qualifies as genetic information. 29 C.F.R. §1635.8(b)(2)(i)(A) (2016). The inclusion of stepchildren, adopted children, and spouses in the definition of family member indicates that the EEOC understands GINA’s family member disease manifestation prong to encompass more than just hereditary risk.

328 See, e.g., Poore v. Peterbilt of Bristol, L.L.C., 852 F. Supp. 2d 727, 731 (W.D. Va. 2012) (“[T]he fact that an individual family member merely has been diagnosed with a disease or disorder is not considered ‘genetic information’ if ‘such information is taken into account only with respect to the individual in which such disease or disorder occurs and not as genetic information with respect to any other individual’” (quoting H.R. Rep. No. 110-28, pt. 2, at 27 (2007))); see also Maxwell v. Verde Valley Ambulance Co., No. CV-13-08044-PCT-BSB, 2014 WL 4470512, at *16 (D. Ariz. Sept. 11, 2014) (citing Poore for that proposition); Allen v. Verizon Wireless, No. 3:12-cv-482(JCH), 2013 WL 2467923, at *23 (D. Conn. June 6, 2013) (also citing Poore for that proposition).
329 Rothstein et al., supra note 196, at 553-54.
condition is not manifested if the diagnosis is based principally on genetic information.” Yet even with this clarification, ambiguities remain. While seemingly logical to Congress, drawing the line at manifestation is far more challenging in practice. Consider symptomatic individuals who go on diagnostic odysseys searching for answers and finally discover an atypical genetic variation that could be responsible. Those people have “manifested” the condition in the sense that it caused impairment, but healthcare professionals were unable to provide answers without genetic testing.

Marfan syndrome, the disease that likely ended Isaiah Austin’s professional basketball career, provides a useful example. Physicians with experience in connective tissue disorders can diagnose that condition with a physical exam, but genetic testing can be helpful in some cases. How much protection would GINA offer? Individuals with Marfan syndrome are already experiencing the deleterious effects of the disease; in that sense, it is manifested. However, in certain circumstances, doctors may be unable to confirm the exact diagnosis without the aid of genetic technology. In that case, is the diagnosis “based principally on genetic information,” meaning that it is not manifested as defined by that statute? Or can Marfan syndrome always be reasonably diagnosed by other means, meaning the condition has manifested? These questions will remain unanswered until the courts weigh in on these kinds of cases.

Furthermore, the statute expressly allows covered entities to acquire, use, and disclose medical information that is not genetic. It specifies that covered entities do not violate the statute by “the use, acquisition, or disclosure of medical information that is not genetic information about a manifested disease, disorder, or pathological condition of an employee or member, including a manifested disease, disorder, or pathological condition that has or may have a genetic basis.” Of course, any acquisition, use, or disclosure of nongenetic information would have to be in accordance with other governing statutes, such as the ADA and perhaps the Health Insurance Portability and Accountability Act (HIPAA).

Genetic information, as defined by the statute, is of potential interest to the NFL and its clubs. First, basic medical examinations, such as preseason physicals, involve collecting information about family medical history.
which implicates an individual’s genetic information. Additionally, while the NFL and its clubs seemingly have not used genetic testing as aggressively as the NBA,338 they could at some point adopt such tests to screen players for genetic risk. As discussed in Part I, genetic tests purporting to evaluate athletic potential are already on the market and could also be of interest to the NFL and its clubs.339

GINA includes both privacy and antidiscrimination protections. Unlike the ADA, GINA does not have specific statutory defenses for safety and job-relatedness. Still, it does include a number of provisions related to the valid acquisition of genetic information.340

1. Privacy

This subsection outlines GINA’s privacy protections, applies them to professional football, and explores the possible exceptions or responses to a claim for the unlawful acquisition of genetic information.

a. Claims

GINA contains protections for privacy and confidentiality. Title II’s privacy protection prohibits employers from “request[ing], requir[ing], or purchas[ing] genetic information with respect to an employee or a family member,” regardless of whether the employer actually acquires the information.341 The accompanying EEOC regulations further explain that there is no exception for medical examinations related to employment:

The prohibition on acquisition of genetic information, including family medical history, applies to medical examinations related to employment. A covered entity must tell health care providers not to collect genetic information, including family medical history, as part of a medical examination intended to determine the ability to perform a job, and must take additional reasonable measures within its control if it learns that genetic information is being requested or required. Such reasonable measures may depend on the facts and circumstances under which a request for genetic information was made.

338 See, e.g., Adi Joseph, Isaiah Austin, NBA Draft Prospect, Has Career-Ending Genetic Disorder, USA TODAY (June 22, 2014, 3:03 PM), www.usatoday.com/story/sports/nba/draft/2014/06/22/isaiah-austin-genetic-disorder-marfan-syndrome-baylor-bears/11236699/ [https://perma.cc/E74Z-UABT] (explaining how the discovery of Isaiah Austin’s Marfan syndrome following pre-draft genetic testing ended his basketball career); Rice, supra note 144 (explaining that the Bulls refused to re-sign Eddy Curry until he received a genetic test to determine whether he had a heart condition).

339 See supra subsection I.B.3.

340 See 42 U.S.C. § 2000ff-11(b) (laying out exceptions to the prohibition on employers requesting, requiring, or purchasing genetic information).

341 Id.
and may include no longer using the services of a health care professional who continues to request or require genetic information during medical examinations after being informed not to do so.\textsuperscript{342}

Thus, even the employment-related inquiries and examinations that are lawful under the ADA would violate GINA if they involved requests for genetic testing or family medical history.

GINA’s privacy provision is unique.\textsuperscript{343} Other federal employment discrimination statutes contain no comparable language; in fact, the closest parallel is the ADA’s medical inquiry and examination provisions,\textsuperscript{344} discussed above.\textsuperscript{345} However, GINA’s enforcement and remedy provisions mirror those of Title VII.\textsuperscript{346} Thus, while claimants can recover for pure privacy violations without associated adverse employment actions, the remedies available in such cases will remain unclear until the case law is more established.\textsuperscript{347}

GINA also includes a stand-alone confidentiality provision, separate from its antidiscrimination sections. It provides that if a defendant possesses “genetic information about an employee . . . , such information shall be maintained on separate forms and in separate medical files and be treated as a confidential medical record of the employee or member.”\textsuperscript{348} GINA further provides that an employer “shall be considered to be in compliance with” the Act by treating the relevant genetic information “as a confidential medical record under section 12112(d)(3)(B) of [42 U.S.C.].”\textsuperscript{349}

\footnotesize{\textsuperscript{342} 29 C.F.R. § 1635.8(d) (2015) (emphasis added).}
\footnotesize{\textsuperscript{343} See Jessica L. Roberts, Protecting Privacy to Prevent Discrimination, 56 WM. & MARY L. REV. 2097, 2130-31 (2015) (describing GINA as “atypical” given its ban on requesting, requiring or purchasing genetic information and distinguishing it from “the vast majority of federal [antidiscrimination] law” that merely prohibits adverse employment actions on the basis of the protected trait without “prohibit[ing] employers from seeking—or even disclosing—information related to [the trait].”).}
\footnotesize{\textsuperscript{344} See id. at 2131 (“The statute provides that, pre-employment, . . . a covered entity shall not conduct a medical examination or make inquiries of a job applicant as to whether such applicant is an individual with a disability or to the nature or severity of such disability.”) (quoting 42 U.S.C. 12112(d)(2)(A))).}
\footnotesize{\textsuperscript{345} See supra subsection II.A.1.}
\footnotesize{\textsuperscript{346} 42 U.S.C. § 2000ff-6.}
\footnotesize{\textsuperscript{347} One, if not the first, of these cases resulted in a very generous award to the plaintiffs. See Lowe v. Atlas Logistics Grp. Retail Servs. (Atlanta), LLC, 102 F. Supp. 3d 1360, 1362-63, 1370 (N.D. Ga. 2015) (finding that defendant warehouse operator violated GINA by requiring employees to provide genetic information as part of its attempt meant to identify which employees had been defecating in the warehouse, even though plaintiff employees were not deemed a match and no adverse employment action was ultimately taken); Gina Kolata, Georgia: $2.2 Million Penalty for Illegal DNA Testing, N.Y. TIMES (June 22, 2015), http://www.nytimes.com/2015/06/23/us/georgia-dollar2-2-million-penalty-for-illegal-dna-testing.html [https://perma.cc/PE5M-HS55] (reporting that the jury in Lowe awarded $2,225,000 to the plaintiffs).}
\footnotesize{\textsuperscript{348} 42 U.S.C. § 2000ff-5(a).}
\footnotesize{\textsuperscript{349} Id.}
The statute states that covered entities cannot disclose an individual’s genetic information except to the individual himself—or the family member who is the receiving genetic services—with the individual’s written request; a researcher doing lawful research; government officials for compliance purposes; a public health agency if it relates to a deadly contagious disease or life-threatening illness; or to respond to a court order or comply with the relevant family medical leave laws.\textsuperscript{350} In many respects, the allowable disclosures mirror the privacy section’s exceptions governing acceptable requests for and acquisitions of genetic information.

GINA also complicates occupational medical recordkeeping. Recall that after a conditional offer of employment, the ADA permits employers to request access to an individual’s full medical records.\textsuperscript{351} However, under GINA, employers must exclude genetic information from those requests.\textsuperscript{352} While this requirement may, at first blush, seem relatively straightforward, it is far more complex. Given the broad definition of genetic information and its potential to appear throughout an individual’s health records, Professor Mark Rothstein deems it “practically impossible for custodians of health records to comply with GINA’s disclosure limitations.”\textsuperscript{353} Thus, even employers that make their best efforts to comply with both the ADA and GINA may still violate GINA’s privacy provisions.

b. Specific NFL Evaluative Technologies

While more limited in its application than the ADA since it concerns only genetic information, GINA is nonetheless relevant to a number of the evaluating technologies that the NFL or its clubs could use to evaluate the health of both current and aspiring players.

i. Medical Examinations and Athletic Drills

Routine physical exams or medical questions could trigger GINA’s Title II protections to the extent they entail asking players to provide family medical history, which constitutes an unlawful request for genetic information.\textsuperscript{354} The extent of liability will depend on the specific circumstances, how broadly the courts construe the scope of protected family medical history (i.e., whether it is limited to information about genetic risk), and the scope of the applicable exceptions.

\textsuperscript{350} Id. § 2000ff-3(b).
\textsuperscript{351} See Rothstein, supra note 186, at 44.
\textsuperscript{352} Id.
\textsuperscript{353} Id.
\textsuperscript{354} See 29 C.F.R. § 1635.8(d) (2015) (noting that GINA’s prohibition on the acquisition of genetic information includes family medical history).
To illustrate how the existing practices may be unlawful, consider the following passage from a 2001 book describing the medical treatment and evaluation of NFL players: “It says here that you have a family history of heart trouble.” “Well yeah, that’s right . . . in my family.” “Well, what exactly kind of heart trouble is that? A heart murmur?” “No, sir.” “Some congenital condition?”355

While such questions may have been lawful when the book was published in 2001 (assuming those inquiries are job-related pursuant to the ADA), they would clearly violate GINA today. Again, it is important to emphasize that the law prevents physicians from asking prospective and current players about family medical history, regardless of whether such questions relate to the player’s ability to play football.356 Thus, the NFLPA, the NFL, the clubs, and likely National Football Scouting as well are prohibited from asking players to provide family medical history. In contrast, the Standard Minimum Preseason Physical Examination, as outlined in the CBA, expressly includes the collection of family medical history as part of the general medical examination.357 By requiring players to provide genetic information in the form of family medical history, the CBA would seem to violate GINA.

As with medical examinations under the ADA, individuals cannot prospectively waive their legal rights under GINA.358 Hence, the fact that the NFLPA agreed to a standard physical that involves requests for family medical history does not insulate the NFL or its clubs from potential liability. Similarly, the fact that the NFLPA has made such an agreement could itself give rise to a GINA Title II claim against the NFLPA. With respect to other employment discrimination statutes, such as Title VII, courts have held that unions cannot collectively bargain to violate the law.359 Thus, insofar as the NFLPA collectively bargained to violate GINA, albeit inadvertently, the union may be found to have violated Title II.360

While traditional medical examinations or physicals might trigger GINA as requests for family medical history, the statute would not apply to athletic drills. Since those metrics generally measure individual performance, they do not deal with genetic testing or family medical history and therefore do not constitute requests for genetic information. We discuss below how GINA would apply to

356 See supra note 342 and accompanying text.
357 Collective Bargaining Agreement, supra note 32, app. K.
358 See supra note 342.
360 See 42 U.S.C. § 2000ff-3(c) (2012) (prohibiting labor organizations from requesting or requiring genetic information with respect to a member).
circumstances in which National Football Scouting, the NFL, or its clubs choose to adopt genetic tests in conjunction with medical exams or physicals.361

ii. Nongenetic Technologies

Given the very specific definitions of “genetic information” and “genetic test,”362 GINA would most likely not apply to the wearable technologies described in Part I.363 While genetic material can be obtained in a number of different ways—such as through buccal swabs, blood, semen, and other bodily materials and tissues—collecting and analyzing data relating to speed, agility, impact, sleep patterns, and heart rate does not involve DNA, RNA, chromosomes, proteins, or metabolites and would not independently reveal information about the content of an individual’s genotype. Thus, the innovative, nongenetic technologies described in Part I are squarely outside the scope of GINA’s protections. James would be unable to challenge them under GINA.

iii. Genetic Tests

If National Football Scouting, the clubs, or the NFL develop a further interest in genetic information (i.e., for injury prevention or enhancement through target training), assuming no exception applies, GINA prevents those organizations from requesting or requiring players to take genetic tests, even if the tests would reveal information related to playing elite football.364 Thus, requesting that James provide his family medical history or take a genetic test would violate GINA on its face.

Although GINA does allow occupational monitoring, it does so only with respect to toxic substances.365 Additionally, the wellness program exception, detailed below,366 is also unlikely to apply. Thus, even if protecting players from future injury were the sole purpose, National Football Scouting, the NFL, or its clubs may not be able to mandate genetic testing, regardless of the possible benefits to player health. Furthermore, even if National Football Scouting, the NFL, or a club lawfully obtained genetic information through

361 See infra subsection II.B.1.b.iii.
362 See 42 U.S.C. § 2000ff(4)(A) (defining genetic information as information about “(i) such individual’s genetic tests, (ii) the genetic tests of family members of such individual, and (iii) the manifestation of a disease or disorder in family members of such individual”); id. § 2000ff(7)(A) (defining a genetic test as “an analysis of human DNA, RNA, chromosomes, proteins, or metabolites, that detects genotypes, mutations, or chromosomal changes”).
363 See supra subsection I.B.2.
364 See 29 C.F.R. § 1635.8(d) (2015) (explaining that GINA does not contain an exception for examinations related to employment).
366 See infra note 375 and accompanying text.
an expansive reading of the exceptions, the statute’s antidiscrimination provisions still forbid acting on that knowledge.

c. Possible Responses and Defenses

GINA’s privacy protection is particularly salient with respect to the interests of both the NFL and its clubs in player health. This point is worth emphasizing: the clubs and the NFL could violate GINA simply by requesting genetic information, including family medical history. Unlike the ADA, under GINA’s outright prohibition, even job-related genetic tests that serve a legitimate business purpose are unacceptable.367 Thus, even genetic testing that comports with the ADA would still violate GINA. Similarly, the labor organization and training program provisions include prohibitions on requesting, requiring, or purchasing the genetic information of an employee or her family member.368 However, GINA does include some possible exceptions and defenses that merit discussion.

Let us again return to James at the Combine and the example of him providing his family medical history, submitting to an EKG, performing a running drill, swallowing a sensory pill, and taking a genetic test. The first potential line of defense against a GINA claim would likely be that the information does not meet the statute’s definition of “genetic information” such that James cannot challenge the EKG, the running drill, or the pill under GINA. But genetic testing quite clearly implicates genetic information.369 In the context of family medical history, the clubs and the NFL could use recent case law to assert that the requested family medical history is not genetic information because it does not demonstrate genetic risk per se.370 James could, of course, respond by arguing that a plain reading of the statute and the regulations support the contrary,371 or by attempting to establish that the requested family medical history does in fact implicate genetic risk.

Regarding requesting, requiring, or purchasing genetic information, the clubs and the NFL could argue that their actions fall within one of the statute’s several exceptions. A covered entity does not violate GINA in the following six circumstances: (1) when the employer inadvertently requests or requires the family medical history of an employee or an employee’s family member; (2) when the employer offers health or genetic services—such as in the context of a wellness program—and participation is voluntary and any individually identifiable genetic information is only disclosed to the

367 See supra note 342 and accompanying text.
369 See id. § 2000ff(4)(A)(i) (listing an individual’s genetic tests as part of the definition of "genetic information").
370 See supra note 328 and accompanying text.
371 See supra note 327 and accompanying text for examples of arguments that he could make.
employer in the aggregate; (3) when the employer requests family medical history to comply with family and medical leave laws; (4) when the employer purchases commercially and publicly available documents (i.e., newspapers but not medical databases or court records) that include family medical history; (5) when the employer requests the information for genetic monitoring of toxic substances in the workplace and follows the appropriate procedures for such monitoring; and finally, (6) when the employer conducts DNA analysis for law enforcement purposes or to identify human remains and requires employee genetic information for quality control reasons. None of these exceptions clearly apply to the NFL or the clubs in the contexts discussed herein. The statute further provides that the use of any genetic information acquired lawfully under one of these exceptions is still governed by GINA’s antidiscrimination and confidentiality provisions.

Of GINA’s six exceptions, the wellness program exception has the greatest potential applicability. Like the ADA, GINA allows employers to obtain health-related information when providing voluntary health services. The statute sets out a number of criteria for lawfully acquiring genetic information. While this exception arguably seems primarily geared toward the kinds of wellness programs encouraged by the Affordable Care Act, the language of the statute might be read to indicate that if an employer provides medical services, it can ask for genetic information. Yet for several reasons, the clubs and the NFL are unlikely to be able to use this exception. This exception targets wellness programs, not the occupational kind of medicine—medical examinations done for the benefit of the employer—that is provided at the Combine and by the NFL and its clubs. Moreover, the exception requires “prior, knowing, voluntary, and written authorization.” Recall that in addition to the broad authorizations signed before participating in the Combine, a player, upon joining a club, is required by his contract and the CBA to make various health-related disclosures. Failing to make those disclosures is grounds for termination and

373 Id. § 2000ff-1(c).
374 Id. § 12112(d)(4)(B).
375 See id. § 2000ff-1(b)(2)(A) (conditioning the wellness program exception upon the individual’s consent; the information being limited to the individual, her family, and the healthcare professional; and the information being provided to the employer only in aggregate terms).
378 See supra note 62 and accompanying text.
379 See supra notes 233–34 and accompanying text.
could undermine a player’s injury grievance. Far from voluntary disclosure, these requirements contractually obligate a player to disclose and seem to directly conflict with GINA’s prohibition on requesting or requiring genetic information. Further, the exception provides that only the individual or an authorized family member and the healthcare professional can receive individually identifiable genetic information. The employer can only receive that information in the aggregate, and the regulations imply that an employer that seeks to disaggregate employee genetic information violates GINA. In sum, James would have strong GINA claims for the requests for family medical history and genetic testing, and the clubs and the NFL would have little means to counter those claims.

As noted, individuals cannot prospectively waive their GINA claims by consenting to discrimination. But, the aforementioned exceptions to GINA’s privacy provision could nonetheless allow the lawful disclosure of genetic information. Of course, even if the NFL or its clubs could lawfully obtain genetic information as part of health or genetic services that it offers, Title II’s antidiscrimination provision would still restrict the ability to act on that information.

While the above arguments could potentially shield an employer from liability under GINA, the employer would face the additional obstacle of justifying its actions in accordance with the ADA.

2. Discrimination

GINA’s antidiscrimination provision forbids employers from taking adverse employment actions on the basis of genetic information. Specifically, it makes it unlawful for an employer

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**Footnotes:**

380 *See supra* note 237 and accompanying text.


382 *See* 29 C.F.R. § 1635.8(b)(2)(i)(D) (2015) (“Any individually identifiable genetic information . . . is not disclosed to the covered entity except in aggregate terms that do not disclose the identity of specific individuals . . . .”).

383 *See id.* (“[A] covered entity will not violate the requirement that it receive information only in aggregate terms if it receives information that, for reasons outside [its control], makes the genetic information of a particular individual readily identifiable with no effort on the covered entity’s part . . . .” (emphasis added)).

384 *See supra* note 324.

385 While no court has yet addressed whether GINA covers mixed-motive claims, some scholars speculate that genetic information must be the “but-for” cause of the discrimination. *See, e.g.,* Brian S. Clarke, *Grossly Restricted Pleading: Twombly/Iqbal, Gross, and Cannibalistic Facts in Compound Employment Discrimination Claims*, 2010 UTAH L. REV. 1101, 1125-26 (2010) (arguing that GINA should be interpreted as requiring a showing of but-for causation since it prohibits discrimination “because of” genetic information (emphasis in original) (internal quotation marks omitted) (quoting 42 U.S.C. § 2000ff-1(a))).
(1) to fail or refuse to hire, or to discharge, any employee, or otherwise to discriminate against any employee with respect to the compensation, terms, conditions, or privileges of employment of the employee, because of genetic information with respect to the employee; or

(2) to limit, segregate, or classify the employees of the employer in any way that would deprive or tend to deprive any employee of employment opportunities or otherwise adversely affect the status of the employee as an employee, because of genetic information with respect to the employee.

Unlike the ADA, GINA does not cover disparate impact (i.e., facially neutral policies that disproportionately exclude individuals on the basis of their genetic information). GINA does, however, include an anticlassification provision, which could limit both negative and positive differential treatment. For example, if a club or the NFL decides to dictate which positions individuals play based in part on their genetic information, the players could arguably challenge the policy as an unlawful classification. Thus, if a defendant differentiates between current or prospective players on the basis of genetic tests results or family medical history, that entity would run afoul of the statute, even if the genetic information in question speaks to the individual’s ability to play professional football. Additionally, GINA prevents labor organizations from discriminating on the basis of genetic information. It forbids them from “caus[ing] or attempt[ing] to cause an employer to discriminate against a member in violation of [the Act].” GINA also prohibits discrimination and classification in the context of training programs.

a. Specific NFL Evaluative Technologies

Given this background on GINA’s antidiscrimination provisions, we now turn to how those protections would apply to the use of evaluative technologies in professional football.

387 See id. § 12112(b)(6) (prohibiting employers from adopting qualification standards that “tend to” screen out individuals with disabilities).
388 See id. § 2000ff-7(a) (clarifying that “disparate impact . . . on the basis of genetic information does not establish a cause of action under this Act”).
390 See Bradley A. Areheart, GINA, Privacy, and Antisubordination, 46 GA. L. REV. 705, 709-10 (2012) (“GINA . . . does not allow the strategic consideration of genetic information to counter future genetic subordination . . . . Nor does the statute allow any positive consideration of genetic information through programs like genetic diversity initiatives.”).
392 Id. § 2000ff-3(a)(3).
393 Id. § 2000ff-4.
i. Medical Examinations and Athletic Drills

GINA's antidiscrimination provision prevents any adverse employment actions on the basis of genetic information, even when the information is lawfully obtained. Hence, even if the NFL or the clubs could legally obtain family medical history or genetic test results, they still could not act on that knowledge. James would therefore be able to challenge any job-related decision based on his genetic information, such as whether to hire him, whether to terminate him, or where to play him. Moreover, the NFL and the clubs have fewer legal responses at their disposal for GINA claims because the statute lacks the job-relatedness and direct threat defenses of the ADA. As with violations of genetic privacy, GINA would not prohibit adverse employment actions based on information obtained through athletic drills, leaving James without actionable GINA claims related to those evaluations.

ii. Nongenetic Technologies

Turning now to the nongenetic technologies from Part I, physiological data, even insofar as it might reveal a genetic defect, would not be considered genetic information because the condition would already have manifested. For example, imagine that BioForce's heart rate monitoring technology over time revealed an athlete's genetic heart condition. While the heart condition might have been caused by a genetic variation, it would have already manifested in the particular athlete in order to be detected by the technology. Thus, while the condition might constitute an actual or perceived disability pursuant to the ADA, it would fall outside of GINA's definition of genetic information. GINA therefore offers little protection with respect to wearable technologies. James's best strategy would be to argue that these evaluations were medical examinations under the ADA.

iii. Genetic Tests

As already discussed, genetic test results unequivocally constitute genetic information. Thus, any employment-related decision by the NFL or one of its clubs based on the results of genetic tests would be challengeable pursuant to GINA.

b. Possible Responses and Defenses

Should James allege that he suffered an adverse employment action on the basis of genetic information, such as being dismissed from the Combine or not being hired as a player, the club or the NFL could argue that the

394 See supra note 362.
information they used was not genetic or that the action they took did not rise to the level of an adverse employment action. As mentioned, data from traditional medical examinations, athletic drills, or wearable technologies are outside the scope of GINA. With respect to what constitutes an adverse employment action, say a club wanted to use James’s lawfully obtained genetic information to construct a training and eating plan designed to maximize his potential. If James challenged the plan as an unlawful classification, the club could respond that the specialized training and eating plan does not adversely affect his status as an employee.

Significantly, GINA does not restrict its coverage to qualified individuals, unlike the ADA’s employment discrimination protections that only apply to individuals who can perform the essential functions of the job despite having a disability. Thus, GINA litigants can avoid the potential issue of establishing which aspects of NFL football constitute essential functions and whether they can perform those functions with comparative excellence.

GINA also does not include statutory defenses designed to ensure safety or efficiency. Title II has no equivalent to the ADA’s direct threat or job-related / business necessity defenses. It likewise does not include a bona fide occupational qualification (BFOQ) defense found in statutes like Title VII of the Civil Rights Act. Thus, even if genetic information relates to an individual’s ability to safely perform a particular job, at present, a covered entity cannot use that fact to defend a decision to act on that person’s genetic information.

395 See 42 U.S.C. § 12111(8) (defining a qualified individual under the ADA as one who “can perform the essential functions” of the job).

396 Wagner, supra note 170, at 92 & n.72. While our focus is on NFL players, it is worth noting that GINA potentially poses unique challenges with respect to the practice of occupational medicine. Occupational physicians providing care to players (rather than exams only) would likely request family medical history and possibly genetic testing and act on the information to improve player care. However, GINA prevents them from doing so, even when the genetic information could speak to the employee’s health and safety. Not surprisingly, then, the American College of Occupational and Environmental Medicine (ACOEM) has expressed concern that GINA could place occupational physicians in ethical quandaries. In a position statement on genetic screening in the workplace, it explained,

It seems reasonable to expect that, in the future, some forms of genetic testing will provide a basis for more effective methods to ensure the health of individual workers, but that preventive actions taken on the basis of such testing might violate GINA. In such situations, both acting on the basis of genetic information to better protect the worker and not acting on that information, and thereby failing to protect the worker, would violate standards of ethical conduct. ACOEM hopes that such potential conflicts can be preemptively resolved without recourse to litigation and the federal court system.

3. GINA Summary

To summarize, Title II of GINA has two relevant kinds of protections: privacy and antidiscrimination. From the perspective of litigating these claims, NFL players would probably enjoy more success under GINA because, unlike the ADA, it lacks both a qualification requirement and job-relatedness and direct threat defenses. At the same time, GINA’s coverage of genetic information is far narrower than the ADA’s coverage of current, past, and perceived disabilities, so instances of genetic-information discrimination would likely be less frequent. For example, GINA would only apply to two of the hypothetical evaluations James was asked to agree to—providing family medical history and taking a genetic test—but he could argue that the ADA should cover most, if not all of them, including submitting to an EKG, performing a running drill, and swallowing a sensory pill. The applicability of and possible defenses under GINA are summarized in Table 3.

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Protections</th>
<th>Defenses</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Genetic test results</td>
<td>Protection against discrimination</td>
<td>• Not genetic information</td>
</tr>
<tr>
<td>(2) Genetic test results of family members</td>
<td></td>
<td>• Did not discriminate / adversely affect</td>
</tr>
<tr>
<td>(3) Manifested disease or disorder in family members (i.e., family medical history)</td>
<td>Protection of privacy</td>
<td>• Not genetic information</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Statutory exceptions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Did not request, require, or purchase</td>
</tr>
</tbody>
</table>

* * *

Current law appears to limit the ability of the NFL, its clubs, and National Football Scouting to obtain and act on information related to player health. Both the ADA and GINA include limitations on acquiring and using knowledge that relates to either disability or genetic information, respectively. With regard to acquisition, the ADA’s medical examination and inquiry provisions and GINA’s ban on requesting, requiring or purchasing genetic information, limit the ability of the NFL and its clubs to seek information, even if it could speak to an individual’s ability to play football. Both

398 Id. § 2000ff-1(a)–(b).
399 Id. § 2000ff-1(b)(1)–(6).
statutes allow applicants and employees to volunteer health-related information under certain circumstances. However, prospective and current players, as well as the NFLPA, cannot simply waive all of the relevant protections. With regard to discriminatory actions, the ADA contains some health- and safety-related exceptions that the NFL or the clubs could use to obtain pertinent information and to act on it in the name of health and safety. GINA, by contrast, contains fewer exceptions and defenses. Thus, the NFL and its clubs should consider whether their actions and policies violate one or both of these federal employment discrimination statutes.

III. GOING FORWARD

When we began working on this project, we imagined its chief import would be to help determine which, if any, of the new types of wearable technologies and genetic testing that are being considered or currently used in the NFL (among other professional sports leagues) violate existing laws, in particular GINA and the ADA. This concern remains an important part of the project, but we were surprised in our research: first on the way in which the testing of professional sports players violates or accords with these laws and second, to learn that even more basic and “lower tech” testing mechanisms that have been in place for a long time in the NFL may be problematic. For that reason, our recommendations going forward pertain both to the new technologies as well as their predecessors still in place.

Admittedly, antidiscrimination claims—a category that includes those alleged under the ADA or GINA—are notoriously hard to win and frequently do not make it past summary judgment. Moreover, the ADA may well be especially pro-defendant. We have no reason to believe that professional athletes would fare any better than other litigants. We do however think litigation by players is special because even if it proves ultimately unsuccessful, filing a case against very public entities like the NFL and its clubs—with attendant media coverage—may be more likely to cause policy change than a typical employment discrimination lawsuit. Moreover, regardless of an individual’s ability to prevail in court, we believe all employers—including the NFL and its clubs—should comply fully with the current law. To that end, our recommendations center around four “C’s: compliance, clarity, circumvention, and changes to existing statutory schemes as


401 See Sharona Hoffman, Settling the Matter: Does Title I of the ADA Work?, 59 ALA. L. REV. 305, 308 (2008) (“Numerous studies have confirmed that plaintiffs experience extremely low win rates in cases decided under Title I of the ADA.”).
applied to the NFL (and perhaps other professional sports leagues). In making all of these recommendations, we believe our suggestions to be the best solutions to the problems we have identified, but we also recognize that the current state of politics makes implementing some of our proposals challenging. Thus, it is not our goal to provide definitive solutions to the issues identified throughout the Article but to begin a conversation that we hope will benefit NFL players and perhaps also the rest of the working population.

A. Compliance

The first upshot of our analysis is that it appears that some of the existing testing of NFL players, both at the Combine and once drafted and playing for a club, seem to violate existing federal employment discrimination laws. Specifically,

1. the medical examinations at the Combine potentially violate the ADA's prohibitions on pre-employment medical exams;
2. post-offer medical examinations that are made public potentially violate the ADA's confidentiality provisions;
3. post-offer medical examinations that reveal a disability and result in discrimination—e.g., the rescission of a contract offer—potentially violate the ADA provided the player can still perform the essential job functions;
4. Combine medical examinations that include a request for a player's family medical history potentially violate GINA; and
5. the preseason physical's requirement that a player disclose his family medical history potentially violates GINA.

While we discuss the possibility of an exemption for professional sports below, the ADA and GINA currently apply to professional football. Accordingly, the NFL, its clubs, and National Football Scouting should not wait for lawsuits alleging violations but should instead proactively work to bring themselves in compliance with the law. In particular, we believe it is essential for the NFL, the clubs, and National Football Scouting to ensure they comply with the statutes’ confidentiality requirements so that current and prospective players do not have private health information about themselves and their families released to the press. We also believe it is important to amend the CBA to no longer require players to disclose their family medical history as part of physicals.

402 See infra subsection III.D.1.
B. Clarity

Beyond this set of practices that seem to contravene the ADA and GINA, there is another set of practices for which there is ambiguity in the application of the existing legislative and regulatory standards, with many issues left untested by litigation. It would therefore be useful for the EEOC or even Congress to weigh in on several different legal issues. Additionally, the NFL itself could issue official statements explaining its position on how to best resolve these ambiguities.

As noted in the Compliance section, the legality of the various employment-related medical examinations is our primary concern. Many of the evaluations performed at the Combine appear to be exactly the kind that the ADA (and possibly GINA) prohibit. Similar open questions relate to the defenses available to employers for post-offer (employee entrance) examinations, done by the clubs themselves after a player has been drafted. Recall that employers can conduct post-offer exams as long as they are universal, confidential, and the results are used in accordance with the ADA. Thus, insofar as the clubs target particular players for additional medical screening, or release the results of the examinations to the press, they are not complying with the ADA. But certain ambiguities render these judgments difficult. We therefore invite the various stakeholders to offer clarification with respect to professional football as employment, the independence of National Football Scouting, the scope of ADA-covered medical examinations, and the scope of GINA’s definition of family medical history.

1. Job-Relatedness and Qualified Individual

Playing for the NFL is not a typical job. Hence, the meaning of legal terms that are intuitive or self-evident in most employment claims becomes stubbornly difficult to define in the context of professional football. Two such examples are essential job functions and what it means for a particular inquiry or qualification standard to be job-related or consistent with business necessity.

Recall that the ADA allows both pre-employment inquiries regarding whether an applicant can “perform job-related functions” and medical examinations and inquiries during employment, so long as they are “job-related and consistent with business necessity.” Moreover, if an employer complies with the statute’s requirements for lawful employee entrance exams, it can legally withdraw an offer of employment if the prospective employee cannot meet a

403 See supra Section III.A.
405 Id. § 12112(d)(2)(B).
qualification standard that is “job-related and consistent with business necessity.” And finally, the ADA’s employment discrimination provisions apply only to “qualified individuals with disabilities,” that is, individuals who can perform “the essential functions of the employment position.” Thus, understanding the scope of the job and which functions are job-related and essential is crucial for applying the ADA.

The statutory text suggests that defining the contours of a particular job is a threshold matter. With a clear definition of the core functions of the specific job in question, an employer can go on to design inquiries or examinations that relate to those core functions, and any individual who cannot meet that basic threshold cannot sue for discrimination. But what are the essential, job-related functions of an NFL player?

The NFL or its clubs might define the essential job function of playing professional football as “being the best—the strongest, the fastest, the healthiest, etc.,—possible player,” making any health- or performance-related inquiry or examination job-related (and also perhaps consistent with business necessity). Moreover, if “being the best” is an essential job function, then any person who is not the highest performing player on his club, or perhaps in the league, will arguably not be a qualified individual entitled to the ADA’s antidiscrimination protections. Thus, under that reading, the clubs or the NFL could lawfully take adverse employment actions against all but a handful of players. Finding the best possible players appears to be what the clubs are really after in the Combine. But adopting a relativist definition of a given job position—i.e., wanting only the best—poses problems for the ADA. Its statutory requirements are transsubstative across industries, such that absent sports-specific amendments to the law, whatever definition applies to the NFL will apply equally in all other employment settings.

To show why a relativist job description could be problematic, it may be helpful to go outside the NFL context for a moment. Suppose that Stanford Law School asked prospective law professors for medical information during the Association of American Law Schools (AALS) Faculty Recruitment Conference. When challenged that its actions violate the ADA or GINA, Stanford could adopt a relativist definition and defend its practices as job-related. It could argue that as an elite law school, it only wants the best professors who will perform at the highest level for the duration of their law school career. However, the ADA’s transsubstantive nature would mean that this same approach could be applied to other employment settings across industries.

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careers. Thus, an applicant’s family medical history of Alzheimer’s could speak to the quality of a candidate’s scholarship across her lifetime appointment; the strength of her heart and her chance of cardiac arrest could speak to her chances of missing a semester due to a heart attack; and so on. Similarly, if “being the best” is an essential job function and a current professor suffers a heart attack or a stroke that lowers her productivity—causing it to fall below that of her colleagues—she would no longer be qualified, as she is no longer the best. Arguably, Stanford could then terminate her, even if she were still able to write and teach. Just like NFL clubs, Stanford has a limited number of available slots and would have an understandable preference to fill those slots with the absolute best possible candidates—not only those who will produce the best scholarship and be the best teachers, but those who will also be productive for the longest amount of time with the fewest distractions, health-related or otherwise. As this example indicates, if jobs are defined in terms of one’s ability to be the “best possible” person for the job and not simply as the ability to meet a certain basic threshold of performance, the job-related exceptions for medical examinations and inquiries will swallow the rule that prohibits them, and the ADA’s employment discrimination provisions will lose their teeth. In other words, the ADA’s protections would essentially disappear.

For this reason, we think the “threshold” model reading of the statute is the better fit. The ADA demands that employers define job positions and their requirements in absolute, not relative terms. That is not to say that an NFL club (or indeed a law school) cannot look at the “whole player,” but they need to do so in a way that is specific and defensible: they should articulate specific standards for the questions they ask at the Combine, identify a threshold value, and defend that value as related to a function of the job. In this way there is no “blank check” for asking any medical question a club may find useful. Instead, the law should require them to generate a carefully articulated and justified list of acceptable inquiries that invade the medical privacy of the player to the least extent possible.

Of course, any threshold requirements for being a professional football player would have to be carefully constructed. Every position is different, and the players are of different sizes and skill levels and fit within their teams differently. Thus, to be useful, any description of the essential, job-related functions of football would have to account for these variations. Although professional football is unique as an occupation, other professions with physical requirements that may want to recruit the best employees have adopted threshold physical requirements and designed their pre-employment and post-offer screenings accordingly. For example, fire departments tend to include extensive descriptions of the physical, mental,
and interpersonal requirements. Essential job requirements include knowledge of firefighting and good communication skills, as well as physical abilities. In Mesa, Arizona, specific physical essential job functions, for example, include “[w]ear[ing] personal protective equipment weighing approximately 70 pounds . . . in high humidity (up to 100 percent) situations . . . [while] rel[y]ing on [a] self-contained breathing apparatus for respiratory ventilation.” In Farmington, New Mexico, the job description includes both general requirements related to physical ability—such as being “frequently required to stand; walk; use hands to finger, handle, or operate objects, tools, or controls; and reach with hands and arms” and “occasionally [being] required to sit; climb or balance; stoop, kneel, crouch, or crawl; talk or hear; and taste or smell”—and specific requirements regarding lifting ability and vision. Thus, while defining specific baselines for physical performance in highly selective and physical jobs may be challenging, it is not impossible. Consequently, to fully comply with the law, the NFL and its clubs may require some clarification regarding how to apply basic employment law concepts like essential job functions and job-relatedness to professional football.

2. Independence of National Football Scouting

Another difficulty warranting further clarification is the way in which the Combine is run. Many of the evaluations described above are not being directly administered by the NFL, or the individual clubs. Instead, National Football Scouting functions as a separate corporate entity, which enters into a contractual agreement with the NFL for the operation of the Combine. The Combine is a scouting service used by the clubs and the NFL to make hiring decisions. It obtains information those entities can use when assessing prospective players. Moreover, while IU Health doctors test players at the Combine, clubs (and their medical staffs) also perform their own examinations and interviews.

However, it is not clear whether National Football Scouting itself independently qualifies as an employer, an employment agency, a labor organization, or a joint labor-management committee. Thus, to argue liability under the ADA or GINA, one would have to assert that National Football

411 Firefighter, supra note 410; Lateral Firefighter, supra note 410.
412 Firefighter, supra note 410.
413 Lateral Firefighter, supra note 410.
414 See supra notes 43–45 and accompanying text.
415 See supra note 49 and accompanying text.
416 See supra note 51 and accompanying text.
Scouting is effectively operating as an agent or an extension of the NFL and its clubs. As mentioned above, if the NFL or the clubs maintain sufficient control over the operation of the Combine, National Football Scouting may likewise be bound by the applicable employment discrimination laws. As we discuss below in our Section on “Circumvention,” we would find any determination that employers can circumvent the ADA’s or GINA’s protections by outsourcing the prohibited examinations to be problematic. We therefore need clarity regarding whether the separate corporate status of National Football Scouting and the existing setup of the Combine immunize the clubs and the NFL from liability.

3. Scope of Medical Examinations and Inquiries (ADA)

Additionally, fully understanding how the ADA applies to professional football also requires clarification regarding how the statute defines medical examinations and disability-related inquiries, particularly with respect to the new technologies outlined above. Certain athletic drills and wearable technologies could reveal the presence of an impairment. If the results of these evaluations convey disability-related information to the NFL or the clubs, could they be considered medical examinations or inquiries covered by the ADA? If they are medical in nature, the ADA would restrict when and how the NFL, the clubs, or National Football Scouting may administer the drills or use the technologies. If they are not medical, the ADA would not regulate their use.

We can again return to firefighters as an illustrative example. The firefighter application process in Houston includes a pre-employment physical ability test that involves various simulations, such as a ladder raise, a dummy drag, and a mile-and-a-half run. After an applicant completes the physical ability test, a civil service exam, and an interview, she may receive an offer of employment contingent on her successful completion of a drug screening and medical and physical exams. Because the physical ability test is not considered a medical examination, fire departments can administer them pre-employment. Likewise, assuming athletic drills and use of wearable technologies are not medical, the NFL, the clubs, and National Football Scouting could require them even before a prospective player has an employment offer. Thus, whether the ADA applies to drills or wearable technologies that reveal impairments is another area that could benefit from further clarification.

417 See supra text accompanying notes 155–56.
418 See infra Section III.C.
The relationship between the ADA and GINA could also be clarified. Genetic tests appear to meet the ADA's definition of a medical examination. Yet in addition to abiding by the ADA's medical examination provisions, employers must follow GINA's prohibition of requests for genetic information. Therefore, if an employer offers genetic testing, it would simultaneously violate both statutes. The relationship becomes somewhat more ambiguous regarding discrimination on the basis of genetic test results. In such cases, GINA would provide a clear remedy. However, a claimant could also argue that an adverse employment action based on her genetic information constitutes discrimination on the basis of a perceived disability. It would be useful to clarify whether the ADA provides concurrent protection in those cases.

4. Scope of Family Medical History (GINA)

Lastly, it would be helpful to have a definitive statement on the scope of GINA's protections for family medical history. As discussed above, the definition of genetic information includes "the manifestation of a disease or disorder in family members of such individual." Neither the statute nor the accompanying regulations restrict this provision to diseases or disorders proven to have a genetic component. Instead, the regulations focus on who is a family member. Perhaps Congress's decision not to cabin GINA's protections to family medical histories that communicate a known genetic risk was a strategic decision, as researchers constantly discover genetic risk factors for more and more conditions. Regardless, the courts have taken it upon themselves to limit the statute's coverage of family medical history to violations dealing only with manifested genetic diseases or disorders. Thus, it

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421 See EEOC, supra note 176 (defining a "medical examination" as a "procedure or test that seeks information about an individual's physical or mental impairments or health").
423 See supra note 327 and accompanying text.
425 See supra note 328 and accompanying text.
would be useful for Congress or the EEOC to specifically address these interpretations. This clarification would be useful in the context of professional football and beyond.

C. Circumvention

Again, National Football Scouting is not technically owned or operated by the NFL but is rather a scouting service that is owned and managed by approximately two-thirds of the league’s clubs.426 Indeed, all thirty-two NFL clubs consider the medical examinations, performed by IU Health doctors and club physicians, to be the most important aspect of the Combine.427 It is worth reiterating that while employers can make job-related inquiries pre-employment, the ADA bans all pre-offer medical examinations,428 rendering what happens at the Combine a clear violation. Although some of the Combine’s interview questions might arguably fall within a broadly construed job-relatedness exception, all of the Combine’s medical examinations would seem to violate the ADA, as the statute applies to the clubs, and National Football Scouting appears to be acting as their agent when running the Combine.

Although we have no evidence to suggest that the corporate structure of National Football Scouting or the Combine in relation to the NFL and the clubs has been intentionally structured in order to circumvent the applicability of the ADA and of GINA, that may nonetheless be the effect. The end result is that through the Combine, the NFL clubs are getting the exact kinds of health-related information that the ADA and GINA seek to prohibit. Should these laws’ protections be rendered toothless because of this contractual end run? We think the answer is no. It would frustrate the purpose of those statutes to allow the corporate and contractual structure of the Combine to immunize misconduct.

A non-football example is informative, especially given that the laws in question are not football-specific. To return to the market for law professors, imagine that AALS set up its own combine—the “AALS Scouting Combine”—as a separately owned and incorporated organization to run a three-day event where all prospective law professors were subjected to medical examinations and inquiries of the kind done by the NFL. Should that be lawful if an individual law school could not do the same testing or ask the same questions due to the ADA’s or GINA’s protections? In other words, should the corporate formality of this combine not being organized by the law schools themselves—even if they send their own doctors and rely on medical reports done by combine

426 See supra note 43 and accompanying text.
427 See supra note 48 and accompanying text.
doctors—immunize the parties from ADA or GINA liability? We think that if the rules restricting medical examinations under the ADA or requests for genetic information pursuant to GINA are to mean anything, such corporate or contractual arrangements cannot be immunity-conferring.

The better rule, and the one for which we would advocate, would discourage any potential circumvention of these protections. It is often said one should “follow the money,” but in this context, one should “follow the data.” Our approach eschews the formalism of corporate organization and contractual relationships in favor of examining who is seeking medical data and to what end it is being sought. Regardless of National Football Scouting’s separate corporate status, the Combine is organized for the benefit of the clubs—a fact made clear given that they even send their own club doctors to interview and examine players there. The data is flowing to the clubs and aiding in their decisionmaking as to whom to hire.

Nor is it any answer to these concerns that players voluntarily go to the Combine and consent to these evaluations. Participating significantly increases a player’s chances of playing NFL football. To say that NFL hopefuls have freely chosen to participate adopts a truncated view of what freedom means. Consenting freely to one activity may mean inadvertently agreeing to subsequent activities, some in which—all things held equal—the person would not have otherwise chosen to do. Hence, when an aspiring NFL player consents to participate in the Combine, he also finds himself consenting to the public release of sensitive medical information—a condition to which, absent the Combine, he might not have agreed. The ADA’s and GINA’s prohibitions were put in place in part to prevent a race to the bottom and to prevent individual employees from facing a choice between consenting to such medical examinations and being beaten out for jobs by other employees who do. If such a purpose is to be effectuated, the design of the corporate form cannot circumvent the underlying obligation.

D. Changes

While we advocate for both compliance and clarification under the current law, we also recognize that playing NFL football—as well as professional sports generally—is not a typical occupation and, therefore, could warrant special treatment under the law. Thus, we propose three possible professional sports exceptions to the ADA and GINA. Additionally, we suggest a general reform to GINA designed to better protect employee safety.

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429 See Jim Reineking, Notable Current NFL Players Who Weren’t Invited to the Combine, NFL (Feb. 16, 2016, 12:51 PM), http://www.nfl.com/photoessays/0ap3000000636359 [https://perma.cc/Z3YC-YZ6J] (noting that 83.6% of players selected in the 2016 NFL Draft had attended the Combine and that no player who did not attend was drafted before the fourth round).
1. General Professional Football (Sports) Exemption

As mentioned throughout this Article, the ADA and GINA apply with equal force to professional sports as they do to traditional occupations. But perhaps they should not. Given the very exceptional nature of NFL football—the salaries, the selectivity, the degree of physical performance, the risk of serious injury, etc.—health-related and medical information takes on an added level of relevance not present when hiring a factory worker or perhaps even a firefighter. While giving the NFL, the clubs, and National Football Scouting access to information that relates to disability or to genetic makeup opens the door for subsequent discrimination, the benefits may outweigh the risks. From the perspective of the clubs and the NFL, those entities want as much information as possible and to be able to make a decision about whether to invest in a particular player. From the perspectives of the players themselves, they also could have reasons for wanting to give the clubs, the NFL, and National Football Scouting medical or genetic information to allow them to make decisions based on that information. Since professional football is so physical, it may be in the interest of players to give as much medical information as possible—and to permit the NFL and the clubs to use that knowledge for work-related decisions, including injury-prevention purposes. Furthermore, medical and health-related information could be used to enhance performance and to help the players reach new levels of play. However, because of the restrictions on medical examinations and requests for genetic information, the NFL and the club may not be able to obtain data that could be used to enhance performance. Moreover, even if they could lawfully gain access to that information via one of the ADA’s or GINA’s exceptions, the statutes’ anticlassification provisions could restrict the ability to act on it. Congress could therefore consider adding a professional sports exemption to the ADA and GINA.

But with that said, the NFL is a workplace like all others. People have as much a right to be free from disability and genetic-information discrimination there as elsewhere. The ADA builds in myriad defenses for an employer, and it is not clear that the NFL or the clubs warrant an extra privilege that is denied to every other employer in America. Thus, if Congress chooses to revisit the applicability of the ADA and GINA to professional sports organizations, it should first conduct extensive fact-finding regarding the benefits and the dangers of such a broad exemption, including the views of current and former players.

2. Exception to Medical Examination Provisions (ADA)

Another possibility would be a more narrow exception for just the ADA’s disability-related inquiry and medical examination provisions, as opposed to an exception to the entirety of Title I of the ADA and Title II of GINA. Pre-
employment medical examinations are the most significant, especially given the central role the Combine plays in hiring. A very narrow professional sports exception might lift the outright ban on pre-employment medical examinations and instead require professional sports employers to conform with the universality, confidentiality, and antidiscrimination requirements imposed on employee entrance exams. Such an exception would leave the ADA's antidiscrimination protections in place and still outlaw discrimination on the basis of disability that is not job-related and consistent with business necessity and that falls short under the direct threat defense. It would also leave intact the full panoply of GINA's Title II protections.

3. Exception for Family Medical History (GINA)

Similarly, Congress could adopt a narrow exception that would allow professional sports employers to obtain and consider family medical history when it is relevant to a player's risk of injury or could be used to improve performance. Such an exception would have to apply to both GINA's privacy and antidiscrimination provisions. To allow access to potentially useful information about family medical history but prohibit the clubs or the NFL from acting on that information would undermine the potential benefit of such an exception.

4. Need for a Direct Threat Defense (GINA)

There is another respect in which we think GINA is too protective. As discussed above, the ADA provides employers a defense to charges of discrimination relating to threats to self or others. As mentioned, GINA has no equivalent defense available for employers who wish to protect the health and safety of their employees. In cases of direct threats to others, we think the fact that such a defense is unavailable in the GINA context is problematic. To be sure, because of the definition of “genetic information” within GINA—which requires that the disorder has not yet manifested at the time of the discrimination—cases involving direct threats to others within the meaning of the statute are likely to be few in number. But if such a case arose—for example, if an NFL club determined through a genetic test that a player was likely to pose a direct threat to the safety of other players—we think that the club ought to have a defense if it refused to employ the player.

Whether there ought to be a similar exception under GINA for cases where a player alleges he was discriminated against because he posed a direct threat to himself is a closer question. To see how this might come about, imagine a genetic

\[430\] 42 U.S.C. § 12113(b).

\[431\] See supra note 330 and accompanying text.
test was developed to determine which players are at higher risk of chronic traumatic encephalopathy (CTE) after suffering a concussion. Such a test would reveal a susceptibility—not a manifested condition, and if the information was genetic in nature, it would fall within GINA’s antidiscrimination protections.

Should the NFL clubs nonetheless be given a prerogative to discharge a player if presented with this information? Our tentative assessment, with one important caveat, is yes. To illustrate, imagine a parallel case involving a susceptibility that had manifested: a player who was already showing signs of cognitive impairment and whom—for that reason—doctors were confident might suffer further (due to second impact syndrome) if he took another hit. Under the ADA, the employer might have a direct threat defense should that player be discharged. Now imagine that a potential player has not yet been injured but has a clear genetic susceptibility to traumatic brain injury. Why should we want a different rule in the context of genetic information? In both cases, the law has made a decision to overrule the autonomy of the player to decide whether or not to continue to play because there is a direct threat to his health that cannot be resolved by a reasonable accommodation. It seems to us the cases should be treated symmetrically, though we acknowledge that the matter is closer.

The caveat we want to emphasize is one about uniformity of application, a kind of equal protection notion. Because the direct threat defense is raised on a case-by-case basis, a club could in theory permissively dismiss one player due to a predisposition to CTE but not dismiss a similarly situated player. Such cherry-picking could be used to unfairly target certain players. That is, if the NFL or the club seeks to defend a discharge on this ground, the player

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432 This example is provided only as a simplified illustration. We recognize that the science of concussions and CTE is complicated and evolving and that there are disagreements on many things, including the causal pathway from football to CTE.

433 Second Impact Syndrome, BRAINANDSPINALCORD.ORG, http://www.brainandspinalcord.org/second-impact-syndrome/ [https://perma.cc/F4YV-7FC8] (“Second impact syndrome is a very rare condition in which a second concussion occurs before a first concussion has properly healed, causing rapid and severe brain swelling and often catastrophic results.”).


435 Perhaps some readers will think that neither the ADA nor GINA should overrule the player’s autonomy in this case, and that the direct threat to self-defense should be eliminated. That is an argument worth discussing at length, though not here. For now, our only point is about symmetry: conditional on believing that such a defense should exist, it is implausible to have it in the ADA but not GINA.
should be able to challenge that defense by showing that it has not been consistently applied to similarly situated players. This strategy has enjoyed at least some success in other employment contexts. For example, a diabetic police officer sued her employer for removing her from patrol duties following her diabetes diagnosis, arguing that the police department did not similarly remove other diabetic officers. The court rejected the employer’s direct threat defense and denied its motion for summary judgment on her ADA claim, and the case later settled. A showing that the employer treated some players one way while others a different way (perhaps based on their perceived support among fans, for example) could demonstrate that the offered defense is pretextual for discrimination, and thus forfeited. Yet even with a clearer uniformity requirement, an employer could still attempt to defend its actions by distinguishing between the two employees’ relevant risks or abilities to safely perform the job.

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A player’s health and fitness directly impact his ability to play professional football. However, at present, federal employment discrimination laws—mainly the ADA and GINA—apply to the NFL’s, the clubs’, and perhaps National Football Scouting’s use of both old and new evaluative technologies. To that end, we first advocate compliance with the current law. Next we request clarity regarding how these statutes apply to the exceptional context of NFL football. We also seek to avoid circumvention of the law’s goals through clever corporate structuring. Finally, we suggest changes that could better balance the interests of the players and of the NFL and its affiliates.

CONCLUSION

As our analysis reveals, several of the accepted practices of the NFL, the clubs, and National Football Scouting could implicate current and prospective players’ rights under the ADA and GINA. First and foremost, we encourage the NFL, the clubs, and National Football Scouting to comply with the

437 See Jackson v. City of New York, No. 06-CV-1835, 2011 WL 1527935, at *1 (E.D.N.Y. Apr. 22, 2011) (adopting the magistrate judge’s recommendation in its entirety, which rejected the direct defendants’ threat defense).
438 Stipulation and Order of Settlement and Discontinuance at 1, Jackson v. City of New York, No. 06 CV 1835 (E.D.N.Y. Dec. 19, 2012).
439 Pugh v. City of Attica, 259 F.3d 619, 626 (7th Cir. 2001) (applying the McDonnell Douglas burden-shifting approach to ADA claims, which includes an analysis of whether the employer’s proffered reason for its adverse employment decision is pretext for illegal discrimination).
existing law. We invite lawmakers and regulators—specifically Congress and
the EEOC—as well as stakeholders in professional football, to offer
clarification about how those statutes apply to professional football players.
We discourage circumvention of the law through clever corporate forms. And
finally, we suggest possible legal reforms, including a broad professional
sports exemption or more modest statutory exceptions.

While NFL players have been the exclusive focus of this Article—and we
have emphasized time and again the players’ uniqueness as individuals and
the uniqueness of their job—this Article has implications beyond professional
sports. Many jobs include some physical element or the risk of potential
injury. While the physical requirements of being a firefighter might be
immediately apparent, administrative assistants must sometimes lift heavy
boxes and nurses must help move patients.

Furthermore, employers have a number of reasons for being interested in
the health of their employees, such as keeping the costs of providing health
insurance down (especially now in the wake of the employer mandate440) and
avoiding lawsuits and workers’ compensation claims. Thus, while the NFL
may be particularly interested in the health of its employee players, health
risk and injury prevention are of interest to a wide range of employers for a
variety of reasons.

As a result, some of our recommendations have implications outside the
realm of professional sports. Specifically, clarifications regarding whether
essential, job-related functions can be relative—as opposed to absolute;
whether the ADA’s construction of medical examinations includes wearable
technology or genetic tests; and whether GINA’s family medical history
protections only cover manifested conditions with genetic components would
be of use to many if not all kinds of work. Moreover, adding a direct threat
defense to GINA could further employee health beyond professional sports,
and requiring uniformity in an employer’s invocation of the direct threat
defense for both the ADA and GINA could avoid using risk as a pretext for
discrimination. Thus, while NFL football is unique, it provides a valuable
analytical lens for exploring the intersections of employment, medical care,
privacy, and antidiscrimination.

440 See ObamaCare Employer Mandate, OBAMACARE FACTS, http://obamacarefacts.com/obama
care-employer-mandate/ [https://perma.cc/L8HU-JN6Y] (“ObamaCare’s ‘employer mandate’ is a
requirement that all businesses with 50 or more full-time equivalent employees . . . provide health
insurance to at least 95% of their full-time employees . . . .”).
Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations

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Holly Fernandez Lynch

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First, the authors would like to thank the staff and research assistants who assisted in the creation of this Report: Thomas Blackmon; Laura Escalona; Elizabeth Guo; Elisa Hevia; Gabrielle Hodgson; Cristine Hutchison-Jones; Jason Joffe; Jose Lamarque; Justin Leahey; Jodie Liu; Sheila Meagher; Jennifer Mindrum; Scott Sherman; Lauren Taylor; and, Valerie Wood. These individuals assisted with a variety of administrative and research tasks, including fact-checking the Report in its entirety. Particular thanks are due to Justin Leahey, Project Coordinator for the Law & Ethics Initiative of The Football Players Health Study, who provided important administrative and research assistance throughout the creation of the Report.

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Finally, the authors would like to thank the stakeholders, organizations, and individuals working in and around the NFL who agreed to be interviewed and/or otherwise provided relevant information for this Report. In the Introduction and in the relevant chapters we provide more detail regarding the stakeholders, organizations, and individuals who were interviewed and/or otherwise provided relevant information. Their cooperation was essential to the accuracy, fairness, and comprehensiveness of this Report. Additional information about the creation and review of this Report is contained in Appendix N.
The 2011 Collective Bargaining Agreement between the National Football League Players Association (NFLPA) and the National Football League (NFL) set aside funds for medical research. The NFLPA directed a portion of those funds to create The Football Players Health Study at Harvard University, of which this Report is a part. Our analysis has been independent of any control by the NFLPA, the NFL, or any other party; this independence was contractually protected in Harvard’s funding agreement with the NFLPA. Per that contract, the NFLPA was only entitled to prior review of the Report to ensure that no confidential information was disclosed.

This report is the principal component of the Law and Ethics Initiative of The Football Players Health Study at Harvard University. Additional background information about The Football Players Health Study is provided in the Preface. We provide more specific information about the Law and Ethics Initiative here.

The Statement of Work agreed to between the NFLPA and Harvard included as one of the Law and Ethics Initiative’s projects to “Develop Ethical Framework and Accountability Structure for Player Health and Welfare.” More specifically, Harvard described the work to be done as follows:

> We will conduct a research project regarding the relative primacy of players’ health among potentially competing goals, and clarifying the roles of medical staff and healthcare providers, team owners, pre-professional schools and institutions (e.g., college, high school, Pop Warner, etc.), equipment manufacturers and suppliers, the media, and players themselves in protecting and advancing player health and welfare. More specifically, we will create recommendations applicable to each of these parties, supported for the first time by an overarching ethical framework and accountability structure for player health and welfare. We will also generate recommendations toward a preliminary baseline set of legally and ethically relevant protections that ought to be afforded to all players.

This project description was intended to be preliminary. The actual scope of the final Report developed over time, as expected, as the result of considerable research, internal discussion, and conversations with experts. Beyond agreeing to the Statement of Work, the NFLPA did not direct the scope or content of this Report.

As is typical with sponsored research, we provided periodic updates to the sponsor in several formats. Pursuant to the terms of Harvard-NFLPA agreement, the NFLPA receives an annual report on the progress of The Football Players Health Study as well as one Quad Chart progress report each year. Additionally, on two occasions (August 22, 2014, and January 23, 2015), we presented a summary of the expected scope and content of the Report to The Football Players Health Study Executive Committee, comprised of both Harvard and NFLPA personnel. Those meetings did not alter our approach in constructing the Report, the conclusions reached, or the recommendations made. Indeed, the only comment from the Executive Committee meetings that resulted in a change to the content of the Report was the suggestion at the beginning of the writing process to include business partners as a stakeholder, which we agreed was important.

In the Introduction, Section (D)(2): Description of Legal and Ethical Obligations, we discuss our research process for the Report. Additional information about our communications with the NFLPA and NFL is also relevant here. During the course of our research, we had multiple telephone and email communications with both NFLPA and NFL representatives to gain factual information. As will be indicated where relevant in the Report, sometimes the parties provided the requested information and sometimes they did not. These communications were not about the progress, scope, or structure of our Report.

We also concluded that it was essential to allow for substantive review of the Report by applicable stakeholders, including the NFLPA and NFL. This was necessary to ensure that we have fully accounted for the realities at hand, avoided factual errors, and fairly considered all sides. Accordingly, we provided each stakeholder group discussed in this Report and that has a clearly identified representative the opportunity to review the parts of this Report applicable to them (in draft form). A list of the stakeholders that reviewed the Report appears in Appendix N. Stakeholders had the opportunity to

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a The applicable contract language provides that the NFLPA is permitted to review publications 30 days in advance “for the sole purpose of identifying any unauthorized use of Confidential Information.”
identify any errors, provide additional information, comment on what we planned to expect from them going forward, and raise further suggestions or objections. Sometimes these comments led to valuable changes in the Report. Other comments we found unpersuasive, and did not result in any changes. While both the NFLPA and NFL provided comments on the Report, it is critical to recognize that no external party, including the NFLPA and NFL, had the ability to direct or alter our analysis or conclusions. Finally, as part of our effort to collaboratively engage with key stakeholders, we invited both the NFLPA and NFL to write a response to the Report, which we offered to publish on The Football Players Health Study website alongside the Report. The NFL took us up on this offer while the NFLPA did not.\footnote{In declining the opportunity to write a response, the NFLPA stated as follows: “Our primary objective in funding Harvard is to advance independent research on the many complex issues facing our members. Harvard’s publications further that objective without formal comment by the NFL.”}

As an additional check on our independent analysis, we engaged a Law and Ethics Advisory Panel (LEAP) with expertise in health law, bioethics, and player issues to review our work, comprised of several academics, players, a player family member, and a retired NFL coach. Additional information about the LEAP, its members, and its role in reviewing the Report is included in Appendix N. We consulted with the LEAP early in the drafting process for the Report, and members were given the opportunity to comment on its organization, selection of stakeholders, and relevant ethical principles. The LEAP also had the opportunity to review a complete draft of the Report and provide detailed feedback.

In addition, we subjected the draft Report to robust peer review by outside experts. We engaged six independent experts in fields relevant to the Report to review it for accuracy, fairness, comprehension, and its ability to positively affect the health of NFL players. Additional information about the reviewers and review process is included in Appendix N. None of these individuals had any declared conflicts of interest. To ensure that we carefully considered the comments of the reviewers and made appropriate changes, we also retained Gabriel Feldman, Associate Professor of Law and Director, Sport Law Program, Tulane University Law School, to serve as a lead peer reviewer. Professor Feldman reviewed the Report and provided comments, while also reviewing the comments of the other reviewers and any changes made by us in response to their comments. Professor Feldman’s role and approval of the review process is further provided in Appendix O.

Finally, the Report’s content is solely the responsibility of the authors and does not represent the official views of the NFLPA or Harvard University.

DISCLOSURES:

- The Law and Ethics Initiative’s allocated budget is a total of $1,257,045 over three years, which funds not only the present Report, but also several other projects.\footnote{Other Law and Ethics projects include: (1) a qualitative interview study (“listening tour”) with players and their families to better understand their legal and ethical concerns related to health and well-being; (2) a comparative legal and organizational policy analysis of various professional sports leagues to identify best policies in protecting player health; (3) an analysis of the legal and ethical implications of current and potential medical tests and devices that might be used by NFL clubs and players; and, (4) an examination of how traditional workplace health and safety laws would apply to professional sports; among others.}
- Deubert’s salary is fully supported by The Football Players Health Study at Harvard University. From August 2010 to May 2014, Deubert was an associate at the law firm of Peter R. Ginsberg Law, LLC f/k/a Ginsberg & Burgos, PLLC. During the course of his practice at that firm, Deubert was involved in several legal matters in which the NFL was an opposing party, including several discussed in this Report. The matters discussed in this Report include the representation of: a former NFL player interested in seeking benefits pursuant to the proposed settlement in the Concussion Litigation, discussed at length in Chapter 7: The NFL and NFLPA; players disciplined pursuant to the NFL’s Policy and Program on Substances of Abuse and the Policy on Anabolic Steroids and Related Substances (now known as the Policy on Performance-Enhancing Substances), discussed in Chapter 7: The NFL and NFLPA; Kevin Williams and Pat Williams in the “StarCaps” case, discussed in Chapter 7: The NFL and NFLPA; and, Jonathan Vilma in the “Bounty”-related legal proceedings, discussed at length in Chapter 9: Coaches. Deubert also was involved in the representation of former Miami Dolphins offensive line coach Jim Turner in the Jonathan Martin “bullying” situation, discussed at length in Chapter 9: Coaches, which was the result of an NFL investigation but did not involve litigation with the NFL. Additionally, Deubert was involved in the representation of both contract advisors and players in litigation and arbitrations under the NFLPA’s Regulations Governing Contract Advisors, discussed at length in Chapter 12: Contract Advisors. Last, since 2007 Deubert has provided research assistance to the Sports Lawyers Association, whose Board of Directors includes many individuals with interests related to this work.
  - Twenty percent of Cohen’s salary is supported by The Football Players Health Study at Harvard University. Cohen has no other conflicting interests to report.
  - Thirty percent of Lynch’s salary is supported by The Football Players Health Study at Harvard University. Lynch has no other conflicting interests to report.
EXECUTIVE SUMMARY

1) INTRODUCTION

Who is responsible for the health of NFL players, why, and what can be done to promote player health? These are the fundamental questions motivating this Report, authored by members of the Law and Ethics Initiative of The Football Players Health Study at Harvard University.4

To date, there has been no comprehensive analysis of the universe of stakeholders that may influence NFL player health, nor any systematic analysis of their existing or appropriate legal and/or ethical obligations. This sort of undertaking, however, is essential to uncovering areas in need of improvement and making clear that the responsibility for player health falls on many interconnected groups that must work together to protect and support these individuals who give so much of themselves—not without benefit, but sometimes with serious personal consequences—to one of America’s favorite sports. It is critical to address the structural and organizational factors that shape the environment in which players live and work. Moreover, acknowledging a variety of potentiality relevant background conditions is an essential and complementary approach to clinical interventions for improving player health.

In identifying the universe of appropriate stakeholders and making recommendations regarding player health, we have taken as our threshold the moment that a player has exhausted or foregone his remaining college eligibility and has taken steps to pursue an NFL career. From that point on what needs to happen to maximize his health, even after he leaves the NFL? We have selected this timeframe not because the health of amateur players—those in college, high school, and youth leagues—is secure or unimportant. Instead, the reason is largely pragmatic: there is only so much any one report can cover, and adding in-depth analysis of additional stakeholders such as the NCAA, youth leagues, and parents would confuse an already complicated picture.

We recognize that what happens at the professional level can have a trickle-down effect on the culture of football across the board, and also that some amateur players may be taking health risks in hopes of eventually reaching the NFL, even when that may be highly unlikely. Moreover, we acknowledge that the legal and ethical issues that arise with regard to individuals who are not competent to make their own decisions (e.g., children) are substantially more difficult. Nonetheless, our goal with this Report, prompted by the limited scope of the request for proposals for this project and in part by the fact that further analysis will be possible by others, is to address the already complicated set of factors influencing the health of NFL players, current, future, and former.

This Report has four functions. First, to identify the various stakeholders who influence, or could influence, the health of NFL players. Second, to describe the existing legal and ethical obligations of these stakeholders in both protecting and promoting player health. Third, to evaluate the sufficiency of these existing obligations, including enforcement and current practices. And fourth, to recommend changes grounded in that evaluation for each of the identified stakeholders.

The issues at hand are complex and nuanced. Consequently, we urge readers to read the entire Report, or at least the Introduction and those chapters of particular interest. In this Executive Summary, we provide only a short synopsis of some of the key issues discussed in the Report.

In the remainder of this Introduction, we describe the definition of “health” used to focus the Report, discuss the ethical principles that guided our analysis, and identify the stakeholders discussed in the Report. In the second part of this Executive Summary, we summarize our discussion of the most stakeholders discussed in the Report (players, club doctors, the NFL, and the NFLPA), including highlighting major recommendations. Then, in the third part of this Executive Summary, we briefly discuss the other stakeholders analyzed in the Report and important
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Lastly, we conclude with some final recommendations.

Before continuing with the Introduction, we provide a list of our “Top 10” recommendations; those recommendations that, if implemented, could have the most meaningful and positive impact on player health. Additional information on these recommendations, including explanations of their significance, is provided in the full Report.

### Top 10 Recommendations

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

2. The NFL and NFLPA should not make player health a subject of adversarial collective bargaining. (Recommendation 7:1-A).

3. As recommended throughout the Report, various stakeholders (e.g., club doctors, athletic trainers, coaches, contract advisors, and financial advisors) should adopt, improve and enforce Codes of Ethics. (Final Recommendation 3).

4. The NFL and NFLPA should continue to undertake and support efforts to scientifically and reliably establish the health risks and benefits of playing professional football. (Recommendation 7:1-B).

5. The NFL, and to the extent possible, the NFLPA, should: (a) continue to improve its robust collection of aggregate injury data; (b) continue to have the injury data analyzed by qualified professionals; and, (c) make the data publicly available for re-analysis. (Recommendation 7:1-C).

6. The NFLPA should consider investing greater resources in investigating and enforcing player health issues, including Article 39 of the 2011 CBA [covering players’ rights to medical care and treatment]. (Recommendation 7:5-A).

7. Clubs and Club medical staff should support players in their right to receive a second opinion. (Recommendation 4:1-A).

8. Players diagnosed with a concussion should be placed on a short-term injured reserve list whereby the player does not count against the Active/Inactive 53-man roster until he is cleared to play by the Concussion Protocol (Recommendation 7:1-E).

9. With assistance from Contract Advisors, the NFL, the NFLPA, and others, players should familiarize themselves with their rights and obligations under the CBA, including all possible health and other benefits, and should avail themselves of applicable benefits. (Recommendation 1:1-A).

10. Players should receive a physical from their own doctor as soon as possible after each season. (Recommendation 6:1-B).

### (A) Defining Health

Our definition of “health” includes and extends beyond the sort of clinical measurements that might immediately be evoked by the phrase. Indeed, the comprehensive mantra of The Football Players Health Study, “The Whole Player, The Whole Life,” motivates our definition. “Health” clearly covers the conventional and uncontroversial reference to freedom from physical and mental illness and impairment. But health is much more than the mere absence of a malady. The full range of non-medical inputs that can influence health, also known as the social determinants of health, must also be considered. These social determinants extend beyond the sorts of things for which one would seek out a doctor’s care, and, according to the World Health Organization, include broadly “the conditions in which people are born, grow, live, work, and age,” as affected by the “distribution of money, power, and resources at global, national and local levels.”

Such social determinants are fully at play in the lives of NFL players. Acknowledging these social determinants of health allows us to recognize that a set of recommendations limited exclusively to medical care, medical relationships, and medical information would not suffice to achieve our goal of maximizing player health. We cannot focus solely on avoiding brain injury, protecting joints, and promoting cardiovascular health, for example, but we must also address wellbeing more generally, which depends on other factors such as the existence of family and social support, the ability to meet economic needs, and life satisfaction.
Thus, for purposes of this Report, health is defined as “a state of overall wellbeing in fundamental aspects of a person’s life, including physical, mental, emotional, social, familial, and financial components.” This definition is patterned on numerous definitions of health, including that of the World Health Organization. According to our definition, we make recommendations not only about ways to influence players’ medical outcomes, but also about ways to positively influence the role of social determinants of their health.

We identify seven overarching ethical principles to guide our assessment of all stakeholder responsibilities and to structure the nature of our recommendations, though we also offer more tailored ethical analyses for each stakeholder. Here, we provide an abbreviated discussion of these ethical principles:

- **Respect:** The NFL is a business that relies on individuals who are exposed to health risks, but no stakeholder can treat players “merely as a means” or as a commodity solely for promotion of its own goals.

- **Health Primacy:** Avoiding serious threats to player health should be given paramount importance in every dealing with every stakeholder, subject only to the player’s Empowered Autonomy.

- **Empowered Autonomy:** Players are competent adults who should be empowered to assess which health risks they are willing to undertake, provided they have been given trustworthy, understandable information and decision-making tools, and the opportunity to pursue realistic alternatives.

- **Transparency:** All parties should be transparent about their interests, goals, and potential conflicts as they relate to player health, and information relevant to player health must be shared with players immediately.

- **Managing Conflicts of Interest:** All stakeholders should take steps to minimize conflicts of interest, and when they cannot be eliminated, to appropriately manage them.

- **Collaboration and Engagement:** Protecting and promoting the health of professional football players depends on many parties who should strive to act together — and not as adversaries — whenever possible to advance that primary goal.

- **Justice:** All stakeholders have an obligation to ensure that players are not bearing an inappropriate share of risks and burdens compared to benefits reaped by other stakeholders.

Over several months, we conducted a comprehensive review of the sports law and ethics literature, and had in-depth conversations with a number of former players and, where they were willing to speak with us, representatives of many of the stakeholders we identified as crucial to our analysis. This allowed us to supplement our existing expertise and understanding to generate a list of 20 stakeholders on whom to focus. The stakeholders discussed in this Report are:

- Players;
- Club doctors;
- Athletic trainers;
- Second opinion doctors;
- Neutral doctors;
- Personal doctors;
- The NFL;
- The NFLPA;
- NFL clubs;
- Coaches;
- Club employees;
- Equipment managers;
- Contract advisors (aka “agents”);
- Financial advisors;
- Family members;
- Officials;
- Equipment manufacturers;
- The media;
- Fans; and
- NFL business partners.

Each stakeholder is discussed in its own chapter except the NFL and NFLPA, which are discussed together in light of their interdependence.

How did we arrive at this list of stakeholders, and determine who was and was not a stakeholder within the ambit of this Report? The key criterion for inclusion was simple: who (for better or worse) does—or should—play a role in NFL player health? The answer to that question came in three parts, as there are individuals, groups, and organizations who directly impact player health, for example, as employers or caregivers; those who reap substantial financial benefits from players’ work; and, those who have some capacity to influence player health. Stakeholders may fall under more than one of these headings, but satisfaction of at least one criterion was necessary for inclusion in this analysis. The result is an extensive mapping of a complex web of parties.
2) **KEY STAKEHOLDERS**

Below, we summarize some of our discussion on those stakeholders we believe to be the most important: players; club doctors; the NFL; and, the NFLPA, but the full Report contains chapters on every stakeholder.

(A) **Players**

The heart of this Report is about protecting and promoting player health. No one is more central to that goal than players themselves, and therefore it is important to understand who they are and what they are doing concerning their own health and the health of their NFL brethren. That said, it is also important to recognize that players are often making choices against a constrained set of background conditions, pressures, and influences—doing so often with limited expertise and information—all of which impact their capacity to optimally protect their own health. Thus, while they are competent adults with a bevy of responsibilities to protect themselves, they cannot do it alone. Players must be treated as partners in advancing their own health by offering them a variety of support systems to do so, all of which will be accompanied by recommendations geared to other stakeholders.

Significant concerns exist about players’ actions regarding their own health. Historically, there is considerable evidence that NFL players underreport their medical conditions and symptoms to avoid missing playing time or jeopardizing their position within a club. This behavior is understandable, but they may be doing so at great risk. Nevertheless, we emphasize that the existing data on player health is incomplete and often unclear, leaving players without sufficient information to make truly informed decisions based on calculations of risk and benefit.

Our most important recommendation to players is **Recommendation 1:1-A**: With assistance from contract advisors, the NFL, the NFLPA, and others, players should familiarize themselves with their rights and obligations under the NFL-NFLPA Collective Bargaining Agreement (CBA), including all possible health and other benefits, and should avail themselves of applicable benefits. Our formal interviews, literature review, and other feedback from stakeholders revealed that many players are not sufficiently aware of their rights, obligations, benefits, and opportunities pursuant to the CBA, or do not take full advantage of them even if they are aware. This prevents players from truly maximizing their health.

Other recommendations concerning players are:

- Players should carefully consider the ways in which health sacrifices now may affect their future health (1:1-B).
- Players should take advantage of opportunities to prepare for life after football (1:1-C).
- Players should seek out and learn from more experienced players, including former players, concerning health-related matters (1:1-D).
- Players should take on a responsibility to one another, to support one another’s health, and to change the culture for the better (1:1-E).
- Players should not return to play until they are fit to do so (1:1-F).
- Players should not sign any document presented to them by the NFL, an NFL club, or an employee of an NFL club without discussing the document with their contract advisor, the NFLPA, their financial advisor, and/or other counsel, as appropriate (1:1-G).
- Players should be aware of the ramifications of withholding medical information from the club medical staff (1:1-H).
- Players should review their medical records regularly (1:1-I).

(B) **Club Doctors**

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

Club doctors are clearly important stakeholders in player health. They diagnose and treat players for a variety of ailments, physical and mental, while making recommendations to players concerning those ailments. At the same time, club doctors have obligations to the club, namely to advise clubs about the health status of players. While players and clubs share an interest in player health—both
want players to be healthy so they can play at peak performance—there are several areas where their interests may diverge, such as when a player feels compelled to return to play from an injury more quickly than is recommended in order to try and help the club win or, if he does not, potentially have his contract terminated.

Given the various roles just described, it is evident that club doctors face an inherent structural conflict of interest. This is not a moral judgment about them as competent professionals or devoted individuals, but rather a simple fact of the current organizational structure of their position in which they simultaneously perform at least two roles that are not compatible. The intersection of club doctors’ dual obligations creates significant legal and ethical quandaries that can threaten player health. Most importantly, the current structure of NFL club medical staff—how they are selected, evaluated, and terminated, and to whom they report—creates an inherent structural conflict of interest in the treatment relationship and poses concerns related to player trust, no matter how upstanding or well-intentioned any given medical professional might be.

Note that in the organ context, this bifurcation of roles is well-established and mandatory. For example, even if an individual doctor swears that he or she is not influenced in declaring a donor’s death by the desire to get the patient an organ, and even though it would be impossible in any particular case to prove or disprove such influence, this bifurcation of roles is required. Moreover, anything short of eliminating such conflict completely would deeply undermine the public’s trust and peoples’ willingness to consider organ donation.

The existing ethics codes and legal requirements are insufficient to satisfy the goal of ensuring that players receive the best healthcare possible from providers who are as free from conflicts of interest as is realistically possible. Of course, achieving this goal is legally, ethically, financially, and structurally complicated. In Recommendation 2:1-A, we propose to resolve the problem of dual loyalty by largely removing the club doctor’s ties with the club and refashioning the role into one of singular loyalty to player-patients.

The recommendation is complex and described at length in the full Report, but the main idea is to separate the roles of serving the player and serving the club and replace them with two distinct sets of medical professionals: the “Players’ Medical Staff” (with exclusive loyalty to the player) and the “Club Evaluation Doctor” (with exclusive loyalty to the club). The Players’ Medical Staff would be selected and reviewed by a committee of medical experts jointly selected by the NFL and NFLPA. The Players’ Medical Staff would then serve as a champion for player health, while clubs are free to hire additional medical professionals for their distinct business needs. Nevertheless, the club will still be entitled to player health information through the player’s medical records and regular written reports from the Players’ Medical Staff, given the importance of players’ physical capacity to their employment.

We believe this recommendation could substantially lessen a major concern about the current club doctor arrangement—the problem of dual loyalty and structural conflict of interest—by providing players with a medical staff that principally has the interests of the players in mind and who they can trust. The Players’ Medical Staff would be almost entirely separated from the club and the pressures inherent in club employment, while being held accountable to a neutral medical committee. At the same time, this recommendation does not interfere with the clubs’ legitimate interests. For these reasons, we believe that this recommendation is critical to improving player health and among the most important set forth in the Report.
Accordingly, it should be adopted as part of the Collective Bargaining Agreement.

Other recommendations concerning club doctors are:

- The NFLPS should adopt a code of ethics (2:1-B).
- Every doctor retained by a club should be a member of the NFLPS (2:1-C).
- The Concussion Protocol should be amended such that if either the club doctor or the Unaffiliated Neurotrauma Consultant diagnoses a player with a concussion, the player cannot return to the game (2:1-D).
- The NFL and NFLPA should reconsider whether waivers providing for the use and disclosure of player medical information should include mental health information (2:1-E).
- Club doctors should abide by their CBA obligation to advise players of all information the club doctors disclose to club representatives concerning the players (2:1-F).
- At any time prior to the player’s employment with the club, the player should be advised in writing that the club doctor is performing a fitness-for-play evaluation on behalf of the club and is not providing any medical services to the player (2:1-G).
- The NFL’s Medical Sponsorship Policy should explicitly prohibit doctors or other medical service providers from providing consideration of any kind for the right to provide medical services to the club, exclusively or non-exclusively (2:1-H).
- Club doctors’ roles should be clarified in a written document provided to the players before each season (2:1-I).
- The NFL, NFLPA, and club doctors should consider requiring all claims concerning the medical care provided by a doctor who is a member of the NFLPS and is arranged for by the club to be subject to binding arbitration (2:2-A).

Consequently, there are still many important changes that the NFL and NFLPA can make that will further advance player health.

The most straightforward way to implement many of the changes we recommend to protect and promote player health would be to include them in the next CBA between the parties. That said, whenever change is possible outside of the CBA negotiating process, such as through side letters, it should not wait—the sooner, the better. Moreover, although the CBA will often be the most appropriate mechanism for implementing our recommendations, we do not want to be understood as suggesting that player health should be treated like just another issue for collective bargaining, subject to usual labor-management dynamics. This is to say that as an ethical matter, players should not be expected to make concessions in other domains in order to achieve gains in the health domain. To the contrary, we believe firmly the opposite: player health should be a joint priority, and not be up for negotiation. For this reason, our first recommendation, Recommendation 7:1-A, is that the NFL and NFLPA should not make player health a subject of adversarial collective bargaining. If as part of its research or otherwise the NFL knows a policy or practice should change, it should do so without waiting for the next round of bargaining or by forcing the NFLPA to concede on some other issue. Similarly, the NFLPA should not delay on player health issues in order to advance other collective bargaining goals.

Other recommendations to the NFL and NFLPA are:

- The NFL and NFLPA should continue to undertake and support efforts to scientifically and reliably establish the health risks and benefits of playing professional football (7:1-B).
- The NFL, and to the extent possible, the NFLPA, should: (a) continue to improve its robust collection of aggregate injury data; (b) continue to have the injury data analyzed by qualified professionals; and, (c) make the data publicly available for re-analysis (7:1-C).
- The NFL and NFLPA should publicly release de-identified, aggregate data from the Accountability and Care Committee’s player surveys concerning the adequacy of players’ medical care (7:1-D).
- Players diagnosed with a concussion should be placed on a short-term injured reserve list whereby the player does not count against the Active/Inactive 53-man roster until he is cleared to play by the Concussion Protocol (7:1-E).
Protecting and Promoting the Health of NFL Players

- The NFL and NFLPA should research the consequences and feasibility of guaranteeing more of players' compensation as a way to protect player health (7:1-F).
- The CBA should be amended to provide for meaningful fines for any club or person found to have violated Sections 1 through 6 of Article 39 of the CBA (7:2-A).
- The NFL and NFLPA should undertake a comprehensive actuarial and choice architecture analysis of the various benefit and retirement programs to ensure they are maximally beneficial to players (7:3-B).
- The purpose of certain health-related committees should be clarified and their powers expanded (7:3-C).
- The NFL and NFLPA should continue and intensify their efforts to ensure that players take the Concussion Protocol seriously (7:4-A).
- The NFLPA should consider investing greater resources in investigating and enforcing player health issues, including Article 39 of the 2011 CBA (7:5-A).
- The NFLPA should continue to assist former players to the extent such assistance is consistent with the NFLPA's obligations to current players (7:6-A).

3) OTHER STAKEHOLDERS

While above we focused on the four most important stakeholders, the remaining sixteen stakeholders are also critical to player health. In the Report, all of the stakeholders are grouped into parts as follows: Part 1: Players; Part 2: The Medical Team; Part 3: The NFL, NFLPA, and NFL Clubs; Part 4: NFL Club Employees; Part 5: Player Advisors; and, Part 6: Other Stakeholders. We briefly discuss these parts and the stakeholders included therein insofar as they were not discussed above.

(A) The Medical Team (Part 2)

A player's medical team includes not only club doctors, but also: athletic trainers; doctors whom players may consult concerning an injury or medical condition to compare or contrast that opinion to that of the club doctor (second opinion doctors); doctors who are called on when there are conflicting opinions or interests (neutral doctors); and, doctors who players see outside of the NFL environment (personal doctors). Each of these medical professionals is important in his or her own way.

Athletic trainers are generally the player's first and primary source of medical care. Nevertheless, some players distrust athletic trainers. Communications among athletic trainers, coaches, and the club's general manager place pressure on players to practice, sometimes causing them to withhold information from the athletic trainer. For this reason, our principal recommendation concerning athletic trainers, Recommendation 3:1-A, matches Recommendation 2:1-A concerning club doctors: to separate the roles of serving “the player and serving the club and replace them with two distinct sets of medical professionals: the “Players’ Medical Staff” (with exclusive loyalty to the player) and the “Club Evaluation Doctor” (with exclusive loyalty to the club).

The athletic trainers' principal day-to-day responsibilities would remain largely the same—providing medical care to the players and updating the club on player health status (just in a different way). Nevertheless, most importantly, the proposed change largely removes the structural conflict of interest in the care being provided to players by athletic trainers and other medical staff.

Under the CBA, players have the right to a second opinion doctor and the surgeon of their choice, provided the player consults with the club doctor and provides the club doctor with a report concerning treatment provided by the second opinion doctor (the full cost of which must be paid by the club). Many contract advisors arrange for their players to receive a second opinion for every injury. Given the importance of this right, we recommend that club medical staff be more supportive of players in obtaining a second opinion (Recommendation 4:1-A).

The 2011 CBA notes three situations where neutral doctors are required: (1) as the on-field emergency physician during games; (2) to perform examinations and provide opinions as part of the Injury Grievance process; and, (3) to investigate allegations of inadequate medical care by a club as part of the Joint Committee on Player Safety and Welfare. In addition to the CBA provisions requiring a neutral doctor, the Concussion Protocol requires an
“Unaffiliated Neurotrauma Consultant” to be assigned to each club for each game to assist in the evaluation of players suspected of having suffered a concussion. The Unaffiliated Neurotrauma Consultants are crucial to the effective operation of the Concussion Protocol, a signature component of player health. There is no indication that neutral doctors have done anything other than perform the roles assigned to them by the CBA and Concussion Protocol. Consequently, we make no recommendations concerning neutral doctors. Indeed, the neutrality of these doctors is a positive benefit to players, and we should look for additional opportunities to have neutral doctor input and involvement.

Personal doctors might be the least utilized of the doctors discussed in this Report. In talking with players, several indicated that frequent moves from city to city and their busy schedules made finding and seeing a personal doctor problematic. Consequently, many players principally rely on club doctors and second opinion doctors for their care. Thus, we recommend that the NFLPA and clubs assist players to access and more frequently utilize the services of personal doctors (Recommendation 6:1-A).

(B) The NFL, NFLPA, and NFL Clubs
(Part 3)

Having discussed the NFL and NFLPA above, we discuss now the remaining stakeholder in Part 3: NFL Clubs. The NFL is an unincorporated association of 32 member clubs that serves as a centralized body for obligations and undertakings shared by the member clubs. Nevertheless, each member club is a separate and distinct legal entity, with its own legal obligations separate and distinct from club owners and employees. NFL clubs are the players’ employers and hire many of the stakeholders discussed in this Report. In this respect, NFL clubs play an important role in dictating the culture concerning player health. They are powerful organizations that employ many people with direct day-to-day interaction concerning player health issues. Like all organizations, the specific culture on important issues varies from club to club.

NFL clubs collectively comprise the NFL. Thus, any recommendations concerning NFL clubs would ultimately be within the scope of recommendations made concerning the NFL. Moreover, NFL clubs act only through their employees or independent contractors, including coaches, other employees, and the medical staff. Thus, any recommendation we make for the improvement of clubs would be carried out through recommendations we make concerning club employees. For these reasons, we make no separate recommendations here and instead refer to the recommendations in the chapters concerning those stakeholders for recommendations concerning NFL clubs. Nevertheless, we do stress that it is important that club owners, as the leaders of each NFL club and its employees, personally take seriously and show leadership in player health issues, including overseeing the response to recommendations made in this Report.

(C) NFL Club Employees (Part 4)

Part 4 discusses the non-medical stakeholders within the purview of the club: coaches; general managers; developmental staff; scouts; and, equipment managers. These stakeholders have varying degrees of influence on player health matters but are nonetheless all important.

Of all of the stakeholders considered in this Report, coaches have the most authority over players, and impose the most direct physical and psychological demands on them. Coaches can help players maximize their potential, but in some cases may also contribute to the degradation of a player’s health. Head coaches are the individuals ultimately most responsible for the club’s performance on the field and thus take on an immense stature and presence within the organization; indeed, some head coaches are the final decision-makers on player personnel decisions. Coaches largely determine the club’s culture, dictate the pace and physicality of practice and workouts, and decide who plays—a decision often borne out by intense physical competition. Moreover, coaches must be successful in order to retain their jobs and face enormous pressure to win. That pressure no doubt affects their relationship with their players and in some cases is felt by the players. To protect against the pressures inherent in coaches’ roles, we recommend that the NFL Coaches Association adopt and enforce a code of ethics that recognizes that coaches share responsibility for player health (Recommendation 9:1-A). We also recommend specific issues that should be addressed in such a code of ethics and that the most important of these ethical principles be incorporated into the CBA (Recommendation 9:1-B).

NFL club general managers and scouts make important decisions concerning a player’s career, often based on a player’s current or expected health status. Relatedly, developmental staff—often ex-players who are responsible for assisting the club’s players with a blend of professional and personal issues—have the opportunity to play an important role in assisting players and making
sure the actions taken are in their best interests. These club employees all have unique relationships with players that provide them an important opportunity to promote player health. Indeed, like coaches, many NFL club employees develop close relationships with players—many are former players themselves—and are thus sensitive to protecting player health. Nevertheless, the inherent pressures of winning and running a successful business can sometimes cause these employees to make decisions or create pressures that negatively affect player health. Thus, we recommend clubs and club employees—in particular general managers and developmental staff—take steps to resolve any concerns discovered about a player’s health (Recommendation 10:1-A). Relatedly, we recommend that clubs adequately support the developmental staff, something that does not appear to always be the case (Recommendation 10:1-B).

Part 5 discusses those individuals closest to the players and who should always have the players’ best interests in mind: contract advisors; financial advisors; and, family members. In reading this part, it is important to remember our broad definition of health, which includes and extends beyond clinical measurements to the social determinants of health, including financial wellbeing, education, and social support. These stakeholders are particularly critical in protecting and promoting players’ long-term health in this sense.

Contract advisors, more commonly known as “agents,” are often players’ most trusted and important resources and allies when it comes to protecting them during their NFL career, including protecting their health. In fact, contract advisors are agents of both players and the NFLPA, pursuant to the National Labor Relations Act. The NFLPA has a program whereby it certifies contract advisors and subjects them to its Regulations Governing Contract Advisors (“Contract Advisor Regulations”). Entering the 2015 NFL season, there were 869 NFLPA-certified contract advisors.
Similarly, financial advisors play a critically important role in a player’s long-term health. Proper financial advice and planning can help a player determine when to retire (if he has that choice), maximize a player’s career earnings, potentially provide the player with a comfortable retirement, help mitigate the consequences of the health issues suffered by many former players, and help avoid financial distress evolving into physical or mental distress. The NFLPA has a program whereby financial advisors can register with the NFLPA and are subject to its Regulations and Code of Conduct Governing Registered Player Financial Advisors (“Financial Advisor Regulations”). While there are approximately 262 NFLPA-registered financial advisors, there are many financial advisors working with NFL players who are not NFLPA-registered, many of whom likely could not meet the registration requirements. Financial advisors are governed by many robust codes of ethics that echo some of the same principles we incorporated into this Report. However, there are a variety of industry practices and realities that are preventing some players from always receiving the best possible financial guidance. Consequently, we make multiple recommendations for amending the Financial Advisor Regulations to provide greater professionalism and transparency to the industry (Recommendation 13:1-B).

Families can play a crucial role in protecting and promoting player health, including encouraging players to seek proper medical care and carefully consider long-term interests; they can also offer support through challenging times. Unfortunately, in some cases, family members can also put inappropriate pressure on players or otherwise negatively influence their health. Consequently, we recommend that family members be cognizant of the gaps in their knowledge concerning the realities of an NFL career, and that the NFL and NFLPA should offer programs or materials to help them become better health advocates (Recommendation 14:1-A). Relatedly, players should select and rely on professionals rather than family members for managing their business, financial, and legal affairs (Recommendation 14:2-A).

Finally, Part 6 discusses several other stakeholders with a variety of roles in player health: officials; equipment manufacturers; the media; fans; and, NFL business partners.

Officials—as the individuals responsible for enforcing the Playing Rules—have an important role in protecting player health on the field. While the NFL consults with officials on changes to the Playing Rules, the officials’ principal job is to enforce them. On that front, we found little criticism that officials are failing to enforce the Playing Rules as enacted by the NFL and thus we have no formal recommendations for them. Officials should be praised for their efforts, particularly considering the high level of scrutiny around these issues. While officials should continue their solid work, they must always be diligent and open to change for additional ways to protect player health.

The football equipment market is dominated by Riddell and Schutt, each of which hold at least a 45 percent share of the football equipment market, across all levels of football. An additional important party in the equipment manufacturing industry is the National Operating Committee on Standards for Athletic Equipment (NOC- SAE), a non-profit organization that determines the safety standards for athletic equipment. Our review shows that equipment manufacturers are generally working to create the safest equipment possible. Equipment manufacturers for a variety of reasons (including both liability and brand image) have generally sought to make equipment safer, and the recent increased emphasis on player health and safety can only have accelerated that interest. We thus expect and recommend that equipment manufacturers continue to invest in the research and development of safer equipment. Similarly, at present, it appears that equipment manufacturers have been more careful than in years past in ensuring they accurately convey the benefits and limitations of their equipment. In this regard, equipment manufacturers should continue this work, and we have no formal recommendations for them.

The NFL and the media have an important and significant relationship that makes the media a key stakeholder in player health. Nevertheless, the media’s coverage of player health issues has been mixed. Many reporters have done
great work to expose problems in the way player health is or has been addressed and the resulting problems suffered by current and former players. At the same time, some of the coverage raises concerns. There have been many important scientific studies concerning the injuries, particularly concussions, suffered by football players. However, with the pressures of deadlines, the media may not always have adequate space or time to convey the implications and limitations of these studies. Similarly, the media has not always accurately reported on player health litigation. The scientific and legal nuances are difficult to understand, which makes accurate reporting on them critically important. Consequently, we recommend that the media engage appropriate experts, including doctors, scientists, and lawyers, to ensure that its reporting on player health matters is accurate, balanced, and comprehensive (Recommendation 17:1-B).

NFL football is the most popular sport in America by a variety of measures, and fans are undoubtedly a central component to the NFL’s success. Fans engage with NFL football and players in a variety of ways, including by watching on television (more than 20 million people watch the primetime broadcasts), attending practices or games in-person (a mean of more than 68,000 people attend every NFL game), by gambling and playing fantasy sports, and through public events where fans might see or speak with players. Fans, ultimately, are what drive the success of the NFL, and they therefore wield incredible power. Consequently, we recommend that fans recognize their ability to bring about change concerning player health (Recommendation 18:1-A). At the same time, increased fan interest and engagement through social media has also resulted in inappropriate behavior, such as cheering injuries or Tweeting racist remarks. Thus, we also recommend that fans recognize that the lives of NFL players are more than entertainment, and that NFL players are human beings who suffer injuries that may adversely affect their health (Recommendation 18:1-B). Fans should not advocate, cheer, encourage, or incite player injuries or pressure players to play while injured.

In the 2015 season, the NFL had approximately 29 official business partners, which collectively paid the NFL more than one billion dollars annually. NFL business partners, due to the power of the purse, have a unique ability to influence the NFL to make positive changes concerning player health. Consequently, we recommend that NFL business partners not remain silent on NFL player health-related policies (Recommendation 19:1-A). Moreover, NFL business partners should consider applying pressure on the NFL to improve player health (Recommendation 19:1-B), should consider supporting organizations conducting due diligence into player health issues (Recommendation 19:1-C), and should engage players concerning player health issues (Recommendation 19:1-D).

In addition to these stakeholders, there are other parties that have some role in player health and are also discussed in Part 7 of the Report: (a) the NCAA; (b) youth leagues; (c) governments; (d) workers’ compensation attorneys; and, (e) health-related companies.

4) CONCLUSION

This Report explains the pressing need for research into the overall health of NFL players; the need to address player health from all angles, both clinical and structural; and, the challenges presented in conducting such research and analysis. The issues and parties involved are numerous, complex, and interconnected. To address these issues—and, ultimately, to protect and improve the health of NFL players—requires a diligent and comprehensive approach to create well-informed and meaningful recommendations for change. This is precisely the focus of this Report.

Nevertheless, our recommendations are only as useful as their implementation. For this reason, we make the following final recommendations: the NFL, NFLPA, and other stakeholders should actively engage with and publicly respond to this Report; the stakeholders identified in this Report, media, academics, and others should actively advocate, encourage, and monitor the promotion of player health; and, as recommended throughout the Report, various stakeholders (e.g., club doctors, athletic trainers, coaches, contract advisors, and financial advisors) should adopt, improve, and enforce Codes of Ethics.

NFL football has a storied history and holds an important place in this country. The men who play it deserve to be protected and have their health needs met and it is our fervent hope that the health needs of these men will be met. We hope this Report succeeds in furthering that cause.
PREFACE:
THE FOOTBALL PLAYERS HEALTH STUDY AT HARVARD UNIVERSITY

There are an estimated 20,000 men alive today who at one time played professional football in the National Football League (NFL). Some of these men played in “The Greatest Game Ever Played” in 1958, the first Super Bowl in 1967, for the undefeated Miami Dolphins in 1973, the Chicago Bears’ 46 defense in the 1980s, and so on through the course of the NFL’s history. They were there when television made the game accessible to the masses, when the NFL merged with the American Football League (AFL) to create the modern NFL, and through the lawsuits of the late 1980s and early 1990s that brought us to today’s NFL. And there are thousands more still playing today or about to join this elite fraternity. NFL players have always been men of seemingly supernatural physical ability, heroes to cities and sometimes the nation. Through it all, the players experience not only the benefits, but also the physical, mental, emotional, and financial tolls of their NFL careers. In the last decade or so it has become impossible to avoid accounts of how those careers affect NFL players, in particular the detrimental health effects many of them experience in the short and long term.

In response to these accounts and related concerns, the 2011 Collective Bargaining Agreement (CBA) between the NFL and the National Football League Players Association (NFLPA) added a number of new health, safety, and welfare provisions. One of these provisions sets aside $11 million per year through 2021 to be dedicated to medical research. Thus, in the summer of 2012, the NFLPA issued a request for proposals to conduct original research and scientific exploration to be supported by these funds, focusing on “new and innovative ways to protect, treat, and improve the health of NFL players.” The NFLPA’s request for proposals specified a number of areas of particular interest, including sports medicine, repetitive brain trauma, wellness, aging, and cardiovascular disease, as well as “Medical Ethics (e.g., examination of health care contexts to obtain a better understanding of internal morality of these practices, accountability, new interventions that avoid harms currently incurred, appropriate informed consent in the context of professional athletics, and consideration of medical care in the labor-management context of professional football).”

To meet the challenge of protecting and improving player health, it is necessary to move beyond clinical issues to simultaneously address structural and organizational issues as well. This is true for healthcare more generally, where it is essential to invest not only in scientific research and development to create new clinical interventions, but also to invest in systems to efficiently administer those interventions to patients in need, as well as in public health approaches that can minimize the need for intervention in the first place. Likewise, to make headway in protecting and improving the health of NFL players, we must go beyond a single-minded focus on their clinical care and instead implement a more comprehensive strategy capable of addressing the myriad of stakeholders and contextual factors (past, present, League-wide, and individual) that play a role in their health. These include not only players’ physical issues and risk factors, but also their relationships with clinicians, their professional motivations, their financial pressures, their family responsibilities, and the centrality of their health to their careers. Add to this mix the competitive nature of the business, constraints on alternative career opportunities for many players, and the like. The relevant stakeholders in player health are similarly varied and extensive.

Thus, when submitting its proposal to the NFLPA, our Harvard team included a variety of critical clinical projects alongside an equally robust set of law and ethics proposals. We agreed from the outset that a focus on diagnosing and treating player health issues—while essential—would be insufficient on its own to comprehensively resolve those issues. Instead, our approach has been to also address precisely those structural and organizational factors that are so important to player health but would be neglected by pursuing a purely clinical approach.

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a Included as Appendix P is a Glossary of Terms and Relevant Persons and Institutions which may help readers.

The NFLPA ultimately agreed, selecting Harvard to receive the funding after a multi-round competitive process involving several universities. In February 2014, Harvard Medical School entered into an agreement with the NFLPA to create the “Football Players Health Study at Harvard University,” a transformative research initiative with the goal of improving the health of professional football players across a broad spectrum. The Football Players Health Study initially included three main components:

1. A Population Studies component, which entails research using questionnaires and testing to better understand player health status, wellness, and quality of life, including the largest ever cohort study of living former NFL players;

2. A Pilot Studies program aimed to develop new prevention strategies, diagnostics, and treatments by funding researchers working on innovative and promising developments that have the potential to impact the health of football players; and,

3. A Law and Ethics component, led by the Petrie-Flom Center for Health Law Policy, Biotechnology, and Bioethics at Harvard Law School (“Law and Ethics Initiative”), which encompasses a variety of distinct projects with the primary goal of understanding the legal and ethical issues that may promote or impede player health, and developing appropriate responsive recommendations.\(^c\)

The existence of the Law and Ethics component differentiates The Football Players Health Study from other studies concerning NFL player health. While there have been many important studies concerning the medical aspects of player health, we are not aware of any that have conducted a comprehensive analysis of the relevant legal and ethical environments.

Additionally, in the Section: Ensuring Independence and Disclosure of Conflicts, we discuss the ways in which the Law and Ethics Initiative interacted with, but was independent of, both the NFLPA and NFL in creating this Report.

In the chapters that follow, we describe the scope of the Report, its goals, and guiding ethical principles. First, however, it is essential to explain the guiding principles of The Football Players Health Study as a whole.

Most importantly, The Football Players Health Study is interested in health issues beyond concussions and neurological trauma. Although we recognize that concussions and their possible long-term sequelae are on the minds of many, and are among the most critical health issues facing players today, we simultaneously recognize that player health concerns are broader than concussions alone. Players also have concerns about cardiac health, arthritis and other joint damage, pain management, and a wide variety of other issues. Moreover, their primary concerns are likely to change over time as they transition from their playing days to retirement to old age. Thus, we have adopted the following mantra for our work: “The Whole Player, The Whole Life.” Rather than a myopic approach, we are taking a wide and long view in order to make players as healthy as they possibly can be over every conceivable dimension for the entirety of their lives.

To meet the challenge of protecting and improving player health, it is necessary to move beyond clinical issues to simultaneously address structural and organizational issues as well.

We approached this project as scholars and social scientists whose goal is to improve NFL player health. We are independent academic researchers first and foremost, regardless of the source of our funding. We have no “client” in this endeavor, other than players themselves, and we have no agenda other than to improve the lives of players, former, current, and future. Indeed, The Football Players Health Study is funded pursuant to funds set aside under the 2011 CBA for research designed to help players. Because of the way the clubs and players split revenues from NFL games and other operations, the funds used for The Football Players Health Study can reduce the amount of money available

\(^c\) Other Law and Ethics projects include: (1) a qualitative interview study (“listening tour”) with players and their families to better understand their legal and ethical concerns related to health and well-being; (2) a comparative legal and organizational policy analysis of various professional sports leagues to identify best policies in protecting player health; (3) an analysis of the legal and ethical implications of current and potential medical tests and devices that might be used by NFL clubs and players; and, (4) an examination of how traditional workplace health and safety laws would apply to professional sports; among others.
current players in the form of salary. Thus, the clubs and players have chosen to pay for The Football Players Health Study. In addition, although our contractual relationship is with the NFLPA, that very same contract protects our academic integrity without exception; no external party has any control whatsoever over our conclusions.

One of our primary concerns is that too little is known about player health. Specifically, too little is known from a rigorous scientific perspective about the risks and benefits of playing professional football because available data are insufficient in a variety of respects. For example, “[w]e do not know what factors exacerbate or mitigate an individual’s risk, including genetics, nutrition, lifestyle, as well as length of time and position played, and injuries sustained during playing years.”

Professional football players are an elite and unique group of men who must be studied directly and often in large numbers before we can really understand how football has affected them. Only then can we fully address any health problems they may have. We come to this work with no pre-existing agenda—we have neither any interest in ending professional football nor any interest in looking the other way if confronted with compelling data of its downsides. Again, we are interested only in helping players lead the healthiest and most productive lives they possibly can. We are committed to going where the science takes us.

Finally, we are forward-looking. Our role is not to evaluate fault or assign blame for player health problems, and The Football Players Health Study is uninvolved in any litigation (current or past) related to these issues. Instead, we are working with a single-minded focus to develop a clear path for addressing and remediating existing player health problems, and for preventing such problems from continuing or occurring in the future, from both clinical and organizational perspectives. Although this process does include assigning shared responsibility for protecting and promoting players’ health to a wide variety of parties, the past is relevant only to the extent it demonstrates ways to successfully improve going forward. We elaborate on our view of the past in the Introduction.

These are the guiding principles motivating every aspect of The Football Players Health Study at Harvard University.

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d The players’ share of NFL revenues is referred to as the Player Cost Amount. 2011 CBA, Art. 12, § 6(c)(i). The Football Players Health Study is funded from a pool of money known as the Joint Contribution Amount. See 2011 CBA, Art. 12, § 5. If the NFL generates new revenue streams, the players are entitled to 50% of the net revenues from those new ventures less 47.5% of the Joint Contribution Amount. 2011 CBA, Art. 12, § 6(c)(ii). Thus, if the NFL generates new revenue streams, the amount that is passed on to the players is reduced by 47.5% of the Joint Contribution Amount, which includes The Football Players Health Study.
This Report, the principal component of the Law and Ethics Initiative of The Football Players Health Study at Harvard University, aims to answer these fundamental questions: Who is responsible for the health of NFL players, why, and what can be done to promote player health? To date, there has been no comprehensive analysis of the universe of stakeholders that may influence player health, nor any systematic analysis of their existing or appropriate legal and/or ethical obligations. However, this sort of undertaking is essential to uncovering areas in need of improvement and making clear that the responsibility for player health falls on many interconnected groups that must work together to protect and support these individuals who give so much of themselves—not without personal benefit, but sometimes with serious personal consequences—to one of America’s favorite sports. Without addressing and resolving these structural and organizational issues, and acknowledging a variety of potentiality relevant background conditions, any clinical approach to improving player health will necessarily fall short.

(A) The Public Debate Surrounding the Health of NFL Players

Before getting into the substance of the Report, it is important to describe our role in the public debate surrounding football. In line with the entirety of The Football Players Health Study, our goal in this Report is to be forward-looking. In seeking answers to our driving questions, we have reviewed the NFLPA, NFL, and every other stakeholder objectively and through an independent, academic lens with the exclusive goal of making the best recommendations possible to protect and promote the health of NFL players going forward. While we do sometimes provide relevant history, this is for the sole purpose of framing what is intended to be a set of prospective analyses and recommendations. In order to fully understand the current responsibilities of various stakeholders to protect and promote player health, it is essential to understand their historical relationships with players and one another, as well as their actions, omissions, controversies, and changes over time. Without this context, our recommendations would lack credibility and likely be too disconnected to influence change; they might also otherwise be simply wrong, impracticable, or ineffective. We necessarily took history into account in making our recommendations, and felt it essential to ensure that the reader can fully grasp the rationale for our suggested approaches. Thus, in the chapters that follow, we have provided substantial factual background. Our goal, however, is not to provide a comprehensive historical account, grapple with various allegations and defenses, judge past behavior, or allocate praise and blame. Instead, our focus is on promoting positive change where needed moving forward, through identification of critical gaps, opportunities for improvement, recognition of power and responsibility, and the like.

With that said, we understand and acknowledge that many people believe some of the stakeholders discussed in this Report, in particular the NFL, have failed to satisfy their obligations to player health. More specifically, due to a number of acknowledged and alleged shortcomings, there is an ongoing public debate about the quality of the NFL’s research efforts regarding the long-term neurological effects of playing in the NFL, as well as the League’s response to emerging data over time.

A series of events in spring 2016 provide a good window into the nature of public debate about professional football and neurological disease, in particular chronic traumatic encephalopathy (CTE). CTE has been defined as a “progressive neurodegenerative disease.” More specifically, due to a number of acknowledged and alleged shortcomings, there is an ongoing public debate about the quality of the NFL’s research efforts regarding the long-term neurological effects of playing in the NFL, as well as the League’s response to emerging data over time.

Who is responsible for the health of NFL players, why, and what can be done to promote player health?
Retrospective case reports have found CTE pathology in the brains of former athletes—including former professional football players—who manifested mood disorders, headaches, cognitive difficulties, suicidal ideation, difficulties with speech, and aggressive behavior. The vast majority of cases in these studies were associated with repetitive head trauma. However, a mechanistic connection between head trauma and CTE has not yet been demonstrated. Similarly, whether CTE is distinct from other neurodegenerative diseases or whether repetitive head traumas are necessary and sufficient to cause CTE has not been definitively established.

Of note, Jeff Miller, the NFL’s Executive Vice President for Health and Safety Policy, participated in a March 14, 2016 roundtable discussion before the U.S. House of Representatives Energy and Commerce Committee on concussion research and treatment. During the roundtable, Miller answered questions from Representative Anna Eshoo (D-CA) following comments from Dr. Ann McKee from Boston University, recognized as one of the foremost experts in CTE research.

McKee: I unequivocally think there’s a link between playing football and CTE. We’ve seen it in 90 out of 94 NFL players whose brains we’ve examined. We’ve found in 43 out of 55 college players, and 6 out of 26 high school players. Now I don’t think this represents how common this disease is in the living population. But the fact that over 5 years I’ve been able to accumulate this number of cases in football players—it cannot be rare. In fact, I think we are going to be surprised at how common it is.

[Eshoo’s comments about youth athletes omitted]

Eshoo: Mr. Miller, do you think there is a link between football and degenerative brain disorders like CTE?

Miller: Well certainly Dr. McKee’s research shows that a number of retired NFL players are diagnosed with CTE, so there . . . the answer to that question is certainly yes. But there are also a number of questions that come with that. What’s the—

Eshoo: So, I guess . . . Is there a link—

Miller: Yes—

Eshoo: ‘Cause we feel, or I feel, that, you know, that was not the unequivocal answer three days before the Super Bowl by Dr. Mitchell Berger.

Miller: Well, I’m not going to speak for Dr. Berger, he’s—

Eshoo: Well you’re speaking for the NFL, right?

Miller: I . . . You asked the question about whether I thought there was a link, and I think certainly based on Dr. McKee’s research there is a link because she’s found CTE in a number of retired football players. My . . . I think that the broader point, and the one that your question gets to, is what that necessarily means and where do we go from here with that information. And so when we talk about a link, or you talk about the incidence or the prevalence, I think that some of the medical experts around the table—just for the record, I’m not a medical physician, so I feel limited here, or a scientist, so I feel limited in answering much more than that, other than the direct answer to your question—I would defer to number of people around the table to, you know, what the science means around the question that you’re asking. And I’m happy to answer this specific question.

Miller’s comments came about six weeks after Dr. Mitch Berger, a member of the NFL’s Head, Neck, and Spine Committee made comments concerning a possible a link between football and CTE. In fact, Berger’s comments on the issue were more nuanced:

Well, what I would say is we know from the former players who have been evaluated, who have CTE, they’ve played football. So the question is, is there an association? We’re concerned of course that there could be an association. Because we recognize the fact that there are long-term effects. But now we have to really understand to what degree those long-term effects occur.

There’s an association between football, we think, or any traumatic brain injury, and possible long-term effects in terms of neurodegeneration. We do know, I would say unequivocally there are former players who have developed CTE. So there can be association. I would be the first one to say that.

In addition to the statistics cited by Dr. McKee in her comments, Boston University researchers have diagnosed CTE in 131 of 165 (79.4 percent) brains of individuals who, before their deaths, played football professionally, semi-professionally, in college, or in high school. In one peer-reviewed study, Mayo Clinic and Boston University
researchers found that the brains of 21 of 66 former contact sport athletes demonstrated CTE, while CTE pathology was not detected in any of 198 individuals without exposure to contact sports.\(^\text{15}\)

Many claimed that Miller’s comments were the first time the NFL had stated there was a connection between playing football and CTE;\(^\text{16}\) while the NFL subsequently insisted Miller’s statement was consistent with its position,\(^\text{17}\) although the NFL had not previously expressed such a position publicly.\(^\text{18}\) In contrast, several club owners later made comments questioning a link between CTE and NFL play.\(^\text{19}\) The owners’ comments may have been based in part on a March 17, 2016 memorandum from NFL general counsel Jeff Pash. Pash’s memorandum cited the District Court’s opinion in the Concussion Litigation settlement decision (discussed in Chapter 7: The NFL and NFLPA),\(^\text{19}\) which explained that the study of CTE is in its early stages and much is still unknown, including its symptoms.\(^\text{20}\) Pash’s memorandum also cited the most recent Consensus Statement on Concussion in Sport from the world’s leading concussion researchers,\(^\text{21}\) which explained that while CTE “represents a distinct tauopathy . . . speculation that repeated concussion or sub-concussive impacts causes CTE remains unproven.”\(^\text{22}\) On the part of the NFLPA, when asked about Miller’s comments, NFLPA President Eric Winston said that the NFLPA “think[s] there’s a link,” but, like Miller, questioned “what does that link mean?”\(^\text{23}\) Winston further explained that the NFLPA’s position will follow “[w]here the science is telling us to go.”\(^\text{24}\)

Around the same time, The New York Times further questioned the NFL’s past research efforts\(^\text{25}\) and ESPN questioned the NFL’s current research efforts,\(^\text{26}\) with both reports receiving immediate counter-responses from the NFL.\(^\text{27}\) As this played out, in a March 28, 2016 New York Times article, Dr. McKee herself cautioned against over-interpreting her group’s research findings, stating that she has “no idea” what percent of former NFL players have CTE due to the fact that her laboratory’s collection of brains is not representative of the former NFL player population. She went on to note, however, that her research at the very least suggests that the condition is not rare among former NFL players.\(^\text{28}\)

As the New York Times acknowledged, there “remains a quieter debate among scientists about how much risk each football player has of developing [CTE]” and unanswered questions as to why “some players seem far more vulnerable to it than others.”\(^\text{29}\) CTE can, at present, only be diagnosed after death, upon physical examination of the brain itself—again, it is exclusively a pathological diagnosis.\(^\text{30}\) As of the date of the Court’s decision (April 22, 2015), only 200 brains with CTE had ever been examined (only some of which were from former NFL players), a figure that experts testified was “well short of the sample size needed to understand CTE’s symptoms with scientific certainty.”\(^\text{31}\) The Court also explained that the studies that have examined CTE have a number of important limitations, including small sample sizes, selection bias in the populations studied, lack of control groups, reliance on family members to retrospectively report subjects’ behavior, and lack of controls for other risk factors such as higher body mass index (BMI), lifestyle changes, age, chronic pain, or substance abuse.\(^\text{32}\) The National Institute of Neurological Disorders and Stroke is now funding research seeking to clarify the link between CTE pathology and specific symptoms.\(^\text{33}\)

Clearly, this is a complicated issue. At present, there is reason to believe there is a link between CTE and professional football, which even the NFL acknowledges, but there remain significant open questions about the significance of that link.

While other components of The Football Players Health Study are working to address various clinical issues and respond to important gaps in available scientific evidence regarding player health, in part through the largest cohort study of former NFL players ever conducted, the Law and Ethics Initiative is specifically focused on the current structural issues influencing player health. Thus, we do not seek here to resolve debates regarding the rapidly evolving science, nor do we seek to conduct an in-depth historical analysis of the NFL or NFLPA’s previous efforts, research, and reporting concerning player health. Such issues have been covered at length in news articles, books, documentaries, and movies, and we do not recapitulate that work here. This choice is guided entirely by our focus on what is needed to protect and promote player health now, rather than any desire or pressure to protect either the NFL or NFLPA; we dissect the past insofar as it is relevant to the future, and in that regard, we do not hesitate in pointing out the failures of any stakeholder to adequately address player health.

Beyond these clarifications regarding scope, it is important to note that we also have not endeavored in this Report to evaluate football as a sport or to radically change its basic nature, instead taking the current game largely as a given. Critics of this approach, many of whom view the NFL as a violent gladiator spectacle, may be unsatisfied with this
starting point, demanding to know why, as ethicists, we have not simply recommended that professional football cease to exist, at least in its present form. There are a number of reasons for this approach that are worth addressing explicitly here.

**B Risks and Autonomy**

As a preliminary matter, we recognize that the level of attention NFL player health is receiving at present—from Congressional hearings to daily media coverage—is such that current and future professional-level players are at least aware of the possibility of significant health risks, even if this has not always been the case in the past and even if the currently available data remain somewhat unclear. Given the range of risks we as a society allow competent adults to accept for themselves in a variety of contexts for a variety of reasons, we do not believe that it is presently appropriate or necessary to suggest that the opportunity to play professional football ought to be withheld as an ethical matter. Of course, reasonable disagreement on this score is expected, and some may prefer a precautionary approach, suggesting that we ought to be convinced of the safety of professional football before allowing it to proceed. While we understand from where such a sentiment comes, our own view is that it is more appropriate to leave it to individual players to make their own decisions about whether or not to play, while empowering them with as much information and assistance to understand what is currently known and not known about the health effects of playing football and requiring all stakeholders to do their part to reduce risks of the game.

In this regard, it is helpful to consider whether there is some threshold level of risk associated with professional football that could, if eventually demonstrated through conclusive scientific evidence, alter this analysis such that simple reliance on the autonomous decisions of competent, adult professionals would no longer be ethically sufficient. In other words, when would we say that the risks of professional football are simply too high for players to be given the choice to accept them? To answer that question, it is important to contemplate when, if ever, interference with individual liberty of competent adults is acceptable, recognizing that this is a heavily contested area of political philosophy often without a clear consensus as to a “right” answer. What level of intervention is appropriate under what circumstances?

At the threshold, it is never problematic to support the exercise of individual autonomy by simply providing education and warnings based on the best available data; indeed, this ought not be considered interference with individual liberty at all, but rather is a liberty-supporting intervention. Thus, as discussed in more detail below, the NFL and NFLPA must, at the very least, continue to provide players with the accurate, timely, objective information likely to be material to their decisions to play and for how long.

It is also generally acceptable to interfere with individual decisions when an individual is not truly an autonomous decisionmaker, i.e., if he is coerced, unduly influenced, or incapacitated in some way. In some sense, this too is not true interference with individual liberty as there is some other feature inhibiting liberty itself. Below, we acknowledge the potential pressures that players may face when deciding whether to proceed in the NFL, and argue for substantial efforts to protect and support their autonomy. However, we do not maintain that these pressures ultimately render players’ decisions coerced, “quasi-coerced,” or impaired to such an extent that the decisions themselves ought to be ignored. Moreover, while it is certainly true that a player may become cognitively impaired, for example, after experiencing a concussion, and in that limited instance his decisions are not appropriately deemed autonomous, this is the exceptional player state—it does not justify a general disregard for player decision making, or withholding the option to play writ large.

Next, we come to the classic justification for true interference with individual liberty, which is that one individual’s exercise of his liberty is interfering with the ability of others to do the same. Thus, in paradigmatic public health examples, we might require vaccination to protect others from becoming sick, or even mandate the use of seatbelts or helmets to spare society from the costs associated with automobile and motorcycle accidents that extend beyond those borne by individuals directly. In the context of preventing an adult from accepting the risks of playing professional football, then, we would need to ask what the externalities of accepting such risks might be—who might the cost of such risks accrue to other than the player himself? And then we must ask whether those externalities are greater than those that occur in the context of other activities that we allow competent adults to pursue.

First, society in general may have to pick up the tab for player healthcare to the extent that the benefits offered by the NFL and NFLPA are insufficient (see Appendix C: Summary of Collectively Bargained Health-Related Programs and Benefits). However, we do not typically
require individual decisions to accept risks or incur costs to be fully self-contained; if we did, we would not allow people to smoke, drink alcohol, eat poorly, or engage in a variety of other behaviors that a free society generally permits. Beyond monetary costs, we might also consider the harm experienced by a player’s family and friends if he is seriously harmed by a professional football career. In that context, however, note that we do not prevent husbands or fathers from skydiving, BASE jumping, or any number of other activities that may be seriously risky over the short or long term, the consequences of which may be borne by others beyond the individual directly taking the risks. Thus, it is difficult to see here what justification there might be for treating professional football differently, especially given the substantial benefits, financial and otherwise.

Finally, there is the possibility that the existence of professional football paves the way for the existence of the game at lower levels for college and youth athletes, such that we should be wary of allowing professionals to take risks that may also then be expected or experienced by amateurs, including children. Limiting the freedom of adult professionals, however, would be an indirect and likely unnecessary approach to ensure the protection of others; instead, the risks of youth and college football could be directly regulated and restricted, if those were the externalities at issue.

In sum, it seems that costs of various kinds that may occur as a result of letting competent adults play professional football are not so much more substantial than those that may occur in other socially permissible activities to justify a prohibition on the practice. Thus, the externalities rationale appears to us to be an inadequate reason to suggest that professional football players should not be permitted to accept even substantial risks to themselves, should that be what the scientific evidence ultimately shows. Of course, we recognize that others may prefer a more paternalistic approach, one that would actually protect players from even their own autonomous decisions that may cause them harm or regret. In that case, however, it would be necessary to identify some feature of professional football that renders players in greater need of protection than other competent adults. We have not been able to identify any such feature, or at least no such feature that would call for an absolute bar on the opportunity to play in the NFL as it currently exists.

Ultimately, we as a society have determined that it is preferable to allow people to make decisions that may cause them harm than to live in a society in which others are allowed to decide what is best for us, and we believe this concept holds with regard to professional football players as well. This certainly does not mean, however, that we advocate a principle of “every man for himself.” To the contrary, we noted above that efforts to educate and support player autonomy are both justified and essential. Indeed, as will be discussed in this Report, the NFL and NFLPA have made important progress in these areas, but even more is needed.

We have not endeavored in this Report to evaluate football as a sport or to radically change its basic nature. Accordingly, we note that it is surely not the case that the NFL can satisfy its obligations by simple acknowledgment or disclosure of risks to players, any more than a company that offers bungee jumping services can simply disclaim the risk of death—it must also take steps to provide safe bungee cords, jump training, environments, and the like. Indeed, occupational safety and health laws in the United States preclude individuals from simply consenting to any workplace risk they may be willing to accept. Instead, employers are required to take various steps to protect against such workplace risks, as we discuss extensively in our forthcoming paper, The NFL as a Workplace: The Prospect of Applying Occupational Health and Safety Laws to Protect NFL Workers. Precisely which steps are required depends on feasibility and the nature of the industry in question, but it is clear from both legal and ethical perspectives that respect for individual autonomy in the face of even substantial risks must be paired with reasonable efforts to abate risk exposure. Again, the NFL has made changes on these issues, including providing “among other things, training on proper tackling (including youth football initiatives), helmets, and protective gear,” as well as implementing “rule changes for the purpose of protecting the players.”
Those efforts may occur through a variety of channels, but here we restrict ourselves to off-the-field interventions, rather than addressing on-the-field rules of play. As lawyers and ethicists, we believe it is beyond our legitimate expertise to recommend such specific changes. This is not to deny, of course, that the rules of play can have an important impact on player health; indeed, rule changes have historically been implemented to increase the safety of the game, and that trend continues today. However, the effects of these changes are not always clear at the outset: some injury-reducing rule changes may inadvertently induce other types of risk-taking behavior, or reduce certain injuries while exacerbating others.

As in any contact sport, a certain number of injuries in football are unavoidable. To produce a truly “safe” (i.e., injury-free) game would require radical reconfiguration from the current status quo, and again, we suggest that this is beyond what is ethically required for a voluntary endeavor between consenting adults (even as we recognize that those consenting adults may be faced with competing priorities between their health and other goals, and may also be constrained by a variety of background conditions addressed below). Which on-the-field changes would be desirable depends on a multifactorial analysis of the benefits and drawbacks of the current version of the game (in regards to health and otherwise), the benefits and drawbacks of moving to a radically different game, and a method of weighing those benefits and drawbacks against the consequences of injuries to players and players’ own desires and goals as they define them. In this regard, we note that The Football Players Health Study is a strong example of the participatory research model: the study is funded by NFL contributions to research as well as the players themselves (through CBA funds that can otherwise be allocated to player salaries) and by the NFLPA specifically, which is tasked with representing player interests, and our study is guided by more than 30 Player Advisors. One message that we have heard loud and clear from the players is that while they hope the study will make important strides toward protecting and promoting player health, they have implored us not to make recommendations that could threaten the continued existence of the game. Thus, while we welcome recommendations for rule changes to improve player safety made by appropriate experts, evaluated in light of what players themselves want, we are not in a position to make these determinations as a definitive matter. Ultimately, we conclude that we are likely to be far more effective in protecting and promoting player health via off-the-field intervention than by suggesting that the game itself fundamentally change.

Before moving on, it is important to note that we have addressed here only the question of whether it is necessary or justifiable to eliminate the very opportunity for competent adults to play professional football, with all its attendant physical risks. As to that question, we believe the answer is “no.” A distinct question exists as to whether it is ethical to watch or support professional football in various capacities as a non-player; a question we do not take on in this Report beyond addressing the roles of various stakeholders to support player health within existing parameters of the game.

* * *

With this critical background in mind, the remainder of this chapter further introduces the Report by describing its audience, articulating the process we used to develop our ultimate recommendations, and clarifying important points about scope and how the recommendations might be considered against the backdrop of the NFL’s and NFLPA’s historical approaches to player health. In the chapter that follows, we articulate a set of guiding ethical principles, before moving on to analysis of the wide range of stakeholders responsible for player health.

### (C) Audience

This Report has several key audiences. First, there are the major change agents: current players; club owners; the NFL; the NFLPA; club medical staff; and, various player advisors. If change is to occur, these are the key individuals and entities that will need to effectuate it. However, we live in an era where discussions about protecting and promoting player health extend far beyond these change agents. Fans, the media, the NFL’s business partners, and others all have a stake in, and more importantly, some power to shape,
how the policies and practices of the NFL might evolve to best protect and promote player health.

Writing for such divergent audiences is a significant challenge. Ultimately, we decided to err in favor of providing a more comprehensive analysis, with all the complexity and length that entails. Although the entire context of the Report is important, the chapters are intended to be read relatively independently, except where there is significant overlap between material. Knowing that some readers will only be interested in reading selected chapters, we made the editorial decision to repeat important text in more than one chapter in order to enable chapters to better stand alone. As further assistance to readers, we have created brief summaries for each of the chapters, which also include our recommendations for moving forward.

It is also important to clarify the nature of our Report, as different audiences may be more accustomed to different research designs and formats depending on their field of practice or academic discipline. Unlike other components of The Football Players Health Study, this Report is not designed or intended to be an empirical analysis, although like much legal and ethical scholarship it relies on quantitative and qualitative data where available. The Report analyzes existing literature, case law, statutes, codes of ethics, policies and practices where available, supplemented with additional information from sources with direct knowledge where possible.

Figure Introduction-A: The Report’s Goals and Process

1) IDENTIFICATION: UNDERSTANDING THE MICROENVIRONMENT AFFECTING PLAYER HEALTH

Over several months, we conducted a comprehensive review of the sports law and ethics literature, and had in-depth conversations with a number of former players and representatives of the many stakeholders we identified as crucial to our analysis. This allowed us to supplement our existing expertise and understanding to generate a list of 20 stakeholders to focus on. The stakeholders are: players; club doctors; athletic trainers; second opinion doctors; neutral doctors; personal doctors; the NFL; NFLPA; NFL clubs; coaches; club employees;
A decision not to play through injury or not to accept certain risks could make the difference between getting a contract or a contract extension and being cut. Moreover, although some players have million dollar contracts, many players make substantially less; even if their salaries are in the range of hundreds of thousands of dollars, they only have that earning potential for a relatively short period of time—they are generally not “set for life.” In this context, players may feel the need to push themselves as hard as possible for as long as possible (and may also feel pressure from coaches, teammates, fans, and others), and face the consequences later. On top of all this, most players love the game. They love to play, they love the physicality, and they love the team mentality. Regardless of their physical limitations, they often want to play and do not want to let their teammates down.

Again, none of this is to suggest that players are not competent moral agents, making voluntary decisions to play football. They certainly are, but the background circumstances that influence their decisions, and that differ for each player, cannot be ignored. Thus, while we recognize that players bear responsibility for their own health, in many cases they simply cannot protect and promote their health entirely on their own, nor may they treat health as their unyielding primary goal. Although the competitive nature of the game and the limited available roster spots are inherent features that will not change, players need a structure that helps them make decisions that will advance their own interests, as they define those interests in the short- and long-term. This requires accurate information, unconflicted practitioners and advisors, social support and safety nets in place when they make choices that turn out poorly, easily accessible opportunities to prepare for life after football, and a culture shift toward greater respect and understanding for players who take steps to protect their health. Without changes in this support structure and other features beyond player control, meaningfully improving player health is impossible.

Thus, while recognizing a critically important role for players, this Report also views a variety of additional stakeholders as key influences, for good or for bad, on player health. It is helpful to understand these stakeholders as falling into several groupings, which mirror the Parts of this Report.

Part 1 begins with the players, the focal point of our analysis.

Part 2 is devoted to the player’s medical team, those stakeholders that provide medical diagnosis and treatment, as well as athletic training, focusing directly on player health. Parts of this team (club doctors, athletic trainers) are largely

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h The National Academy of Medicine is a nonprofit, nongovernmental organization that conducts research and provides advice concerning medical and health issues.
within the club, or at the League level (neutral doctors). Others (the player’s personal doctor and second opinion doctors) are available to the player outside the ambit of the club or the League.¹

The second grouping, contained in Part 3, includes the chief policymakers for all matters related to promoting and protecting players’ health: the NFL; the NFLPA; and, the individual clubs. These stakeholders represent the club owners and the players respectively, and their policies are primarily codified in the various CBAs. Because so many of our recommendations are ones that we envision being enacted through the CBA process, we spend considerable time in this Report discussing the NFL’s and NFLPA’s past efforts concerning player health to ground our recommendations for the future.

While there are a number of critical League-wide policies, when it comes to player health there can also be heterogeneity among the practices of individual clubs. Our third grouping, discussed in Part 4, examines the stakeholders that, apart from the medical team, influence player health at the club level: club employees; and, equipment managers.

Of course, players often look outside the club or the League for advice related to their health and for social support. The fourth grouping looks at who they turn to: contract advisors; financial advisors; and, family members. Part 5 examines these stakeholders.

More on the periphery is a somewhat miscellaneous set of stakeholders we discuss in Part 6: officials; equipment manufacturers; the media; fans; and, NFL business partners. In keeping with our assessment that their effects on players’ health and ethical duties are more attenuated, we spend less time analyzing and making recommendations for this group. Nonetheless, they are an important part of understanding the full range of stakeholder influences on player health.

Finally, Part 7 briefly discusses several groups that are “interested parties” but do not quite rise to the level of a true stakeholder in the microenvironment that has the health of professional players at the center: the National Collegiate Athletic Association (NCAA); youth leagues; governments; worker’s compensation attorneys; and, health-related companies. Understanding these parties may be helpful for understanding the broader context in which player health issues arise and are addressed, but we make no recommendations relating to these groups, for reasons discussed in Part 7.

Figure Introduction-B on the next page shows the intersections of these stakeholders in the microenvironment of player health.

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¹ At the beginning of Part 2, we acknowledge that there are other medical professionals who work with NFL players, including but not limited to physical therapists, massage therapists, chiropractors, dentists, nutritionists, and psychologists. While a health care professional from any one of these groups might play an important role in a player’s health, it is our understanding that their roles are not so systematic and continuous to require in-depth personalized discussion, i.e., they are typically not as enmeshed within the culture of a given NFL club to generate some of the concerns that are discussed in Part 2. Moreover, the obligations of and recommendations towards these professionals are substantially covered by other chapters in this Report. To the extent any of these healthcare professionals are employed or retained by the Club, Chapter 2: Club Doctors and Chapter 3: Athletic Trainers are of particular relevance. To the extent any of these healthcare professionals are retained and consulted with by players themselves, then Chapter 6: Personal Doctors is relevant.

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It is essential to recognize that although they are competent adults, players make choices against a constrained set of background conditions.
How did we arrive at this list of stakeholders? The key criterion for inclusion was simple: who (for better or worse) does—or should—play a role in NFL player health? The answer to that question came in three parts, as there are individuals, groups, and organizations who directly impact player health, for example, as employers or caregivers; those who reap substantial financial benefits from players’ work; and, those who have some capacity to influence player health. Stakeholders may fall under more than one of these headings, but satisfaction of at least one criterion was necessary for inclusion. The result is an extensive mapping of a complex web of parties.

2) DESCRIPTION OF LEGAL AND ETHICAL OBLIGATIONS

Once our stakeholders were identified and appropriately organized in line with the microenvironment discussed above, we undertook a comprehensive analysis of their existing legal obligations and the ethical codes applicable to each (if any) through legal research, review of academic and professional literature, and interviews with key experts. We conducted formal and informal interviews with a number of current and former players, NFL and NFLPA representatives, sports medicine professionals, contract advisors, financial advisors, player family members, members of professional organizations representing coaches, athletic trainers, officials, and equipment managers, the media, and others working in and around the NFL. In the hope of encouraging full and candid disclosure, we offered these individuals the opportunity to have their comments be used confidentially and we have honored their preferences in this Report. The interviews were not intended to be representative of the different stakeholder populations or to draw scientifically valid inferences and they should not be used for that purpose. Instead, they were meant to be informative of general practices in the NFL.

Additionally, in the Section: Ensuring Independence and Disclosure of Conflicts, we discuss our methodology for obtaining relevant information from both the NFLPA and NFL. During the course of our research we had multiple telephone and email communications with both NFLPA and NFL representatives to gain factual information. As will be indicated where relevant in the Report, sometimes the parties provided the requested information and

\[\text{(During the course of reviewing this Report for confidential information, the NFLPA requested information obtained from the NFLPA be attributed to the NFLPA generally, rather than specific NFLPA employees. For our purposes, the specific individual that provided the information was irrelevant, so long as the NFLPA provided the information. Thus, we agreed not to identify specific NFLPA employees.)}\]
sometimes they did not. These communications were not about the progress, scope, or structure of the Report.

As is typical with sponsored research, we provided periodic updates to the sponsor in several formats: Pursuant to the terms of Harvard-NFLPA agreement, the NFLPA receives an annual report on the progress of The Football Players Health Study as well as one Quad Chart progress report each year. Additionally, on two occasions (August 22, 2014, and January 23, 2015), we presented a summary of the expected scope and content of the Report to The Football Players Health Study Executive Committee, comprised of both Harvard and NFLPA personnel. Those meetings did not alter our approach in constructing this Report, the conclusions reached, or the recommendations made. Indeed, the only comment from the Executive Committee meetings that resulted in a change to the content of the Report was the suggestion at the very beginning of the writing process to include business partners as a stakeholder, which we agreed to be important.

More specific information about our player interviews is also important. To better inform our understanding of players and all of the stakeholders and issues discussed in this Report, we conducted approximately 30-minute interviews with 10 players active during the 2015 season and 3 players who recently left the NFL (the players’ last seasons were 2010, 2012, and 2012 respectively). The players interviewed were part of a convenience sample identified through a variety of methods; some were interested in The Football Players Health Study more generally, some we engaged through the Law and Ethics Advisory Panel (LEAP) and Football Players Health Study Player Advisors, and some interviews were facilitated by a former player now working for the NFLPA. The players interviewed had played a mean of 7.5 seasons, with a range of 2 to 15 seasons, and for a mean of between 3 and 4 different clubs (3.4 clubs), with a range of 1 to 10 clubs. In addition, we interviewed players from multiple positions: one quarterback; two fullbacks; one tight end; three offensive linemen; two linebackers; one offensive end; two safeties; and, a special teams player (not a kicker, punter, or long snapper). We aimed for a racially diverse set of players to be interviewed: seven were white and six were African American. Finally, the players also represented a range of skill levels, with both backups and starters, including four players who had been named to at least one Pro Bowl team.

In addition to these more formal interviews, we engaged in informal discussions and interviews with many other current and former players to understand their perspectives. As stated above, these interviews were not intended to be representative of the entire NFL player population or to draw scientifically valid inferences, and should not be read as such, but were instead meant to be generally informative of the issues discussed in this Report. We provide anonymous quotes from these interviews throughout the Report, and urge the reader to keep that caveat in mind throughout.

The key criterion for inclusion was simple: who (for better or worse) does—or should—play a role in NFL player health?

We were not always able to achieve as much access to interview subjects or documents as would have been ideal. In November 2014, we notified the NFL that we intended to seek interviews with club personnel, including general managers, coaches, doctors, and athletic trainers. The NFL subsequently advised us that it was “unable to consent to the interviews” on the grounds that the “information sought could directly impact several lawsuits currently pending against the league.” Without the consent of the NFL (the joint association for NFL clubs, i.e., the employers of these individuals), we did not believe that the interviews would be successful and thus did not pursue them at that time; instead, we provided those stakeholders the opportunity to review a draft of the Report. We again requested to interview club personnel in July 2016 but the NFL did not respond to that request. The NFL was otherwise cooperative; it reviewed our Report and facilitated its review by club doctors and athletic trainers. The NFL also provided information relevant to this Report, including but not limited to copies of the NFL’s Medical Sponsorship Policy (discussed in Chapter 2: Club Doctors) and other information about the relationships between clubs and doctors.

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

The absence of individual interview data from club personnel is an important limitation to our work. The result is that we instead rely largely on the perspectives of players concerning these individuals. Nevertheless, we believe this gap is mitigated by our extensive research and the NFL’s and club doctors’ review of this Report.

3) EVALUATION OF LEGAL AND ETHICAL OBLIGATIONS

Once we had a better sense of the existing obligations, or lack thereof, and how those obligations were or were not complied with or enforced, we were able to begin normative analysis, evaluating the current successes as well as gaps and opportunities for each stakeholder in protecting and promoting player health.

4) RECOMMENDATIONS

Finally, we applied a series of legal and ethical principles, discussed in the next chapter, to the current state of affairs for each stakeholder in order to arrive at recommendations for positive change where needed. For every recommendation we describe both the reason for the change and, where applicable, potential mechanisms by which it may be implemented. However, we avoided being overly specific or prescriptive when multiple options for implementation may exist, and where we lacked sufficient information to determine which mechanism might be best.

While we consider and discuss all changes that could improve player health, we purposefully chose to focus on actionable recommendations that could be realistically achieved between the publication of this Report and execution of the next CBA (discussed in detail below). This pragmatic approach does not mean that we are giving stakeholders a pass to simply accept the many current barriers to change that may exist, but it does recognize that change may be difficult in this complex web of relationships and in a culture that has developed over the course of many decades and is deeply entrenched. Furthermore, certain changes might require further information, research, or discussion than we were able to achieve in this Report. When we concluded that was the case, we so indicated by recommending only that a change be “considered” or that additional information be sought. Our recommendations may not be easy to achieve, but we have taken into account various realities.

Finally, it is important to recognize that we do not view our recommendations as the exclusive changes that the various stakeholders should consider. We do, however, view these as minimum next steps forward—a floor, but not a ceiling.

Each chapter largely follows the goals and process outlined above. The sections of each chapter include: (A) Background; (B) Current Legal Obligations; (C) Current Ethical Codes; (D) Current Practices; (E) Enforcement of Legal and Ethical Obligations; and, (F) Recommendations.

(E) The Collective Bargaining Agreement (CBA)

As discussed above, it is important that our recommendations be actionable. Moreover, we recognize that the most realistic way in which change will be effectuated is through the CBA. Thus, we provide a primer on the CBA.

Pursuant to the National Labor Relations Act (NLRA), the NFLPA is “the exclusive representative” of current and rookie NFL players “for the purposes of collective bargaining in respect to rates of pay, wages, hours of employment, or other conditions of employment.” Also pursuant to the NLRA, NFL clubs, acting collectively as the NFL, are obligated to bargain collectively with the NFLPA concerning the “wages, hours, and other terms and conditions of employment” for NFL players. Since 1968, the NFL and NFLPA have negotiated 10 CBAs. The most recent CBA (executed in 2011) is 301 pages long and governs nearly every aspect of the NFL. Generally speaking, most important changes in NFL policies and practices are the result of the CBA process. Consequently, CBAs are of paramount importance to understanding how the business of the NFL functions and making recommendations for improvement. Appendix B shows the health-related changes in the CBAs over time.
Throughout this Report, we refer to the CBAs by years, such as the 1968 CBA, 1993 CBA, or 2011 CBA. The years reference the dates the CBAs became effective, which is usually, but not always, the year in which the CBA was agreed to, i.e., some CBAs had retroactive application.

Why discuss the past CBAs and the CBA process so heavily in this Report? The CBA represents the key covenant between players (via the NFLPA) and club owners (via the NFL), on all matters pertaining to player health (alongside many other important issues that matter to these parties). The most straightforward way to implement many of the changes we recommend to protect and promote player health will be to include them in the next CBA. That said, however, whenever change is possible outside of the CBA negotiating process, it should not wait—the sooner, the better. Moreover, although the CBA will often be the most appropriate mechanism for implementing our recommendations, we do not want to be understood as suggesting that player health should be treated like just another issue for collective bargaining, subject to usual labor-management dynamics. This is to say that as an ethical matter, players should not be expected to make concessions in other domains in order to achieve gains in the health domain. To the contrary, we believe firmly the opposite: player health should be a joint priority and not be up for negotiation.

Now that we have explained the significance of the collective bargaining relationship between the NFL and NFLPA, we provide a short historical summary of the parties’ approach to player health. In Chapter 7: The NFL and NFLPA, we provide a more detailed discussion (including relevant citations) of the issues summarized here.

The 1960s and 1970s were marked by the League’s growth into the modern enterprise that it is today. Under the leadership of Commissioner Pete Rozelle, the NFL achieved stability by merging with its competitor league, the American Football League (AFL), and important new revenue as a result of the broadcasting of NFL games on television, aided by the passage of the federal Sports Broadcasting Act. The increased revenues coincided with an emerging NFLPA, led by its first Executive Director, Ed Garvey. Although progress was made on basic medical issues (such as medical insurance and disability benefits) during this time, the principal items of negotiation were compensation issues and free agency.

The 1980s were characterized by labor strife. The players engaged in unsuccessful strikes during the 1982 and 1987 seasons as part of their efforts to obtain a system of free agency, which by that point existed in all the other major professional sports leagues. While the players did not gain on this issue, the 1982 CBA did make progress on several health initiatives, including required certifications for club doctors and athletic trainers, the players’ right to a second medical opinion paid for by their club, and the players’
right to choose their own surgeon at their club's expense. In this decade, former NFL player Gene Upshaw took over for Garvey at the NFLPA, and former outside counsel Paul Tagliabue replaced Rozelle as Commissioner. The 1980s ended with a series of ongoing antitrust lawsuits concerning the NFL’s compensation rules.

As an ethical matter, players should not be expected to make concessions in other domains in order to achieve gains in the health domain.

In 1993, the NFL and NFLPA reached a settlement on the outstanding litigation and created a new, comprehensive CBA that set the framework for every CBA since. The players gained the right to unrestricted free agency for the first time in exchange for a hard Salary Cap. Nevertheless, the 1993, 1996, and 1998 CBAs made almost no substantive changes to player health provisions, other than mild increases in the benefit amounts. At the same time, concussions were starting to become an issue of concern to players and were gaining media attention. In 1994, the NFL formed the Mild Traumatic Brain Injury Committee (MTBI Committee) to study concussions, led by New York Jets club doctor Elliot Pellman.

The CBA was extended in 2002 with minimal conflict and again minimal gains on player health provisions. Of note, offseason workout programs were reduced from 16 to 14 weeks and the NFL established a Tuition Assistance Plan. Beginning in 2003, the MTBI Committee published research that became controversial, as discussed in more detail in Chapter 7: The NFL and NFLPA.

A new CBA was reached in 2006 that made some changes concerning player health, including a Health Reimbursement Account, and the “88 Benefit” to compensate retired players suffering from dementia. After completing the 2006 CBA, Roger Goodell replaced Tagliabue as NFL Commissioner.

Concerns about concussions and player health accelerated during the late 2000s. Both the NFL and NFLPA faced criticism on these issues, including at multiple Congressional hearings. At a 2009 hearing, NFLPA Executive Director DeMaurice Smith, who replaced the recently deceased Upshaw, emphasized that the NFLPA considered player health its top priority and would increase its attention to these issues. For his part, Goodell deferred to the scientific debate about the extent to which football caused brain injuries, while he also emphasized progress the NFL had made concerning its concussion protocols and research it was funding. After the hearing, the NFL effectively overhauled the MTBI Committee, renaming it the Head, Neck and Spine Committee and replacing its members with independent experts. Nevertheless, further progress on these issues was complicated by the NFL’s decision, in 2008, to opt out of the 2006 CBA after the 2010 season over economic issues.

The 2011 CBA negotiations ultimately resembled a condensed version of what took place between 1987 and 1993. After extensive litigation and public politicking, the NFLPA and NFL reached a new CBA in July 2011. The 2011 CBA substantially amended and supplemented player health and safety provisions. In short, the 2011 CBA created new health-related benefits and programs, increased existing benefit amounts, reduced on-field exposure, improved the number and type of doctors clubs must retain, and set aside funds for further research. Those funds are used to fund The Football Players Health Study at Harvard University and other research initiatives.

(G) Dispute Resolution

With a brief understanding of the CBA and the NFL’s and NFLPA’s approaches to player health, it is important to understand how players and other stakeholders resolve disputes about the CBA or parties’ policies and practices. In this Report we discuss ways in which players have enforced and can enforce stakeholder obligations, i.e., ways in which players can seek to either have the stakeholder punished for failing to abide by the stakeholder’s obligations, and/or for the player to be compensated for that failure. The two principal methods by which players seek to enforce stakeholder obligations are through civil lawsuits or in arbitrations, typically through procedures outlined in the CBA. Arbitrations are a private alternative to litigation in public courthouses. As is discussed in this Report, there are often legal disputes about the forum in which a player is required to bring his claim.

Nevertheless, we do not strongly advocate for one dispute resolution system over another. There are benefits and drawbacks to each, as detailed in Appendix K: Players’ Options to Enforce Stakeholders’ Legal and Ethical Obligations. What is important for our purposes is that players have meaningful mechanisms through which to address their claims. In places where we think players’ ability to enforce stakeholder obligations is unclear or inefficient, we have made recommendations designed to improve players’ rights.
Finally, it is our hope that player health will become a shared issue of concern, and less of one subject to dispute. For this reason, mediation can also be an effective form of alternative dispute resolution. Mediation involves a trained third party working with both sides to reach a mutually acceptable agreement. Through mediation, players and the various stakeholders discussed herein might be able to reach fair outcomes without resorting to more adversarial proceedings such as lawsuits and arbitrations.

**Scope of the Report**

As already alluded to, the scope of this project is to generate legal and ethical recommendations that will improve the health of professional football players, current, future, and former. To fully grasp what is to come, it is essential to clarify these parameters.

1) **Defining Health**

First, it is necessary to understand what we mean by “health” and to explain the rationale for our definition, which extends beyond the sort of clinical measurements that might immediately be evoked by the phrase. Indeed, our mantra “The Whole Player, The Whole Life” motivates definition used in this Report. “Health” clearly covers the conventional and uncontroversial reference to freedom from physical and mental illness and impairment. But health is much more than the mere absence of a malady. As a prominent medical dictionary notes, the

... state of health implies much more than freedom from disease, and good health may be defined as the attainment and maintenance of the highest state of mental and bodily vigour [sic] of which any given individual is capable. Environment, including living and working conditions, plays an important part in determining a person’s health, as do factors affecting access to health such as finance, ideology, and education.\(^n\)

Other groups take the definition of “health” even further. For example, rather than recognizing environment, living and working conditions, finance, ideology, and education as factors that determine a person’s health or access to health, the World Health Organization (WHO) treats them as part of health itself, which it defines as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”\(^{48}\) (emphasis added). Because the WHO definition is so broad as to make nearly any question a health question, we do not directly adopt it here.

However, we do maintain the importance of considering the full range of nonmedical inputs that can influence health, also known as the social determinants of health. These social determinants extend beyond the sorts of things for which one would seek out a doctor’s care, and include broadly “the conditions in which people are born, grow, live, work, and age,” as affected by the “distribution of money, power, and resources at global, national and local levels.”\(^{49}\) Indeed, the NFL’s Player Engagement Department itself includes “physical strength,” “emotional strength,” “personal strength,” and “financial strength” within its concept of “total wellness.”\(^{50}\)

In Chapter 13: Financial Advisors, we discuss several reports and studies with conflicting information about the financial health of NFL players. Nevertheless, it is clear that there are serious concerns about former players’ financial challenges. The relationship between physical and financial health goes in both directions. Without adequate savings and benefits during and after NFL play, players may find themselves insufficiently prepared to meet their physical and mental health needs, especially in the event of crisis.\(^{51}\) On the flip side, crises in physical and mental health are closely tied to bankruptcy, home foreclosure, and other serious financial setbacks.\(^{52}\) At its worst, these two outcomes can lead to a vicious cycle—poor health outcomes lead to financial losses, which worsen the ability to combat physical and mental health impairments, which in turn further deplete financial resources. Additionally, financial health is also in and of itself an important component of a person’s health. Financial difficulties can cause stress that contributes to or exacerbates psychological and physical ailments.

Acknowledging these social determinants of health allows us to recognize that a set of recommendations limited exclusively to medical care, medical relationships, and medical information would not suffice to achieve our goal of maximizing player health. Acknowledging the social determinants of health recognizes that a set of recommendations limited exclusively to medical care, medical relationships,
and medical information would not suffice to achieve our goal of maximizing player health. We cannot focus solely on avoiding brain injury, protecting joints, and promoting cardiovascular health, for example, but we must also address well-being more generally, which depends on other factors, such as the existence of family and social support, the ability to meet economic needs, and life satisfaction.

Acknowledging the social determinants of health recognizes that a set of recommendations limited exclusively to medical care, medical relationships, and medical information would not suffice to achieve our goal of maximizing player health.

We define health for purposes of this Report as “a state of overall well-being in fundamental aspects of a person’s life, including physical, mental, emotional, social, familial, and financial components.” While our expansive definition of health might be more applicable to some stakeholders than others, we believe it is important to provide one definition that applies to all stakeholders.⁰

Accordingly, this Report makes recommendations not only about ways to influence players’ medical outcomes, but also ways to positively influence the role of social determinants in their health. This translates to recommendations about financial management, retirement planning, the contract advisor and financial advisor industries, education and training for careers after the NFL, and others—ultimately factors that can become significant stressors if not handled appropriately, with serious consequences for physical, social, and financial health in the short and long term.⁵³

Although reference to “health and well-being” is more descriptive of the breadth we have in mind, going forward, we will simply refer to “health” as shorthand to refer to both medical issues (physical and psychological) and social determinants of health.

A second clarification about our understanding of health is also worth making explicit. This is to draw a distinction, as has become common in public health, bioethics, human rights, and political philosophy, between “capabilities” and “functionings.” Capabilities are central, essential entitlements needed to live a life that is a truly good life for a human being; they are what is needed to allow for human flourishing.⁵⁴ On one particularly influential list from the philosopher Martha Nussbaum these include, among other things, living a normal life span, bodily health, bodily integrity, being able to use the senses, the imagination, and thought, and experiencing normal human emotions.⁵⁵ But these capabilities are really possibilities, not mandates. They refer to the capability to do X, rather than a mandate that a person do X (a functioning). To define what makes a life good in terms of functioning instead of capability would threaten to push “citizens into functioning in a single determinate manner, [and] the liberal pluralist would rightly judge that we were precluding many choices that citizens may make in accordance with their own conceptions of the good.”⁵⁶

For this reason, whenever we discuss promoting player health in this Report we are discussing promoting players’ capabilities related to health. As we recognize and discuss in greater depth below in our principle of “empowered autonomy,” whether and how players decide to exercise those capabilities for health is something that is left up to them. We will have satisfied our duties to players if we can support their capabilities for health, whatever they decide to do with those capabilities. That said, however, we recognize, as explained above, that players face a wide variety of constraints and pressures that may influence their ability and willingness to exercise their capabilities for health. As such, we endeavor in this Report to minimize those constraints and pressures to the extent possible.

Finally, it is important to understand the temporal dimension of health we aim to improve. A driving theme for the entire Football Players Health Study is the idea that we are focused on the whole player, over his whole life. When we discuss promoting player health we have in mind the “long game,” and the goal is not only to keep players healthy during their playing years or immediately afterwards, but throughout their (hopefully long) lifetimes.

⁰ For example, some might believe our definition of health is too broad to be imposed on employers such as the NFL and NFL clubs. However, as is explained in this Report, the NFL and clubs have voluntarily taken on responsibilities and facilitated many programs that address the components of our broader definition of health, including but not limited to programs concerning mental and financial health. Additionally, we note that employers are increasingly adopting initiatives, such as wellness programs, to advance employee health rather than to simply prevent injuries on the job. See Kristin Madison, Employer Wellness Incentives, the ACA, and the ADA: Reconciling Policy Objectives, 51 Willamette L. Rev. 407, 411–14 (2015).
2) A FOCUS ON PROFESSIONAL FOOTBALL PLAYERS

In identifying the universe of appropriate stakeholders and making recommendations regarding player health, we have taken as our threshold the moment that a player has exhausted or foregone his remaining college eligibility and has taken steps to pursue an NFL career. From that point on what needs to happen to maximize his health, even after he leaves the NFL? The reason we have selected this frame is not because the health of amateur players—those in college, high school, and youth leagues—is secure or unimportant. Instead, the reason is largely pragmatic: there is only so much any one report can cover, and adding analysis of additional stakeholders such as the NCAA, youth leagues, and parents would confuse an already complicated picture. We recognize that what happens at the professional level can have a trickle-down effect on the culture of football across the board, and also that some amateur players may be taking health risks in hopes of eventually reaching the NFL, even when that may be highly unlikely. Moreover, we acknowledge that the legal and ethical issues that arise regarding individuals who are not competent to make their own decisions (e.g., children) are substantially more difficult. Nonetheless, our goal with this Report is to address the already complicated set of factors influencing the health of NFL players, current, future, and former.

That said, many of our recommendations will be most relevant to current and future players, simply because former players may not continue to be engaged with or affected by many of the stakeholders that we have covered, or may be past the point at which implementation of particular recommendations could help them. For example, no matter what improvements we recommend related to club doctors, these could not affect players who are no longer affiliated with any club.

We nonetheless acknowledge that concerns about the health of former NFL players have been an important contributing motivation for research on NFL player health issues, including The Football Players Health Study. Although we focus on current players, the health benefits available to players after their career are an important component of player health. We have summarized these benefits in Appendix C. In addition, in our forthcoming Report, Comparing the Health-Related Policies and Practices of the NFL to Other Professional Sports Leagues, we provide an in-depth analysis of these benefits and compare them to those available in other professional sports leagues. Comparing the benefits raises difficult questions of what players are entitled to and when they are entitled to it. We address these issues in our forthcoming Report.

With this Introduction to our work at hand, we next outline our governing ethical principles before moving on to discussions of the stakeholders comprising the microenvironment of player health.
Chronic Traumatic Encephalopathy in Athletes: Progressive Tauopathy

After Repetitive Head Injury

Chronic Traumatic Encephalopathy (CTE) is a progressive neurodegenerative syndrome caused by consequence of single or repetitive closed head injuries for which there is no treatment and no definitive pre-mortem diagnosis.; Bennet Omalu et al., Emerging Histophormorphic Phenotypes of Chronic Traumatic Encephalopathy in American Athletes, 69 Neurosurgery 173 (2011) (defining CTE as “a progressive neurodegenerative syndrome caused by single, episodic or repetitive blunt force impacts to the head and transfer of acceleration–deceleration forces to the brain.”); Ann McKee et al., Chronic Traumatic Encephalopathy in Athletes: Progressive Tauopathy After Repetitive Head Injury, 68 J. Neuropathology & Experimental Neurology 709 (2009) (describing CTE as “shar[ing] many features of other neurodegenerative disorders”).


See Joseph C. Maroon et al. Chronic Traumatic Encephalopathy in Contact Sports: A Systematic Review of All Reported Pathological Cases, PLOS ONE (2015) (summarizing CTE case studies to date); Ann C. McKee et al., The spectrum of disease in chronic traumatic encephalopathy, 136 Brain 43 (2013); Bennet I. Omalu, Chronic Traumatic Encephalopathy, Suicides and Parasuicides in Professional American Athletes, 31 Am. J. Forensic Med. Pathol. 130 (2010); What is CTE?, BU CTE Center, http://www.bu.edu/cte/about/what-is/cte/ (last visited Mar. 31, 2016), archived at https://perma.cc/W86H-R96C (CTE is associated with “athletes (and others) with a history of repetitive brain trauma,” and “is associated with memory loss, confusion, impaired judgment, impulse control problems, aggression, depression, and, eventually, progressive dementia.”)

See Maroon, supra note 6.


See Maroon, supra note 6.

See McCrory, supra note 8, at 257.


Mike Florio, NFL challenged over failure to fund study for CTE test in living patients, ProFootballTalk (Feb. 4, 2016, 8:10 PM), http://profootballtalk.nbcports.com/2016/02/04/nfl-challenged-over failure-to-fund-study-for-cte-test-in-live-patients/, archived at https://perma.cc/R5JW-FV8F.

Mike Florio, NFL challenged over failure to fund study for CTE test in living patients, ProFootballTalk (Feb. 4, 2016, 8:10 PM), http://profootballtalk.nbcports.com/2016/02/04/nfl-challenged-over failure-to-fund-study-for-cte-test-in-live-patients/, archived at https://perma.cc/R5JW-FV8F.


See Maroon, supra note 6.

See McCrory, supra note 8, at 257.


12 Mike Florio, NFL challenged over failure to fund study for CTE test in living patients, ProFootballTalk (Feb. 4, 2016, 8:10 PM), http://profootballtalk.nbcports.com/2016/02/04/nfl-challenged-over failure-to-fund-study-for-cte-test-in-live-patients/, archived at https://perma.cc/R5JW-FV8F.


19 Letter from Jeff Pash to authors (July 15, 2016).


21 Letter from Jeff Pash to authors (July 15, 2016).


24 Id.


29 Id.

30 Id. at 397.

31 Id. at 398.

Norman Daniels, *Chevron v. Echazabal: Protection, Opportunity, and Paternalism*, 93 Am. J. Pub. Health 545, 547 (2003) (acknowledging that individual workers should have less choice about which risks to undertake if they are “quasi-coerced” in the sense of having a reduced range of opportunities in terms of education, job training, and mobility than might be deemed just or fair).


Marian Moser Jones and Ronald Bayer, *Paternalism and Its Discontents: Motorcycle Helmet Laws, Libertarian Values, and Public Health*, 97 Am. J. Pub. Health 208, 213 (noting that it is possible to find a social cost for any behavior, but that approach would allow limitless interference with individual liberty).

See id.


NFL Comments and Corrections (June 24, 2016).

The players’ share of NFL revenues is referred to as the Player Cost Amount, 2011 CBA, Art. 12, § 6(c)(i). The Football Players Health Study is funded from a pool of money known as the Joint Contribution Amount. See 2011 CBA, Art. 12, § 5. If the NFL generates new revenue streams, the players are entitled to 50% of the net revenues from those new ventures less 47.5% of the Joint Contribution Amount. 2011 CBA, Art. 12, § 6(c)(ii). Thus, if the NFL generates new revenue streams, the amount that is passed on to the players is reduced by 47.5% of the Joint Contribution Amount, which includes The Football Players Health Study.


Id.


As explained in the Introduction, the goal of this Report is to determine who is and should be responsible for protecting and promoting the health of NFL players, and why. In some cases, the law will at least partially answer these questions, at least from a descriptive standpoint. But in all cases it is necessary to undertake ethical analysis in order to evaluate the sufficiency of existing legal obligations, make recommendations for change, and determine the proper scope of extralegal responsibilities. It is ethics that will help us explain the conclusions and recommendations that follow.

In this chapter we outline seven foundational ethical principles that we believe ought to govern the complex web of stakeholders related to player health as described in the Introduction. These principles, generated for the unique context of professional football, served to guide the proper scope and direction of the recommendations set forth for each stakeholder in the chapters that follow, and also as a litmus test for inclusion of various recommendations in the Report. We describe these principles and their development below. Then, in each of the subsequent chapters, we consider more specific ethical obligations of each individual stakeholder as to player health, acknowledging, among other things, existing ethical codes and legal obligations.

(A) Existing General Principles

The principles that guide this Report are neither matters of natural law nor derived from pure reason, nor were they entirely driven by case study of the NFL. Instead, we recognized that “[n]either general principles nor paradigm cases adequately guide the formation of justified moral beliefs . . . .” Instead, principles must be designed for specific cases and case analysis must be guided by general principles. Thus, we took both top-down and bottom-up approaches, cognizant of the sometimes fraught relationships of the relevant stakeholders, in order to develop a set of tailored principles applicable to our driving questions about the who, how, and why of protecting and promoting player health.

Stated another way, we began with widely recognized, if not necessarily universally revered, general principles from bioethics, as well as from professional and business ethics and human rights, where applicable—a top-down approach. Here, our question was “which ethical principles have already been established or suggested that may have relevance to this context?” However, it was particularly important not to simply apply “off the shelf” general ethical principles to the setting of professional football because these principles often are meant to govern a particular kind of relationship—e.g., physician-patient, researcher-subject, business-consumer—and not all the stakeholders we examine fit those molds. Thus, we simultaneously considered unique features of the NFL context to generate more specific and novel principles for this setting—reasoning from the bottom up.

In the end, our approach was to build on ethical analyses that have come before, while recognizing that “[a]ppropriate moral judgments occur . . . through an intimate acquaintance with particular situations and the historical record of similar cases.”

1) GENERAL PRINCIPLES OF BIOETHICS

The literature on principles that guide bioethics is vast. Not only are there numerous proposals for principles that ought to be considered, but there are also strong voices against the use of principles altogether. Without providing a comprehensive review of this debate, we began our analysis with the most prominent set of principles in modern bioethics: Respect for Autonomy; Non-Maleficence; Beneficence; and, Justice. These four principles have become the foundation of an approach called “Principlism,” which calls for application of these principles and balancing them against one another in order to reach moral conclusions about particular situations.

What do these principles mean? In brief:

• **Respect for Autonomy** means at a minimum respecting “self-rule that is free from both controlling interference by others and limitations that prevent meaningful choice, such as inadequate understanding.”

• **Non-Maleficence** refers to the duty to avoid harm. It is “distinct from obligations to help others” and “requires only intentional avoidance of actions that cause harm.”

• **Beneficence** is the duty to positively do good, an obligation “to prevent . . . [and] remove evil or harm” and promote the welfare of the relevant party.
• Finally, the principle of Justice refers primarily to distributive justice, the “fair, equitable, and appropriate distribution determined by justified norms that structure the terms of social cooperation.”9 This principle may be framed for our context as fairness in distribution of burdens and benefits of a given enterprise.

Other principles have also been suggested as alternatives or additions. Scholars coming from the ethics of care tradition have suggested that a principle of Compassion be added to the mix, as a supplement to Beneficence, and feminist and non-Western scholars have pressed for an approach less focused on individual autonomy, with greater recognition that individuals are situated in a much richer community and context.10

These values sometimes conflict, and on the Principalist view, much of the moral decisionmaker’s work is to come to some appropriate balance among them. A primary criticism of Principlism, however, is that it offers no substantive guidance on how to reach such balance, leading to a great deal of subjectivity. Framed in such general terms, these principles are helpful starting points, but they cannot suffice to resolve the question driving this Report: what role should various stakeholders hold in protecting and promoting the health of NFL players? Further specification is needed.

That said, one final principle that has more recently emerged in the bioethics literature, and indeed offers some method of achieving balance among other potentially competing principles, is the principle of Community Engagement. Community Engagement entails collaborative inclusion in the decision-making process of those affected by particular systems and decisions, rather than relying on purely expert or hierarchical decision making.11 This idea is related to Democratic Deliberation, or the process of actively engaging with relevant stakeholders for debate and decision making in a way that “looks for common ground wherever possible” and strives for “mutually accepted reasons to justify” policy proposals.12

As described in the introductory sections of this Report and in Appendix N, we endeavored to engage in a robust process for working with all available stakeholders to make sure their perspectives were appropriately accounted for in this Report and its recommendations. In addition to being ethically imperative to give weight to stakeholders’ own perspectives, this approach supported the development of a set of recommendations that are well-informed, practical, and realistic. Thus, we have adopted the principle of Community Engagement, specified as “Collaboration and Engagement,” in our set of guiding principles for the NFL ecosystem, as described in further detail below.

2) PROFESSIONAL ETHICS
Moving beyond broad bioethical principles, many of the stakeholders considered in this Report are members of professional groups—doctors, athletic trainers, attorneys, financial professionals, and the like—with their own systems of education, requirements for licensure or certification, special knowledge and skills, legal and ethical duties, codes of ethics, and systems of self-regulation and discipline.13 Consequently, it was also important for us to consider the specific principles already in place to guide their behavior. Professionals have heightened ethical obligations to those they serve in part for tautological reasons: one of the things that has historically defined professions as such is the fact that they seek to help others and have goals beyond mere profit. Professionals are often granted special privileges, special access to information, and special trust, and as a result, have special duties of competence, trust, and beneficence, among others.

Professionals are often granted special privileges, special access to information, and special trust, and as a result, have special duties of competence, trust, and beneficence, among others.

The specific principles of professional ethics applicable to each professional stakeholder are discussed in greater detail in the chapters that follow. However, several principles emerge as themes across the board (and indeed are repeatedly emphasized in sports medicine ethics): managing conflicts of interests (dual loyalty); transparency; maintaining confidentiality; and, balancing autonomy with justified paternalism.14 In short, this means three things:

• minimizing conflicts of interest to the extent possible, and when they cannot be avoided, making sure that all those potentially affected are aware of the interests at stake;

• using confidential information only for the purpose for which it was disclosed, and being forthcoming about all of the ways in which disclosed information may be shared or protected; and,

• providing individuals with the information they need to make decisions for themselves, but in rare instances, stepping in to avoid complicity with serious and irreversible harm that would result from biased or misinformed decisions.
Each of these concepts is incorporated in our set of guiding principles below.

3) HUMAN RIGHTS NORMS

Another perspective useful as a starting point for generating governing principles comes from international human rights. In particular, the United Nations Educational, Scientific and Cultural Organization (UNESCO) has carved out a distinctive role for human rights in formulating normative principles of bioethics in its Universal Declaration on Bioethics and Human Rights, finally adopted by UNESCO in 2008.15

This Declaration, in its goals, goes far beyond governing the relations of states and instead aims, among other things:

To guide the actions of individuals, groups, communities, institutions and corporations, public and private . . . to promote respect for human dignity and protect human rights, by ensuring respect for the life of human beings, and fundamental freedoms, consistent with international human rights law . . . to recognize the importance of freedom of scientific research and the benefits derived from scientific and technological developments, while stressing the need for such research and developments to occur within the framework of ethical principles set out in this Declaration and to respect human dignity, human rights and fundamental freedoms; . . . to foster multidisciplinary and pluralistic dialogue about bioethical issues between all stakeholders and within society as a whole; . . . to promote equitable access to medical, scientific and technological developments as well as the greatest possible flow and the rapid sharing of knowledge concerning those developments and the sharing of benefits, with particular attention to the needs of developing countries.16

The Declaration lists many principles, but particularly relevant to our context is its emphasis on respecting human dignity, empowering individuals to make their own decisions while also requiring that they bear responsibilities for those decisions, the importance of just and equitable treatment of all participants in a social institution, the recognition of conflicts of interest and the need to be transparent about them, public engagement on issues of bioethics, and the importance of using the best available scientific methods and knowledge.17

To be sure, some of these concepts like the notion of “human dignity” have been simultaneously criticized as too vague and championed as fundamental.18 Moreover, we are not claiming that any of the problems we discuss in this Report or which NFL players face by playing football rise to the level of human rights violations, given the simple fact of consent to play and payment for services, the difficulties players face do not compare to the numerous and ongoing tragedies around the world that human rights law is thought to govern. Nonetheless, these UNESCO principles, like the others discussed above, form a useful foundation for generating more specific principles that can govern our analysis of protecting and promoting player health.

4) PRINCIPLES OF CORPORATE SOCIAL RESPONSIBILITY

Finally, because some of the stakeholders we examine are businesses, it is important to understand their ethical obligations through the lenses of business ethics and corporate social responsibility. The most influential articulation of corporate social responsibility principles is the United Nations Guiding Principles on Business and Human Rights, published in 2011 (Guiding Principles).19

We rely on these Guiding Principles in particular in Chapter 19: NFL Business Partners, but some of their spirit is more generally applicable. In particular, the emphasis on engaging in “meaningful consultation with potentially affected groups and other relevant stakeholders,”20 and the importance of considering the “leverage” available to various stakeholders in calibrating their ethical responsibilities,21 are two features that shape our approach in this Report more generally.

B) Generating Specific Ethical Principles to Promote NFL Player Health

As mentioned above, we view the general principles derived from bioethics, professional ethics, human rights discourse, and corporate social responsibility as helpful starting points, but in general, insufficiently nuanced to account for the unique circumstances of the NFL. Thus, through a series of literature reviews, stakeholder interviews, and expert discussions we sought to formulate a more nuanced set of principles that address the actual issues facing NFL players through bottom-up analysis. In particular, some of the existing general principles demand modification or supplementation to go from their current role—e.g., delineating the ethical roles of healthcare and other professionals—to the larger sphere of this project, analyzing the obligations and making actionable recommendations for all stakeholders who can or should play a role in protecting and promoting player health.
In undertaking that analysis we arrived at the following seven principles. We note that these principles are rooted in and support the foundational position described in the Introduction to this Report, in which we set forth our view that competent adults ought to be allowed the opportunity to decide to accept the risks of professional football, so long as they have adequate information and efforts are made to appropriately abate excessive risks.

**Respect:** The NFL is undeniably a business, but it is a business that relies on individuals who are exposed to substantial risks. These are not passive, inanimate widgets, but persons with inherent dignity and interests, social relationships, and long-term goals of their own. One principle, most prominently espoused by philosopher Immanuel Kant, is that we wrong another when we treat his person “merely as a means” rather than as an “end in himself”\(^22\), or in other words, when we use someone only as a tool to achieve some other benefit or goal, rather than as an intrinsically valuable person. This is a paradigmatic way of treating human beings as lacking in the dignity they deserve. Thus, no matter the enjoyment gained by the half of all Americans who count themselves as professional football fans,\(^23\) the revenue generated, or the glory to players themselves, no stakeholder may treat players “merely as a means” or as a commodity for promoting their own goals.

**Health Primacy:** The fact that football is a violent game and that injuries are relatively common, ranging from the transient to the severe, does not mean that player health is unimportant any more than these facts would suggest that we may permissibly ignore the health risks in other lines of potentially dangerous work. Indeed, part of what the principle of Respect dictates is valuing, protecting, and promoting players’ health capability as a basic good, regardless of how many ready, willing, and able players may be queued up, eager to get their shot at professional success despite the risks.

Health is special because it is foundational to all other pursuits, from the ability to meet basic needs to higher order interests, such as pursuing education, leisure, social relationships, and the full enjoyment of life. For this reason, health capability ought to be accorded special moral weight as compared to other possible goods, and we should be particularly wary in cases where goods will accrue to those whose health is not put at risk by the activities in question.\(^24\)

When players are expected or encouraged to sacrifice their health for the game, or even when they are simply not discouraged from doing so, they are potentially treated as mere means to an end. This is particularly problematic given the background conditions described in the Introduction in which the alternatives available to some players are dramatically less attractive than playing professional football, potentially leading to substantial pressures to accept risks that they might otherwise prefer to avoid. Players have a moral right to have their health at the very least protected, and often promoted. To be clear, however, this does not mean that all risk must be eliminated. Bumps and bruises and even more serious harms that will be of limited duration do not raise the same kinds of red flags as the serious, long-term, irreversible health consequences that are our focus here.

Thus, as a general rule, avoiding serious threats to player health should be given paramount importance in every dealing with every stakeholder. This principle is supported by the overarching principles of Non-maleficence and Beneficence, because it calls on stakeholders to avoid harm and promote health, as well as Justice, because it prevents players from bearing unfair burdens for the benefit of others. Indeed, the NFL too acknowledges this principle. In the NFL’s 2015 Health and Safety Report, Commissioner Roger Goodell declared that “[t]here must be no confusion: The health of our players will always take precedence over competitive concerns. That principle informs all of the work discussed in [the Health and Safety] report.\(^25\)

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\(^{24}\) With regard to obesity, for example, we know that on the one hand, food consumption is in the realm of an individual’s “choice,” but on the other, it is deeply constrained by poverty, geography (e.g., so-called “food deserts”), and a host of other issues.
opportunities for advancement, including those available to professional football players, be paternalistically withheld from competent adults, recognizing that we are all subject to various pressures, responsibilities, and contexts that might technically impede our unfettered autonomy. Thus, while health matters, and indeed is often at the top of any pyramid of human values, we do not maintain that players must, or even should, always choose health over all other goods. Instead, we recognize that players may be reasonably balancing along many different dimensions as to what makes a life go well, and in some instances this may mean choosing to sacrifice their health, to some extent. In these cases, we can say that Health Primacy must be balanced against the principle of Empowered Autonomy, as described below, and that in some instances Empowered Autonomy will trump.

That said, it is critically important that such tradeoffs between health and other goods ought not be accepted as conditions of entry into the game of football, signals of “toughness,” or otherwise praiseworthy, per se. All stakeholders bear an obligation to try to reduce these instances of tradeoff as much as possible, and to reject an institution that demands or expects that players sacrifice their health on a regular basis.

**Empowered Autonomy:** Serious risks to players’ health in football must be minimized as a structural matter. Beyond that, though, players are ultimately the ones most able to make decisions and take steps to protect and promote their health. In order to effectively do so, however, like all individuals they often need support and empowerment. While they need factual information (including that covered by the principle of Transparency, below), such information alone is not enough. They need information to be presented in a way they (and their families, friends, and other trusted advisors) can understand and utilize, and in a way that accounts for their own deeply held values and goals. They need decision-making tools that help them see not only short-term benefits and costs, but also longer term implications. They need to have unfettered access to competent doctors whose conflicts of interest are minimized, contract advisors, financial advisors, and others they trust to have open and frank conversations without fear of the information being shared in a way that would cause them harm. The goal is not merely to allow players to choose for themselves which capabilities and values to prioritize, but also to promote informed and authentic choice.26

Such choice also requires that players have access to good options and alternatives—such as unconflicted and qualified medical advisors, educational opportunities and assistance with post-play career transitions, and the like—with the freedom to select among them without undue pressure from others. Of course, this does not mean that players must be guaranteed absolute autonomy, as they will always have competing responsibilities and the compensation available in professional sports will remain more lucrative than the vast majority of alternative career paths. Thus, pressures to play are likely to remain, for some players even more than others, but their autonomous decisions about which risks to take and which to avoid nonetheless can be better supported through information and other structural changes.

In addition, players have to contend with the uncertainty of the risks they are considering. Even when the risks of injury and the health consequences of those injuries are known, well-supported statistical inferences about groups still provide no certainty about what will happen to a given individual. If there is a 50 percent risk of some injury, for example, a player will of course still not know which half of the group he will ultimately land in, injured or uninjured. In addition, some risks will be affected by the player’s own circumstances. For example, while the rate of anterior cruciate ligament (ACL) injuries among NFL players may be known, an individual player’s position or size might make him more or less susceptible to such an injury. As a final component of uncertainty, it is important to recognize that the contours of many risks are still unknown—many important questions about the health effects of a career in the NFL remain unclear. While the long-term effects of ACL injuries are fairly well known, the long-term effects of concussive and sub-concussive impacts are still being studied. These additional layers of uncertainty make a player’s choices even more challenging.

Although perhaps not a perfect resolution of the various background pressures players may face, it is essential to take steps to at least ensure that player choice regarding matters related to their health will be free from misinformation, lack of understanding, bias, and avoidable negative influences. Other stakeholders have a responsibility to help achieve these criteria whenever possible. Where they are lacking, however, as in situations of cognitive impairment or unresolved biases, the principle of Health Primacy reigns supreme. Certain stakeholders must also be attuned to situations in which apparent restriction of autonomy might actually be autonomy enhancing, in the sense of effectuating a player’s true desires. For example, given the culture of the game today, a player may prefer to be pulled “involuntarily” from play rather than being seen as not tough enough to play through injury.

**Transparency:** Again, to avoid treating players as mere means, and to promote Empowered Autonomy, all parties
should be transparent about their interests, goals, and potential conflicts as they relate to player health. Failure to do so disrespects players and may also result in player health being inappropriately subrogated to other interests. Thus, information relevant to player health must be shared with players immediately and never hidden, altered, or reported in a biased or incomplete fashion. This means revealing medical information about themselves and about risks to players in general, including new information that would be sufficiently credible to be taken seriously by experts, even if not fully validated or “proven.” This also means information about relationships that could influence judgment and recommendations related to player health. Promoting transparency will allow players to make better decisions for themselves, and also promote trust in all those who play a role in their health.

Managing Conflicts of Interest: Transparency alone will often be insufficient to protect and promote player health. While it is helpful to explain to players where conflicts of interest exist, as it may allow them to be on guard to better protect their own interests, mere disclosure will not help players when sufficient alternatives are lacking. Instead, all stakeholders should take steps to minimize conflicts of interest, and when they cannot be eliminated, appropriately manage them. Often conflicts of interest are painted as nefarious or the result of bad intentions by bad actors, but they need not be. Many conflicts of interest are structural; the way in which a system is set up may create challenges for even well-intentioned and ethical individuals to do the right thing. When structure is the problem, it is structure that must be changed. Among other things, this will often involve removing problematic incentives, altering conflicted relationships, creating separate and independent sources of advice, and auditing the behavior of those with incentives that diverge from the primacy of player health.

Collaboration and Engagement: As will become evident in the chapters that follow, protecting and promoting the health of professional football players cannot fall to any single party given the interconnected nature of the various stakeholders. Instead, it depends on many parties who should strive to act together whenever possible to advance that primary goal. Further, part of treating players as ends in themselves and not as mere means is to refrain from making decisions about them and instead to make decisions with them. Players should be engaged by stakeholders in all matters that influence their health.

Justice: Finally, as a simple matter of fairness, all stakeholders have an obligation to ensure that players are not bearing an inappropiate share of risks and burdens compared to benefits reaped by other stakeholders. Stakeholders should also be aware of the ways in which changing rules, laws, or programs—for example, trading benefits to former players for benefits to current players—may have differential effects on certain subcategories of players, and be attuned to ways in which those disadvantages can be blunted or recompensed. The principle of Justice also demands awareness of implications of actions beyond the NFL itself. The way in which player health is protected and promoted at the top echelons of the sport will influence policies, practices, and culture all the way down the line, influencing the health not only of future NFL players, but also the vastly larger pool of Americans who will play football and never make it to the NFL. Stakeholders should always consider the way their choices will affect this larger population and consider their policies and behaviors in this light.

* * *

In sum, the ethical principles that we advance in this Report reflect well-established principles applied to the unique context of the NFL. They may not prove exhaustive, and we anticipate several others will be generated through critical public reflection on the work herein, but they are the right starting point for further discussion. Ultimately, we can offer one simple meta-principle to guide all the relevant stakeholders, which is a combination of two prominent ethical tools: Kant’s categorical imperative (which demands that we treat others the way we wish to be treated) and philosopher John Rawls’ veil of ignorance (which helps identify as ethical standards those rules of behavior we would select if we did not know which role we would inhabit in a given relationship). That simple principle is this: in every scenario, ask what system and rules you would wish to be in place to protect and promote health if you or your son were an NFL player.

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b Harvard Law School professor Lawrence Lessig among others has termed this kind of structural conflict to be a problem of “institutional corruption,” which he writes “is manifest when there is a systemic and strategic influence which is legal, or even currently ethical, that undermines the institution’s effectiveness by diverting it from its purpose or weakening its ability to achieve its purpose, including, to the extent relevant to its purpose, weakening either the public’s trust in that institution or the institution’s inherent trustworthiness.” Lawrence Lessig, “Institutional Corruption” Defined, 41 J. L. Med. & Ethics 553, 553 (2013).
## Summary of Ethical Principles to Promote Player Health

<table>
<thead>
<tr>
<th>Principle</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1. Respect</strong></td>
<td>The NFL is a business that relies on individuals who are exposed to health risks, but no stakeholder can treat players “merely as a means” or as a commodity solely for promotion of its own goals.</td>
</tr>
<tr>
<td><strong>2. Health Primacy</strong></td>
<td>Avoiding serious threats to player health should be given paramount importance in every dealing with every stakeholder, subject only to the player’s Empowered Autonomy.</td>
</tr>
<tr>
<td><strong>3. Empowered Autonomy</strong></td>
<td>Players are competent adults who should be empowered to assess which health risks they are willing to undertake, provided they have been given trustworthy, understandable information and decision-making tools, and the opportunity to pursue realistic alternatives.</td>
</tr>
<tr>
<td><strong>4. Transparency</strong></td>
<td>All parties should be transparent about their interests, goals, and potential conflicts as they relate to player health, and information relevant to player health must be shared with players immediately.</td>
</tr>
<tr>
<td><strong>5. Managing Conflicts of Interest</strong></td>
<td>All stakeholders should take steps to minimize conflicts of interest, and when they cannot be eliminated, to appropriately manage them.</td>
</tr>
<tr>
<td><strong>6. Collaboration &amp; Engagement</strong></td>
<td>Protecting and promoting the health of professional football players depends on many parties who should strive to act together—and not as adversaries—whenever possible to advance that primary goal.</td>
</tr>
<tr>
<td><strong>7. Justice</strong></td>
<td>All stakeholders have an obligation to ensure that players are not bearing an inappropriate share of risks and burdens compared to benefits reaped by other stakeholders.</td>
</tr>
</tbody>
</table>
Endnotes

1 Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics 404 (7th ed. 2013).
2 Id. at 396 (7th ed. 2013).
3 The term “bioethics” has been defined in many different ways, but generally refers to a field of inquiry broader than medical ethics, which is specifically concerned with the relationships between patients and their healthcare providers, and focuses on the welfare of patients and medical professionalism. Bioethics, in contrast, refers to the normative analysis of ethical problems raised by advances in medicine and biology, and includes dilemmas ranging from the intimate doctor-patient relationship to those facing entire systems that influence health. For further discussion, see Daniel Callahan, Bioethics and Policy — A History, The Hastings Ctr., http://www.thehastingscenter.org/Publications/BriefingBook/Detail.aspx?id=2412 (last visited Aug. 7, 2015), archived at http://perma.cc/4ZPL-04V5. More simply, bioethics refers to the application of ethics — the philosophical discipline pertaining to notions of right and wrong — to the fields of medicine and healthcare. What is Bioethics?, Ctr. For Practical Bioethics, http://www.practicalbioethics.org/what-is-bioethics (last visited last visited Aug. 7, 2015), archived at http://perma.cc/SQ3M-9UAS.

4 For a good summary, see Renée C. Fox & Judith P. Swazy, Observing Bioethics 168–173 (2008).

5 For the most current version of this classic text, see Tom L. Beauchamp & James F. Childress, Principles of Biomedical Ethics (7th ed. 2013).

6 Id. at 101.

7 Id. at 150–153.

8 Id. at 152.

9 Id. at 250.

10 See, e.g., Jan Crosthwaite, Gender and Bioethics, in A Companion to Bioethics 36 (Helga Kuhse & Peter Singer eds., 2d ed. 2009).


16 See id.

17 Id.


20 Id. at 19.

21 Id. at 22.


STAKEHOLDERS

Next, we provide an in-depth analysis of each stakeholder in NFL player health. We have organized the stakeholder discussions into parts that are indicative of their relationship to NFL players as well as other stakeholders, as follows:

- Part 2. The Medical Team: Club Doctors; Athletic Trainers; Second Opinion Doctors; Neutral Doctors; and, Personal Doctors.
- Part 3. The NFL; NFLPA; and, NFL Clubs.
- Part 4. Club Employees: Coaches; Club Employees; and, Equipment Managers.
- Part 5. Player Advisors: Contract Advisors; Financial Advisors; and, Family Members.
- Part 6. Other Stakeholders: Officials; Equipment Manufacturers; The Media; Fans; and, NFL Business Partners.

In addition, Part 7 examines the role of Other Interested Parties: The NCAA; Youth Leagues; Governments; Workers’ Compensation Attorneys; and, Health-Related Companies.

Finally, it is important to recognize that while we have tried to make the chapters accessible for standalone reading, certain background or relevant information may be contained in other parts or chapters, specifically Part 1 discussing Players and Chapter 7 discussing the NFL and NFLPA. Thus, we encourage the reader to review other parts of this Report as needed for important context.

Stakeholders in NFL Player Health

- Club Doctors
- Athletic Trainers
- Second Opinion Doctors
- Neutral Doctors
- Personal Doctors
- Coaches
- Club Employees
- Equipment Managers
- Contract Advisors (Agents)
- Financial Advisors
- Family
- NCAA
- Youth Leagues
- Government
- Workers’ Comp. Attys
- Health-related Companies
Part 1: Players
The heart of this Report is about protecting and promoting player health. No one is more central to that goal than players themselves. Therefore, it is important to understand who they are and what they are doing concerning their own health and the health of their NFL brethren with regard to behaviors with both positive and negative effects. That said, as we emphasized in the Introduction, players are making choices against a constrained set of background conditions, pressures, and influences, and sometimes with limited expertise and information, all of which can affect their capacity to optimally protect their own health, especially given potentially competing interests. Thus, while they are competent adults with a bevy of responsibilities to protect themselves, they cannot do it alone. Players must be treated as partners in advancing their own health by offering them a variety of support systems to do so, recommendations for which will be accompanied by others geared toward other stakeholders.
As discussed in the Description of Legal and Ethical Obligations Section of the Introduction, to better inform our understanding of players and all of the stakeholders and issues discussed in this Report, we conducted approximately 30-minute interviews with 10 players active during the 2015 season and 3 players who recently left the NFL (the players’ last seasons were 2010, 2012, and 2012 respectively). The players interviewed were part of a convenience sample identified through a variety of methods—some were interested in The Football Players Health Study more generally, some we engaged through the Law and Ethics Advisory Panel (LEAP) and Football Players Health Study Player Advisors, and some interviews were facilitated by a former player that now works for the National Football League Players Association (NFLPA).

The interviews had a mean of 7.5 seasons, with a range of 2 to 15 seasons, and for a mean of between 3 and 4 different clubs (3.4 clubs), with a range of 1 to 10 clubs. In addition, we interviewed players from multiple positions: one quarterback; two fullbacks; one tight end; three offensive linemen; two linebackers; one defensive end; two safety; and, a special teams player (but not a kicker). Each NFL club’s roster has 53 players eligible to play each week, reduced to 46 active players on game days. In addition, clubs are permitted to have a nine man practice squad, injured players may be placed on the Injured Reserve or Physically Unable to Perform (PUP) lists, and suspended players may be placed on the Reserve/Suspended list. In total, NFL clubs are permitted to have rosters of up to 80 players during the season. Indeed, during an NFL season, clubs routinely approach the 80 player limit.

According to official NFL and NFLPA playtime figures, in 2015, 2,251 players played in at least one regular season NFL game.

The age range of NFL players is narrow. On any given NFL club, the vast majority of players are in their 20s, while approximately 20 percent are in their 30s. In the NFL’s 94-year history, only 56 players have ever played after the age of 40.

NFL players are generally either white or African American. According to the University of Central Florida’s 2015 Racial and Gender Report Card, of the 2,877 players employed by NFL clubs in 2014, 1,957 (68.0 percent) were African American, 813 were white (28.3 percent), 31 were Asian (1.1 percent), 19 were Latino (0.7 percent), 27 were other races (0.9 percent), and 30 were described as “international” (1.0 percent). Individuals’ relationships with their doctors and the medical community are always filtered through the lens of their cultural and other experiences. The strong African American demographic may be noteworthy in the context of player health, given that there is some evidence to suggest that race may be correlated with distrust of the medical profession and medical establishment, although this may be mediated by a variety of factors, including geography and socioeconomic status.

NFL players come from almost every state in the country. As might be expected and according to an analysis done by Sporting News, the states that have produced the most players are among the largest and with the highest populations: (1) California (225 players in 2013); (2) Florida (186); (3) Texas (184); (4) Georgia (95); (5) Ohio (74); (6) New York (61); (7) Maryland (60).

We have also undertaken a “Listening Tour” of former players, current players, and their family members to better understand their perspectives and the issues affecting them, but the results of that research are not yet available.

(A) Background

Each NFL club’s roster has 53 players eligible to play each week, reduced to 46 active players on game days. In addition, clubs are permitted to have a nine man practice squad, injured players may be placed on the Injured Reserve or Physically Unable to Perform (PUP) lists, and suspended players may be placed on the Reserve/Suspended list. In total, NFL clubs are permitted to have rosters of up to 80 players during the season. Indeed, during an NFL season, clubs routinely approach the 80 player limit.

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While all players attended college, it is unclear how many are college graduates. Many (if not most) players stop attending college once their senior season is complete, spending the spring preparing for the NFL Draft rather than attending classes. However, many take online classes or return in the off-season to try and complete their degree. A 2009 NFL-funded study of former NFL players by the University of Michigan (“Michigan Study”) provides some data. The Michigan Study, conducted through telephone interviews of 1,063 former NFL players, found that 56.8 percent of former players between the ages of 30 and 49 obtained their degree before or during their NFL careers. Another 12.4 percent obtained their degree after their career, for a total of 69.2 percent of former players who obtained a college degree. By comparison, only 30.0 percent of American men between the ages of 30 and 49 have a college degree.

The Michigan Study also found that 76.3 percent of former players between the ages of 30 and 49 were married before or during their NFL careers.

There are two potential limitations to the Michigan Study. First, the Michigan Study population only included players that had vested rights under the NFL’s Retirement Plan, meaning the players generally had been on an NFL roster for at least three games in at least three seasons. There is likely a significant but unknown percentage of NFL players that never become vested under the Retirement Plan. Second, responders to the survey were 36.8 percent African American and 61.4 percent white—a complete reversal of the NFL’s population of current players. While the racial demographics of former players is likely closer to the population of the Michigan Study, i.e., there were more white players than in the current NFL, the Michigan Study did not provide such data on the former player population and did not adjust or account for the racial demographics of the former player population. In a telephone call with Dr. David Weir, the lead author of the Michigan Study, he explained that: (1) due to limited resources, the population of players to be studied and contacted was restricted to the data and contact information available to and provided by the NFL; and, (2) the NFL did not provide racial demographics of former players and thus the study could not adjust for that factor. Weir also believes that the racial demographics of former players is substantially similar to the racial demographics of the Michigan Study’s participants. Finally, Weir explained that, during the internal review process with the NFL, the study was leaked to the media, preventing the study from being amended and submitted to a peer-reviewed publication.

The NFL and NFLPA disagree on the mean career length of NFL players. The NFLPA has long stated that the mean career is about 3.2 years. The NFL insists players’ mean career length is about 6 years. The difference arises from which population of players is being examined. The NFLPA seems to include in their calculation every player who ever signed a contract with an NFL club, regardless of whether they ever make it into the club or play in an NFL regular season game, while also including players who are still active (and whose careers will thus exceed their current length). On the other hand, the NFL’s calculation comes from players who made the opening day roster and played between 1993 and 2002, a slightly different era from today’s NFL. The website sharfootballanalysis.com ultimately found that players who were drafted between 2002 and 2007 have a mean NFL career length of 5.0 years.

The different career lengths also lead to different estimates of mean career earnings. Based on a mean career length of approximately 3 years, the NFLPA has estimated that the mean career earnings of an NFL player are $4 million after taxes. Using a mean salary of $1.9 million and a mean career length of 3.5 years, others have estimated NFL players earn about $6.7 million in their careers, a figure largely on par with that of the NFLPA’s. However, one

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4 A 2016 Wall Street Journal article estimated that the average career of an NFL player between 2006 and 2014 was 3.66 years. Rob Arthur, The Shrinking Shelf Life of NFL Players, Wall St. J., Feb. 29, 2016, http://www.wsj.com/articles/the-shrinking-shelf-life-of-nfl-players-1456694959, archived at https://perma.cc/F68T-WIAH. However, we have several questions about the methodology used to generate this statistic, including: (1) The analysis does not describe its inclusion criteria, i.e., if the analysis included everyone who ever signed an NFL contract, even if they never played in a regular season game, the estimated average career length would be shorter; (2) It is unclear how players were counted who were still playing at the time of the analysis, but who also played between 2008 and 2014, i.e., if a player began play in 2014 the analysis might have calculated his career length as only 1 season, when he might in fact have played 5 or 10 more seasons. This too would have caused the average estimated career to be shorter than is actually the case.
Protecting and Promoting the Health of NFL Players

can clearly see that if one uses a longer mean career length, the mean career earnings can increase by several million dollars. Finally, it is important to point out that the mean in this case does not reflect the median career earnings of NFL players, i.e., the career earnings of your typical NFL player.

Next, it is important to understand the different aspects of player health that we are looking to improve, including both physical and mental health.

1) PLAYERS AND PHYSICAL HEALTH

In 1980, the NFL created the NFL Injury Surveillance System (NFLISS) to document, track, and analyze NFL injuries and provide data for medical research. When an injury occurs, the club’s athletic trainer is responsible for opening an NFLISS injury form and recording the medical diagnosis (including location, severity, and mechanism of injury) and details about the circumstances (date, game or practice, field surface) in which it occurred. Prior to 2015, a reportable injury was defined as only those associated with any time lost from practice or games, football-related or not, or specific conditions regardless of time lost, including but not limited to concussions, fractures, dental injuries requiring treatment, health-related illness requiring intravenous fluid administration, and injuries or illness requiring special equipment (e.g., a knee brace). Beginning with the 2015 season, all injuries, regardless of whether or not they result in time lost from practice or games, are included in the NFLISS. The athletic trainer is required to update the injury form with details about all medical treatments and procedures the player receives, including surgery. Since 2011, the NFLISS has been managed by the international biopharmaceutical services firm Quintiles. Quintiles provides injury data and reports to the NFL and NFLPA throughout the year.

The NFLISS provides the best available data concerning player injuries and thus we use it here. Although the NFL’s past injury reporting and data analysis have been publicly criticized as incomplete, biased, or otherwise problematic, those criticisms have been made about studies separate from the NFLISS and we are not aware of any criticism of the NFLISS.

The tables below compile NFLISS data on player injuries. We pulled aggregate statistics from various reports containing NFLISS data and performed simple calculations to arrive at mean figures. The NFL also provided the most recent NFLISS data. In considering these data, it is important to know that the NFL’s injury reporting systems have undergone substantial change in recent years. An electronic version of the NFLISS was launched as a pilot with five clubs in 2011; the electronic NFLISS expanded to all 32 clubs in 2012; then, in 2013, the NFL launched an electronic medical records (“EMR”) system on a pilot basis with eight NFL clubs, which was expanded to all clubs in 2014. The EMR system integrates with the NFLISS and provides the most accurate injury reporting data in NFL history. Consequently, the different reporting structures over time almost certainly contributed to fluctuations in the injury rates identified below. Therefore, it is not possible to be certain whether injury rates have increased in recent years, or if, instead, the increases are due to improved injury reporting. Similarly, increased attention to player injuries in recent years, concussions in particular, might also lead to higher reported injury totals.

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g The costs of treating a player’s injury are almost always covered by the club, as is discussed in Chapter 2: Club Doctors and Chapter 4: Second Opinion Doctors.
Table 1-A:
Number of Practice, Game and Total Injuries in NFL Preseason (2009–2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Practice Injuries</th>
<th>Number of Game Injuries</th>
<th>Total Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>551</td>
<td>360</td>
<td>911</td>
</tr>
<tr>
<td>2010</td>
<td>560</td>
<td>410</td>
<td>970</td>
</tr>
<tr>
<td>2011</td>
<td>641</td>
<td>399</td>
<td>1,040</td>
</tr>
<tr>
<td>2012</td>
<td>675</td>
<td>431</td>
<td>1,106</td>
</tr>
<tr>
<td>2013</td>
<td>688</td>
<td>416</td>
<td>1,104</td>
</tr>
<tr>
<td>2014</td>
<td>823</td>
<td>503</td>
<td>1,326</td>
</tr>
<tr>
<td>2015</td>
<td>780</td>
<td>498</td>
<td>1,278</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>3,138</strong></td>
<td><strong>2,016</strong></td>
<td><strong>7,735</strong></td>
</tr>
</tbody>
</table>

Table 1-B:
Mean Number of Practice, Game and Total Injuries in NFL Preseason (2009–2015)

<table>
<thead>
<tr>
<th>Mean Number of Practice Injuries</th>
<th>Mean Number of Game Injuries</th>
<th>Mean Number of Total Injuries</th>
</tr>
</thead>
<tbody>
<tr>
<td>623.0</td>
<td>403.2</td>
<td>1026.8</td>
</tr>
</tbody>
</table>

Table 1-C:
Number of Practice, Game and Total Injuries, and Mean Number of Injuries Per Game in NFL Regular Season (2009–2015)*

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Practice Injuries</th>
<th>Number of Game Injuries</th>
<th>Total Regular Season Injuries</th>
<th>Injuries per Regular Season Game</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>165</td>
<td>1,372</td>
<td>1,537</td>
<td>5.36</td>
</tr>
<tr>
<td>2010</td>
<td>176</td>
<td>1,346</td>
<td>1,522</td>
<td>5.25</td>
</tr>
<tr>
<td>2011</td>
<td>295</td>
<td>1,426</td>
<td>1,721</td>
<td>5.57</td>
</tr>
<tr>
<td>2012</td>
<td>262</td>
<td>1,380</td>
<td>1,642</td>
<td>5.39</td>
</tr>
<tr>
<td>2013</td>
<td>264</td>
<td>1,500</td>
<td>1,764</td>
<td>5.86</td>
</tr>
<tr>
<td>2014</td>
<td>401</td>
<td>1,823</td>
<td>2,224</td>
<td>7.12</td>
</tr>
<tr>
<td>2015</td>
<td>336</td>
<td>1,730</td>
<td>2,066</td>
<td>6.76</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>1,899</strong></td>
<td><strong>10,577</strong></td>
<td><strong>12,476</strong></td>
<td><strong>N/A</strong></td>
</tr>
</tbody>
</table>

* Each year, there are 256 regular season NFL games. Thus, the injuries per regular season game statistic is derived by dividing the “number of game injuries” by 256.
Table 1-D:  
Mean Number of Practice, Game and Total Injuries, and Mean Number of Injuries Per Game in NFL Regular Season (2009–2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Mean Number of Practice Injuries</th>
<th>Mean Number of Game Injuries</th>
<th>Mean Number of Total Regular Season Injuries</th>
<th>Mean Number of Injuries per Regular Season Game</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>271.3</td>
<td>1,511.0</td>
<td>1,782.3</td>
<td>5.90</td>
</tr>
<tr>
<td>2010</td>
<td>25</td>
<td>44.6</td>
<td>158.9</td>
<td>243.9</td>
</tr>
<tr>
<td>2011</td>
<td>45</td>
<td>159</td>
<td>224</td>
<td>.62</td>
</tr>
<tr>
<td>2012</td>
<td>43</td>
<td>168</td>
<td>263</td>
<td>.66</td>
</tr>
<tr>
<td>2013</td>
<td>48</td>
<td>167</td>
<td>252</td>
<td>.65</td>
</tr>
<tr>
<td>2014</td>
<td>41</td>
<td>173</td>
<td>261</td>
<td>.68</td>
</tr>
<tr>
<td>2015</td>
<td>52</td>
<td>148</td>
<td>229</td>
<td>.58</td>
</tr>
<tr>
<td>Totals</td>
<td>283</td>
<td>1,112</td>
<td>1,707</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 1-E:  
Number of Practice, Game and Total Concussions, and Mean Number of Concussions Per Game in NFL Regular Season (2009–2015)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Practice Concussions (Pre-And Regular Season)</th>
<th>Number of Preseason Game Concussions</th>
<th>Number of Regular Season Game Concussions</th>
<th>Total Concussions</th>
<th>Concussions per Regular Season Game</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>25</td>
<td>40</td>
<td>159</td>
<td>224</td>
<td>.62</td>
</tr>
<tr>
<td>2010</td>
<td>45</td>
<td>50</td>
<td>168</td>
<td>263</td>
<td>.66</td>
</tr>
<tr>
<td>2011</td>
<td>37</td>
<td>48</td>
<td>167</td>
<td>252</td>
<td>.65</td>
</tr>
<tr>
<td>2012</td>
<td>45</td>
<td>43</td>
<td>173</td>
<td>261</td>
<td>.68</td>
</tr>
<tr>
<td>2013</td>
<td>43</td>
<td>38</td>
<td>148</td>
<td>229</td>
<td>.58</td>
</tr>
<tr>
<td>2014</td>
<td>50</td>
<td>41</td>
<td>115</td>
<td>206</td>
<td>.45</td>
</tr>
<tr>
<td>2015</td>
<td>38</td>
<td>52</td>
<td>182</td>
<td>272</td>
<td>.71</td>
</tr>
<tr>
<td>Totals</td>
<td>283</td>
<td>312</td>
<td>1,112</td>
<td>1,707</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Table 1-F:  
Mean Number of Practice, Game and Total Concussions, and Mean Number of Concussions Per Game in NFL Regular Season (2009–2015)

<table>
<thead>
<tr>
<th>Mean Number of Practice Concussions (Pre-And Regular Season)</th>
<th>Mean Number of Preseason Game Concussions</th>
<th>Mean Number of Regular Season Game Concussions</th>
<th>Mean Number of Total Concussions</th>
<th>Mean Number of Concussions per Regular Season Game</th>
</tr>
</thead>
<tbody>
<tr>
<td>40.4</td>
<td>44.6</td>
<td>158.9</td>
<td>243.9</td>
<td>.62</td>
</tr>
</tbody>
</table>

Each year, there are 256 regular season NFL games. Thus, the mean number of injuries per regular season is derived by dividing the “mean number of game injuries” by 256.
Table 1-G: Number of Regular Season Game Concussions Per Player, and Mean Number of Regular Season Game Concussions Per Player Per Season (2009–2015)\(^1\)

<table>
<thead>
<tr>
<th>Year</th>
<th>Number of Regular Season Game Concussions</th>
<th>Number of Regular Season Players</th>
<th>Rate of Concussions per Player-Season</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009</td>
<td>159</td>
<td>2,123</td>
<td>0.075</td>
</tr>
<tr>
<td>2010</td>
<td>168</td>
<td>2,187</td>
<td>0.077</td>
</tr>
<tr>
<td>2011</td>
<td>167</td>
<td>2,144</td>
<td>0.078</td>
</tr>
<tr>
<td>2012</td>
<td>173</td>
<td>2,183</td>
<td>0.079</td>
</tr>
<tr>
<td>2013</td>
<td>148</td>
<td>2,188</td>
<td>0.067</td>
</tr>
<tr>
<td>2014</td>
<td>115</td>
<td>2,202</td>
<td>0.052</td>
</tr>
<tr>
<td>2015</td>
<td>182</td>
<td>2,251</td>
<td>0.081</td>
</tr>
<tr>
<td>Totals/Rate</td>
<td>1,112</td>
<td>15,278</td>
<td>0.073</td>
</tr>
</tbody>
</table>

In considering the mean number of concussions per player-season, it is important to point out that the number of players who played in a regular season NFL game includes both players who played all 16 games in a season and those who played only 1 game in a season. Thus, while there is a mean of 0.073 concussions per player per regular season, the mean is likely different for different populations, i.e., depending on how many games a player played in that season.

Table 1-H: Concussion Incidence by Player Position in the Regular Season (2013)

<table>
<thead>
<tr>
<th>Position</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Offensive Line</td>
<td>19</td>
</tr>
<tr>
<td>Running Back</td>
<td>15</td>
</tr>
<tr>
<td>Tight End</td>
<td>16</td>
</tr>
<tr>
<td>Quarterback</td>
<td>6</td>
</tr>
<tr>
<td>Wide Receiver</td>
<td>17</td>
</tr>
<tr>
<td><strong>Offense Total</strong></td>
<td><strong>73 (49.3%)</strong></td>
</tr>
<tr>
<td>Defensive Secondary</td>
<td>25</td>
</tr>
<tr>
<td>Defensive Line</td>
<td>12</td>
</tr>
<tr>
<td>Linebacker</td>
<td>11</td>
</tr>
<tr>
<td><strong>Defense Total</strong></td>
<td><strong>48 (32.4%)</strong></td>
</tr>
<tr>
<td>Special Teams Total</td>
<td><strong>27 (18.2%)</strong></td>
</tr>
</tbody>
</table>

\(^1\) The number of regular season players was obtained from official NFL and NFLPA playtime figures. To be clear, these statistics only include players who played in a regular season game and thus does not include players who only played in the preseason.
While the above tables present some information concerning NFL player injuries, it is not complete. The 2015 season-end injury report from Quintiles contains data and information on other player injuries and related issues. However, we were not permitted to include that data and information in the Report. The NFLPA provided us with the 2015 season-end injury report from Quintiles but, pursuant to the terms of The Football Players Health Study—NFLPA agreement, identified the report as confidential and would not permit use of the data in this Report. The NFLPA considered the document confidential in light of HIPAA. We do not agree with such concerns. The data we requested is de-identified aggregate data that does not implicate the personal medical records of any player. Additionally, the Health Insurance Portability and Accountability Act (HIPAA), which the NFLPA seems to be referencing, has no relevance here as neither we nor the NFLPA are covered entities under HIPAA. Moreover, if HIPAA concerns were present in the manner the NFLPA suggests, the NFLPA would have potentially already violated HIPAA by providing us the report, regardless of whether we incorporated the data in our Report. Finally, the above tables incorporate data from the 2013 season-end Quintiles report. The 2013 season-end report was provided by the NFLPA, and it never indicated that we could not use those data in this Report for confidentiality reasons or otherwise. It is regrettable that both the NFL and NFLPA are not providing players with all data and information concerning player health that is in their possession. In Recommendation 7:1-C, we recommend that the NFL, and to the extent possible, the NFLPA, should: (a) continue to improve its robust collection of aggregate injury data; (b) continue to have qualified professionals analyze the injury data; and (c) make the data publicly available for re-analysis.

Moving on, as shown above in Table 1-I, the mean number of injuries per play in 2013 was 0.035, indicating that an injury occurred on 3.5 percent of all plays. Additionally, from the available information regarding the total number of injuries, total number of players per game, games per year, and years of data, we can calculate the overall rate of injury per player-game as 0.064 per player-game. In other words, for every particular game there are 5.90 injuries (0.064 injuries per player-game x 92 players per game). That equates to one injury for every 15.6 players in that game.

We can also determine the mean rate of how often concussions occur in a game. Between 2009 and 2015 there were a total of 1,112 regular season concussions. Using the available information regarding the total number of concussions, total number of players per game, games per year, and years of data, we can calculate the overall rate of concussion per player-game as 0.0067 concussions per player-game.

We can also determine the rate of injuries per player per regular season. During the 2009 to 2015 seasons, there were a total of 15,278 player-seasons played. During this same time period there were a total of 10,577 game injuries. This equates to an overall rate of 0.69 injuries per player-season (10,577/15,278). Some readers, particularly players, may be surprised that this rate is not higher. It is important to remember that this statistic is the mean of all players who played in the NFL during these seasons, including players who might have only played in one game. Additionally, the statistic does not include injuries that occurred during preseason practices or games or regular season practices. Finally, these statistics count all injuries the same, regardless of their severity or the amount of time

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1 This statistic is calculated by dividing the total number of regular season game injuries from 2009 to 2015 (10,577) by the total number of game exposures over the same time period (164,864). The 164,864 statistic is calculated by multiplying 7 seasons by 256 regular season games per season by 92 players per game. Clubs are limited to 46 active players during a game, 2011 NFL CBA, Art. 25, § 1, thus, 92 players have the opportunity to play each week.

2 This statistic is calculated by dividing the total number of regular season game concussions from 2009 to 2015 (1,112) by the total number of game exposures over the same time period (164,864). The 164,864 value is calculated by multiplying 7 seasons by 256 regular season games per season by 92 players per game.

3 In other words, a mean of 2,182.6 players played in a regular season NFL game each season. The number of player-seasons was obtained from official NFL and NFLPA playtime figures.

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The statistic for total number of players was obtained from calculations derived from official NFL and NFLPA playtime statistics.
lost due to the injury. Thus, while helpful, this statistic is an incomplete picture of the injuries suffered by NFL players during the course of a season.

One useful question concerns ascertaining the mean number of games a player plays before suffering an injury. We calculated above that the rate of injuries per regular season game per player was 0.064. Thus, we can calculate that players play a mean of 15.6 games before suffering one injury (1/0.064). We can also calculate the mean number of games a player plays before suffering a concussion. We calculated above that the rate of concussion per regular season game per player was 0.0067. Thus, we can calculate that players play a mean of 149.25 games before suffering one concussion (1/0.0067). With 16 regular season games, players theoretically play a mean of 9.3 seasons before suffering a concussion. For context, although there is a debate about career lengths generally, the mean career length for a drafted player is about 5 years. Nevertheless, it is important to remember that this is a mean statistic and thus includes players who play very little in the game or players who play positions less likely to suffer concussions. Players with a lot of game time and players at certain positions are likely to suffer concussions at rates higher than those provided here.

Finally, we can calculate what percentage of player injuries are concussions. Between 2009 and 2015 there were a total of 10,577 regular season injuries (Table 1-C). During this same time period, there were 1,112 regular season concussions (Table 1-E). Thus, concussions represented 10.5 percent of all regular season injuries (1,112/10,577).

Finally, below is some additional information from the NFLISS:

- The most common types of injuries during regular season practices in 2013 were hamstring strains (46), groin adductor strains (10), high ankle sprains (6), and shoulder sprains (6).

- The five most common types of injuries during regular season games in 2013 were concussions (147), hamstring strains (approximately 128), medial collateral ligament (MCL) sprains (approximately 76), high ankle sprains (approximately 58), and groin adductor strains (approximately 47).

- The most common mechanisms of concussions during regular season games in 2013 were contact with other helmets (49.0 percent), contact with the playing surface (16.3 percent), contact with another player’s knee (10.2 percent), and contact with another player’s shoulder (7.5 percent).

Injured NFL players are placed on different lists depending on the expected duration of the injury and the timing of the injury.

If a player fails the preseason physical, i.e., the club doctor determines the player is not physically ready to play football, and is unable to participate in training camp but is expected to be able to play later in the season, the player can be placed on the PUP List. A player on the PUP List cannot practice or play until after the sixth game of the regular season and does not count toward the club’s 53-man Active/Inactive List during that time.

Players who are injured during the preseason or regular season and are unable to return that season are placed on Injured Reserve, which typically precludes them from practicing or playing further that season. Players on Injured Reserve do not count toward the club’s 53-man Active/Inactive List. In 2012, the NFL and NFLPA amended the rules to permit clubs to allow one player in any season to return from Injured Reserve after a minimum of six weeks.

Finally, the less severely injured players are only given a different status on the day of the game. NFL clubs have a 53-man Active/Inactive List. This is the universe of players from which clubs have to choose each week. On the day of the game, the number of players that are permitted to play, i.e., the Active List, is reduced to 46 players. Thus, seven players are declared Inactive and cannot play. Generally, at least some of the seven players declared Inactive have been so declared due to injury (the rest would be for skill reasons). A player is Inactive for that particular game, but can be Active for the next game. In this way, the Inactive List serves as a short-term, non-durational injured list.

Players are paid their base salaries while on any of these injury lists; however, younger players often have “split” contracts whereby if they are placed on either the PUP List or Injured Reserve, they are paid a lesser amount, typically about half of their base salary. In addition, injured players might be entitled to additional compensation pursuant to the Injury Protection benefit.

Finally, despite the physical tolls of an NFL career, in a 2014–2015 survey of 763 former players by Newsday, 89 percent of respondents said they would still play in the NFL.

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* Statistics for injuries other than concussions are only available in bar graph form. Consequently, we estimate the injury statistic based on the graph available.
if they had the chance to make the decision again.45 There are, however, limitations to the Newsday survey: (1) the survey was sent via email and text message by the NFLPA to more than 7,000 former NFL players, thus eliminating former players who were less technologically savvy and also possibly skewing the sample toward those former players closer to the NFLPA; (2) the response rate for the survey was low (approximately 11 percent); and, (3) the study does not discuss the demographics of those that responded, making it difficult to ascertain whether those who responded are a representative sample of all former players. Nevertheless, we provide the reader with the best existing data.

A waiver executed by players permitting disclosure of their medical information “expressly includes all records and [protected health information] relating to any mental health treatment, therapy, and/or counseling, but expressly excludes psychotherapy notes.”

2) PLAYERS AND MENTAL HEALTH

As we have emphasized in the Introduction to this Report, our focus is not just players’ physical health, but also their health more generally, and those factors that play a role in determining their health. This, of course, includes their mental health. According to the National Institute of Mental Health, 43.7 million American adults, or 18.6 percent, suffer from some form of mental illness.44

One goal of the Population Studies component of The Football Players Health Study at Harvard University is to develop better epidemiologic data specific to football players. But in the meantime, extrapolating from the above data strongly suggests that there are hundreds of current NFL players, and likely thousands of former NFL players, suffering from some form of mental illness.45 Indeed, the Michigan Study46 found that 25.6 percent of former NFL players interviewed had “either been diagnosed with depression or experienced an episode of major depression in their lifetime.”46,5 However, another study (partially funded by the NFLPA) of 1,617 former players found that 14.7 percent experienced depressive symptoms.47 Finally, a third study concerning depression among former NFL players conducted by the University of North Carolina found that of the 2,434 former players who responded to a questionnaire with complete data, 269 (11.1 percent) reported having been diagnosed previously with clinical depression. Of note, the last two studies mentioned found rates of depression substantially lower than that found by the Michigan Study and also lower than the rate of depression in the general population.5 Nevertheless, concerns about players and mental health exist. In this vein, star NFL wide receiver Brandon Marshall has been vocal in the last few years about his own struggles with mental illness and has strongly advocated for acceptance and understanding in the NFL community.48

The issue of mental health is also important in light of the fact that “medical literature and clinical practice has associated [emphasis in original] psychological symptoms such as anxiety, depression, liability, irritability and aggression in patients with a history of concussions.”49 Similarly, some research has also found an association between traumatic brain injury and suicide rates.50 Nevertheless, as the District Court in the Concussion Litigation (discussed in detail in Chapter 7: The NFL and NFLPA, Section D: Current Legal Obligations of the NFL) recognized, the question of a causal connection is contested in the medical literature, and, for at least partially this reason, the Court determined that these conditions did not need to be covered by the settlement in that case.51 This is clearly an area of important continued research.

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4 In the background section of this chapter, we provide some limitations to the Michigan Study.

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Players do have resources for mental healthcare. The standard training camp PowerPoint presentation includes slides about the importance of mental health and advises players to use resources available to them, including club doctors. In addition, in 2012, the NFL, in partnership with other organizations, created the Life Line program, a 24/7 hotline for players and their families in need of assistance during crises. Finally, players are able to receive mental healthcare through their player insurance plans.

Nevertheless, Current Player 2 indicated his belief “there is not enough invested in the mental health and well-being and the emotional well-being of our players.” The player also explained that he “think[s] the mental and emotional health of the players is just as important, if not more important, as the physical well-being of our players.”

Aside from the resources that do exist, players are likely concerned about clubs knowing whether they have sought mental healthcare. On this issue, the NFL’s insurance plan provides that the submission of claims by players or their family members for mental health, substance abuse, and other counseling services provided for under the insurance program “will not be made known to [the] Club, the NFL or the NFLPA.” However, a waiver executed by players permitting the disclosure of their medical information to the NFL, the club, and others “expressly includes all records and [protected health information] relating to any mental health treatment, therapy, and/or counseling, but expressly excludes psychotherapy notes.” Thus, players are unable to receive confidential mental healthcare.

One source of assistance concerning player mental health is the club chaplain. Current Player 2 explained that he thought the club chaplain was “great” for the players. Every club generally has a chaplain who will visit practice once or twice during the week and be present before games. The chaplains often hold small studies or sermons but avoid overly religious messaging, instead focusing on themes relevant to football and the players or other themes as directed by the coaching staff. Importantly, one former player indicated that chaplains are often able to provide important words of encouragement and positive feedback in an environment that is often lacking both.

We examine players’ legal and ethical obligations from two perspectives: (1) players’ obligations concerning their own health, as it is broadly defined for this Report; and, (2) players’ obligations concerning the health of other players.

1) PLAYERS AND THEIR OWN HEALTH

As we will discuss, players, like all people or patients, have certain obligations concerning their own health, although they often need a range of support, education, access, and unconflicted relationships in order to fully satisfy these obligations and goals.

a) Current Legal Obligations

From a legal perspective, NFL players undoubtedly have both certain rights concerning their health as well as obligations.

The Standard NFL Player Contract imposes certain health-related obligations on players. Specifically, players are:

1. forbidden from engaging “in any activity other than football which may involve a significant risk of personal injury”;
2. obligated to maintain themselves in “excellent physical condition”;
3. 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.”

Indeed, published with this Report is a Patient Bill of Rights for NFL Players. Appendix A to the 2011 CBA is the Standard NFL Player Contract. The Standard Player Contract is 9 pages in length and contains the most basic and important provisions concerning the terms and conditions of NFL player employment. Most player contracts include multi-page addendums addressing more specific compensation or contractual issues.

2011 CBA, App. A, § 3. NFL player contracts often include addendums that prohibit “hazardous activities which involve a significant risk of personal injury and are non-football in nature, including, without limitation, water or snow skiing, surfing, hang gliding, bungee jumping, scuba diving, sky diving, rock or mountain climbing, race car driving as driver or passenger, riding a motorcycle, motor bike, all-terrain or similar vehicle as driver or passenger, travel on or flight in any test or experimental aircraft, or serving as a pilot or crew member on any flight.” Copies of NFL player contracts are on file with the authors. Professional athletes have had their contracts terminated after being injured in motorcycle accidents or playing pickup basketball. See Herzog, Bob. Basketball Injury Might Cost Boone Big Part of Contract. Newseday, Jan. 28, 2004, available at 2004 WLNR 1117940.
Players also seemingly have an ongoing obligation to report injuries to their club, outside of the physical exam. The 2011 collective bargaining agreement (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.56

In reviewing a draft of this Report, the NFL stated that a player has an “obligation to fully and honestly disclose his physical condition to the Club,” citing the above provisions,57 while also arguing that a player who fails to be forthcoming about his medical needs is violating his contract and the CBA.58 We think the NFL may over read the relevant provisions. It appears from the above-described provisions that NFL players have obligations to: (a) promptly report injuries; and, (b) be completely honest about their condition when undergoing a physical. However, if a player is not undergoing a physical and has not recently suffered an injury, he does not have to tell the club about his medical needs. Thus, it does not appear that the player has any obligation to keep the club medical staff apprised of his recovery from an injury previously reported to the club if the club does not request a physical. Additionally, during the offseason, it does not appear that the player has an obligation to report consultations with medical professionals outside the club or to disclose a variety of medical conditions that are not physical “injuries,” such as mental health treatment, heart conditions, or general muscle soreness.

The 2011 CBA also contains numerous health benefits and programs for players. Fortunately for players, the vast majority of the programs contain no statute of limitations for filing or eligibility. The only benefit that requires filing by a certain date is the Injury Protection benefit, which requires filing by October 15 of the League Year in which the benefit is being claimed.59 The benefits available to players are discussed in more detail in Chapter 7: The NFL and NFLPA and in Appendix C: Summary of Collectively Bargained Health-Related Programs and Benefits.

Player grievances under the CBA are subject to statutes of limitations. A player must commence an Injury Grievance within 25 days if the player’s contract was terminated at a time that the player was physically unable to perform the services required of him.60 Additionally, a player could commence a Non-Injury Grievance if the player is unsatisfied with some aspect of his medical care (or a wide variety of other things) within 50 days from the date or the occurrence or non-occurrence on which the grievance is based.2 These grievance mechanisms will be discussed in more detail as relevant in specific chapters.

b) Current Ethical Codes

As a preliminary matter, we note that players only have obligations to promote their own health to the extent health maximization is of interest to them. In practice, we know that players often make decisions sacrificing their health in favor of some other benefit, typically career-, performance- or finance-related. In some cases, the need for those sacrifices could be avoided through structural change, and we make recommendations to that effect throughout this Report in order to advance the principle of Health Primacy. That said, our principle of Empowered Autonomy seeks to recognize a fully informed, competent player’s right to voluntarily weigh his health against other interests. While we recognize that players currently lack sufficient information to be fully empowered, assuming that players are concerned with maximizing their health, they do have some obligations to help support that goal.

While not specific to NFL players, one of the most useful articulations of a player’s obligations to care for his own health comes from prominent statements of patients’ responsibilities. Opinion 1.1.4 of the American Medical Association’s (AMA) Code of Medical Ethics, for example, recognizes a patient’s right to direct his or her own healthcare but declares that “[w]ith that exercise of self-governance and choice comes a number of responsibilities.”61 The responsibilities most relevant to NFL players require them to:64

(a) [Be] truthful and forthcoming with their physicians and strive to express their concerns clearly.

(b) Provide as complete a medical history as they can, including providing information about past illnesses, medications, hospitalizations, family history of illness, and other matters relating to present health.

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2 The term “Non-Injury Grievance” is something of a misnomer. The CBA differentiates between an “Injury Grievance” and a “Non-Injury Grievance.” An “Injury Grievance” is exclusively “a claim or complaint that, at the time a player’s NFL Player Contract or Practice Squad Player Contract was terminated by a club, the player was physically unable to perform the services required of him by that contract because of an injury incurred in the performance of his services under that contract.” 2011 CBA, Art. 44, § 1. Generally, all other disputes (except System Arbitrations, see 2011 CBA, Art. 15) concerning the CBA or a player’s terms and conditions of employment are “Non-Injury Grievances.” 2011 CBA, Art. 43, § 1. Thus, there can be disputes concerning a player’s injury or medical care that are considered “Non-Injury Grievances” because they do not fit within the limited confines of an “Injury Grievance.” Additionally, although a Non-Injury Grievance is one method by which a player could seek changes to his medical care, there are two committees specifically designated for these issues, as discussed in more detail in Chapter 2: Club Doctors and Chapter 8: NFL Clubs.

64 It is important to note that the AMA is an organization with a substantial interest in protecting doctors’ interests and thus its description of patient obligations might not match the expectations of some patients.

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1 An NFL League Year begins and ends in early March. 2011 CBA, Art. 1.
Players

(c) Cooperate with agreed-on treatment plans. Since adhering to treatment is often essential to public and individual safety, patients should disclose whether they have or have not followed the agreed-on plan and indicate whether they would like to reconsider the plan.

(f) Recognize that a healthy lifestyle can often prevent or mitigate illness and take responsibility to follow preventative measures and adopt health-enhancing behaviors.

(g) Be aware of and refrain from behavior that unreasonably places the health of others at risk. They should ask about what they can do to prevent transmission of infectious disease.62

The principal obligations affecting NFL players are responsibilities (a) and (b) of the AMA Code, requiring open communication with doctors and full disclosure of their medical conditions and history. Although such disclosures might improve a player’s treatment, as will be discussed, players are often (understandably) wary of informing the club doctor of a physical ailment because the club might use that information as a basis to terminate the player’s contract or otherwise negatively affect the player’s employment.

Similar codes of patient responsibility also exist from the American Hospital Association,63 the National Health Council,64 and individual healthcare providers.65 These codes generally emphasize the obligation of patients to fully disclose their medical conditions and history, actively participate in medical decision making, and cooperate with and follow the recommended treatment.

Whether a patient follows these generally accepted guidelines for their own medical care can also have legal significance. Where a patient has failed to disclose important medical history, follow a doctor’s recommended treatment, or otherwise engaged in behavior contrary to the patient’s own medical best interests, the patient may, at least in some states, be barred or limited from recovering in a medical malpractice action.66

2) PLAYERS AND OTHER PLAYERS’ HEALTH

a) Current Legal Obligations

NFL players also have health-related obligations toward one another that might arise from a variety of sources. However, the CBA is generally not one of them, since NFL players do not negotiate the CBA against one another. Thus, the CBA does not establish any legally enforceable obligations or rights among the players.

NFL playing rules seemingly create the principal mechanism for analyzing players’ obligations to each other. The Official Playing Rules (Playing Rules) of the NFL are created and authorized pursuant to the NFL Constitution and Bylaws.67 The NFL is empowered to enact and amend its own Constitution and Bylaws, including the Playing Rules, provided the Constitution and Bylaws does not conflict with the CBA and that any such amendment does not “significantly affect the terms and conditions of employment of NFL players.”68 Paragraph 14 of the Standard NFL Player Contract, which is included as Appendix A of the 2011 CBA, also effectively obligates players to follow NFL policies.69

NFL Playing Rules come with penalties for violations, whether it be a five-yard penalty incurred by the penalized player’s team or, in more extreme cases, ejection of the penalized player from the game, and possibly fines or suspension imposed after the fact by the NFL. Violations of the Playing Rules do not of themselves generate legal liability (just because a tackle amounts to the foul of unnecessary roughness does not make it a crime or a tort).6x However, as indicated below, intentional inflictions of injury that occur wholly outside the bounds of the game might sometimes give rise to legal liability.

Assuming that players are concerned with maximizing their health, they do have some obligations to help support that goal.

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For more information on NFL rules and rule changes, see Chapter 7: The NFL and NFLPA, Section A: Background on the NFL, and Appendix I: History of Health-Related NFL Playing Rule Changes.

While no court has ever cited the Playing Rules as a basis for liability, in Hackbart v. Cincinnati Bengals, Inc., 601 F.2d 516 (10th Cir. 1979), the United States Court of Appeals for the Tenth Circuit did discuss the Playing Rules as discussed in further detail below.
The Preface to the Playing Rules seeks to make clear that a violation of the Playing Rules will not necessarily, or even ordinarily, generate legal liability:

Where the word “illegal” appears in this rule book, it is an institutional term of art pertaining strictly to actions that violate NFL playing rules. It is not meant to connote illegality under any public law or the rules or regulations of any other organization.

The word “flagrant,” when used here to describe an action by a player, is meant to indicate that the degree of a violation of the rules—usually a personal foul or unnecessary roughness—is extremely objectionable, conspicuous, unnecessary, avoidable, or gratuitous. “Flagrant” in these rules does not necessarily imply malice on the part of the fouling player or an intention to injure an opponent.

Players also have common law obligations toward one another. In contact sports, such as football, one player can recover for injuries suffered only if the other player intentionally, recklessly, or willfully and wantonly, injured the plaintiff-player. This rule has become known as the “contact sports exception.” The contact sports exception recognizes that “[p]articipants in team sports, where physical contact among participants is inherent and virtually inevitable, assume greater risks of injury than nonparticipants or participants in noncontact sports.” Thus, players can only recover from other players where the defendant player has acted exceptionally badly.

b) Current Ethical Codes

There are no known codes of ethics for players concerning the health of other players.

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\( ^a \) Common law refers to “[t]he body of law derived from judicial decisions, rather than from statutes or constitutions.” Black’s Law Dictionary (9th ed. 2009).

\( ^b \) Beyond these better established theories of liability, some might argue that players could develop a fiduciary relationship with one another, thus giving rise to liability. Generally speaking, a fiduciary is “a person who is required to act for the benefit of another person on all matters within the scope of their relationship; one who owes to another the duties of good faith, trust, confidence, and candor.” Black’s Law Dictionary “Duty” (9th ed. 2009). Whether a fiduciary relationship exists is a fact-based inquiry into the nature of the relationship. Ritani, LLC v. Aghayan, 880 F.Supp.2d 425, 455 (S.D.N.Y. 2012) (applying New York law); Carcano v. JESS, LLC, 200 N.C.App. 162, 177 (N.C.App. 2009); L.C v. R.F., 563 N.W.2d 799, 802 (N.D. 1997); Allen Realty Corp. v. Hohert, 227 Va. 441, 447 (Va. 1984); Murphy v. Country House, Inc., 307 Minn. 344, 350 (Minn. 1976). Some players, particularly younger players, might develop a relationship with a captain, veteran or other team leader whereby the younger player relies on the older player for advice and guidance. Over time, it is conceivable that a relationship of trust and confidence could develop to the point of becoming an actionable fiduciary relationship. Nevertheless, there are no known litigations in which one athlete alleged another athlete owed and/or violated a fiduciary obligation.

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(C) Current Practices

Significant concerns exist about players’ actions regarding their own health. Historically, there is considerable evidence that NFL players underreport their medical conditions and symptoms, which is predictable, albeit undesirable. In an effort to not miss playing time, players might try to intentionally fail the Concussion Protocol’s baseline examination, avoid going through the Concussion Protocol, or avoid telling the club that he suffered a substantial blow to the head. Although there are no reliable statistics as to the incidence of this behavior, it does happen, and some doctors believe that players are at fault for failing to cooperate with the Concussion Protocol.

For these reasons, one contract advisor interviewed agreed that players can sometimes be their “own worst enemy” after sustaining a blow to the head. The players we interviewed did not believe that players were doing a good job of taking care of themselves (for a variety of reasons, ranging from youthful optimism to pressures to succeed) and all of those who were asked agreed that players often need to be protected from themselves. Nevertheless, we again emphasize that the existing data on player health are incomplete and often unclear, leaving players without sufficient information to make truly informed decisions about their own health.

The pressures to perform and remain on the field at all costs can be extraordinary. According to Hall of Fame New York Giants linebacker Harry Carson (1976–88):

“Football players are very insecure people. Players are interchangeable parts. Someone played your position before you, and when you leave, someone else is going to be in your place. You are only there for a short period of time, so you want to make as much as you can in the short time given you. You do not want to give anyone else a shot at your job. Football players understand that if they give someone the opportunity to do the job better, their days are numbered.”

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\( ^a \) The Concussion Protocol, attached as Appendix A, dictates the way in which clubs must diagnose and manage players who have potentially suffered concussions.

\( ^b \) A 2015 study found that 64.4 percent of clinicians (doctors or athletic trainers) in college sports reported having experienced pressure from athletes to prematurely clear them to return to participation after a concussion. Emily Kroshus, et al., Pressure on Sports Medicine Clinicians to Prematurely Return Collegiate Athletes to Play After Concussion, 50 J. Athletic Training 944 (2015).

\( ^c \) Former Player 3: “You’d rather get knocked out cold than pull yourself out of the game. And there’s no way they’re coming out. So you do need someone that can make that decision for them at times.”
There is no shortage of stories from NFL players, former and current, about the depths to which they went to continue playing—fighting through and hiding injuries to stay on the field. Players have a variety of motivations for doing so: to try and help the club win; to prove their toughness to teammates, coaches, and fans, for example; and out of fear of losing their spot in the lineup or on the roster if they do not. \(^{41} \)

The San Francisco 49ers provided a useful recent example. In 2012, 49ers quarterback Alex Smith was having a successful season when he suffered a concussion that forced him to miss a game. Smith’s backup, Colin Kaepernick played well in place of Smith. \(^{80} \) Even though Smith was healthy enough to play two weeks later, the 49ers kept Kaepernick as the starter \(^{81} \) and Smith never started for the 49ers again. In response, Smith stated “I feel like the only thing I did to lose my job was get a concussion.” \(^{82} \)

Former Player 1 gave a useful in-depth description of the pressures to keep playing:

> [T]he pressure to play when you’re injured or to get back before you’re healthy is just incredible . . . I saw guys play through all kinds of things . . . just knowing you had to be out there just to try to make a team and then after that trying to get your spot, trying to keep your starting spot . . . I can’t express to you the pressure you feel to play, not just games that you’re a little hurt, but I mean major, major injuries. If you can walk, if you can go, if you can move your arms a little bit, you felt like you have to be out there. \(^{4} \)

Current Player 1 echoed these sentiments:

> [T]here’s definitely a pressure to be out there for every practice and to never miss a game or anything like that because of injuries. Just because you know there’s always a threat of another guy playing your position. And you never want somebody else to outshine you or you don’t want the coaches to feel like you’re unreliable and not a player that can play through injuries. \(^{48} \)

Indeed players feel pressure to play through injuries not only from their coaches \(^{83} \) but also from teammates, opponents, \(^{84} \) fans, media, and others.

Players and contract advisors we talked to expressed their view that club medical staff sometimes encourage players to return to the field when they are less than 100 percent healthy so that the club can obtain evidence of the player’s supposed health and also his diminished performance. \(^{85} \) In their perspective, the club will then terminate the player’s contract, claiming it was based on the player’s diminished performance and refuse to pay the player any additional compensation. \(^{86} \) While the player might file an Injury Grievance seeking compensation for the duration of the injury (during the season of injury only), the player will have undermined his claim by returning to the field of play and at least appearing to be uninjured. \(^{87} \)

Players we interviewed also generally did not believe that they were doing a good job of protecting their own health or that of their teammates: \(^{4} \)

Current Player 2: “I think as players we can do a better job of how we communicate our injuries . . . I think that guys, and specifically as it relates to concussions, are not communicating their symptoms or not speaking up when they have taken hits to the head because they fear . . . losing playing time and . . . in the long-term the loss of potential earnings.”

Current Player 4: “I don’t know that players genuinely care about the health of other players.”

Current Player 5: “Not very good . . . I think guys only really care about their health when they have a major health issue.”

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\(^{4} \) A common refrain from players, current and former, is that a player “can’t make the club in the tub.” Current Player 5 used this phrase as did John Yarno, Seattle Seahawks center from 1977 to 1982: “[T]here are two expressions we’ve always had in the NFL. One was, ‘Get hurt, lose your job!’ Because if you’re not on the field, somebody else is, and at that level, he’s probably a pretty good athlete. [...] The other expression is, ‘You can’t make the club in the tub.’ If you’re not on that field every day and on the practice film the coaches study at night, then you’re not in their minds. I mean, it’s extremely competitive. It’s very difficult. When I was with the Hawks, we’d take maybe 125 guys into summer camp for 48 jobs. If somebody went down, it was like, ‘Drag that carcass off the field or move the drill, and let’s go!’ So it was a very violent lifestyle. But I would do the whole thing again in a heartbeat. I have no remorse about that.” Pierce E. Scranton, Jr., Playing Hurt: Treating and Evaluating the Warriors of the NFL (2001).

\(^{4} \) Former Player 2: “I just wanted to play. The problem was that playing was the ultimate goal and most guys like myself would try to do everything they can to play . . . sometimes you have to do things that necessarily aren’t right . . . I guess that’s just the nature of the business we were involved in.” Former Player 3: “The player is going to do anything he can to get out there.”

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\(^{8} \) Longtime NFL General Manager and executive Tom Donahoe explained the importance of player health in roster decisions: “Durability becomes a significant factor because there is so much money involved . . . If a guy misses five or six games a year, you’ll think about whether you want to sign him. And I don’t know about all coaches, but many would rather have a guy with less talent who is more dependable than a more talented guy who you don’t know when he’ll show up.” Dave Sell, Football’s Pain-Taking Process, Wash. Post, Dec. 8, 1996, available at 1996 WLNR 6482132.

\(^{4} \) We reiterate that our interviews were intended to be informational but not representative of all players’ views and should be read with that limitation in mind.
Current Player 6: “Young guys have no idea how to take care of their bodies.”

Players we interviewed also generally did not believe that they were doing a good job of preparing for life after football and taking advantage of the programs and benefits available to them:

Current Player 2: “[T]he focus that’s required in order to be successful at this level is off the charts. So I think it’s hard for some guys to put everything they have into their playing career while at the same time preparing themselves for life after football . . . [Players] are not often times taking advantage of the resources that are out there for us[.]”

Current Player 3: “I think there are a lot of programs out there that benefit guys getting ready for life after football . . . [but] at the end of the day, I think it’s the players that have to want to prepare. The NFL can’t make you go to all those programs.”

Current Player 6: “I think there are guys that consider life after football and careers after football, but I wouldn’t say that it’s the majority.”

Current Player 10: “I think players can do a better job of [taking advantage of programs].”

From a financial perspective, our interviews and existing reports suggest that players are often unrealistic about their likely career trajectories, believing that their careers will exceed the average length and that they will continue to make hundreds of thousands if not millions of dollars a year for the foreseeable future. Moreover, players, like many people, tend to value today over tomorrow, preferring to spend now rather than save for later.

Contract advisors and financial advisors we interviewed acknowledged that young players routinely fail to grasp the likely brevity of their career and the need to handle their health and financial matters responsibly. While some players make mistakes about these matters early in their career and are able to learn from them, few players are in the NFL long enough to capitalize on that learning process. The contract advisors we interviewed maintained that this situation persists today even though players are generally more aware of the risks and realities of a football career due to increased media attention and education efforts by contract advisors, financial advisors, the NFL, and the NFLPA.

In our interviews, we found two somewhat divergent views emerged concerning players and their rights and benefits. First, some believe that players are not sufficiently made aware by either the NFL or NFLPA of their rights and benefits. Second, some believe that players are sufficiently made aware of their rights, benefits, and opportunities, but that some players fail to take advantage of them for a variety of reasons, including lack of motivation.

Nevertheless, both views support the general belief that many players are not receiving the benefits to which they are entitled.

Players’ interactions with specific stakeholders are discussed in those stakeholders’ chapters.

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[64] Current Player 8 had a more optimistic view: “The amount of rehab, pre-hab, strength programs, even watching diets and pills and things like that, I think players have—at least the players who stick around—have approached their health as their main concern.”

[65] Current Player 10 also believes that the biggest improvement still needed concerning player health is “taking care of players post-career.”

[66] Contract Advisor 4: “[S]top convincing the players that they all could become superstars and rich . . . [B]ut no player thinks it’s going to happen to them. They think they’re going to be the next Richard Sherman and make $15 million and be on commercials. While the odds are they probably have just as good a chance of developing CTE and potentially dying as they do of becoming a $15 million player in the NFL.”
Almost all incidences of unnecessary player on player violence are resolved through the NFL’s imposition of a fine or suspension for the player who violated the rules. The NFL’s League Policies for Players contains a schedule of minimum fines for various rules violations. In 2015, on the low end of the spectrum, players who committed face masks, late hits, and chop blocks faced a minimum penalty of $8,681 for a first offense and $17,363 for a second offense. On the other end of the spectrum, the largest minimum fines of $23,152 for a first offense are reserved for spearing, impermissible use of the helmet, initiating contact with the crown of the helmet, hits on defenseless players, and blindside blocks.

The League Policies for Players emphasizes that the schedule of fines are minimums and that suspensions or fines are to be determined by the degree of violation. Indeed, the NFL has regularly increased its discipline against repeat offenders.

While the NFL’s disciplinary process may partly satisfy its deterrence function, it does not provide the injured player any opportunity to recover from his injuries. Only in a handful of situations have professional athletes sought recompense for their injuries by instituting legal action against another athlete.

As discussed earlier, one player can recover for injuries suffered only if the other player intentionally, recklessly, or willfully and wantonly, injured the other player. This standard is routinely applied in youth sports. Youth sports, because of their wide levels of participation, provide a forum for most tort-based sports litigation and legal rules that are then often applied in professional sports.

In McKichan v. St. Louis Hockey Club, L.P., a minor league hockey goalie sued an opposing player and his team after he was injured by the player’s post-whistle check. A jury granted the goalie $175,000 in damages but the Missouri Court of Appeals reversed and vacated the award, finding

That the specific conduct at issue in this case, a severe body check, is a part of professional hockey. This body check, even several seconds after the whistle and in violation of several rules of the game, was not outside the realm of reasonable anticipation. For better or for worse, it is “part of the game” of professional hockey. As such, we hold as a matter of law that the specific conduct which occurred here is not actionable.

The McKichan case stands for the proposition that a violation of the playing rules generally will not be dispositive as to whether a legal duty has been violated, i.e., whether a tort has been committed.

Nevertheless, a different result occurred in Hackbart v. Cincinnati Bengals, Inc., a lawsuit brought Denver Broncos defensive back Dale Hackbart in the 1970s. The
trial court found that a Cincinnati Bengals running back “acting out of anger and frustration, but without a specific intent to injure . . . stepped forward and struck a blow with his right forearm to the back of the kneeling plaintiff’s head and neck with sufficient force to cause both players to fall forward to the ground.”96 The trial court nonetheless determined that such violent conduct was inherent to the game of football and entered judgment for the defendants.97

The United States Court of Appeals for the Tenth Circuit reversed, declaring that “there are no principles of law which allow a court to rule out certain tortious conduct by reason of general roughness of the game or difficulty of administering it.”98 The Tenth Circuit also discussed the Playing Rules in determining whether Hackbart consented to intentionally being injured during the course of a football game. The Court determined that the Playing Rules “are intended to establish reasonable boundaries so that one football player cannot intentionally inflict a serious injury on another.”99 The Tenth Circuit remanded the case for a new trial in which the running back’s actions would be examined pursuant to a recklessness standard.100 After remand, the case settled for an unknown sum.101

After the Hackbart case, there is only one other known case in which a player sued another player for conduct that took place during an NFL game.102 In Green v. Pro Football, Inc., former NFL player Barrett Green sued the Washington, D.C. football club, its former defensive coordinator Gregg Williams, and former Washington, D.C. player Robert Royal. Green alleged that he was injured as a result of an illegal play by Royal that was part of a scheme whereby players were financially rewarded for injuring opposing players.103 The court denied the defendants’ motion to dismiss in part and found that Green stated a viable claim for battery.104 The case was subsequently settled on confidential terms.105 Nevertheless, the Green case supports the proposition that players can be held liable for intentional acts that are beyond the reasonable bounds of the game.

It is also important to note that regardless of potential civil liability, several players have been charged criminally for dangerous actions taken on the field of play.106

As discussed above, players also bear responsibility and have obligations for their own health. Clubs may seek to enforce players’ health disclosure obligations where the player’s failure to do so negatively affects the club. In 2012, the NFL, on behalf of the New England Patriots, commenced a System Arbitration against Jonathan Fanene. Prior to the 2012 season, the Patriots and Fanene agreed to a three-year contract worth close to $12 million, including a $3.85 million signing bonus.107 As part of a pre-employment questionnaire, Fanene, according to the Patriots, stated that he took no medications regularly even though he had been taking significant amounts of painkillers to mask chronic pain in his knee.108 The Patriots cut Fanene during training camp citing Fanene’s alleged failure to disclose his medical condition, and initiated a System Arbitration to recoup $2.5 million in signing bonus money already paid to Fanene.109 Specifically, the Patriots alleged Fanene violated his obligations to negotiate the contract in good faith.110

The NFLPA sought to have the Patriots’ claims dismissed, arguing that signing bonus forfeiture was not an available remedy for the alleged wrongful act by Fanene.112 After the NFLPA’s motion to dismiss was denied, the parties settled by allowing Fanene to keep the $2.5 million already paid, but releasing the Patriots’ from their obligation to pay Fanene the remaining $1.35 million of the signing bonus.113

In a related proceeding, the NFLPA filed a grievance against the Patriots concerning Patriots doctor Tom Gill’s care of Fanene, discussed in further detail in Chapter 8: NFL Clubs.

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96 A System Arbitration is a legal process for the resolution of disputes between the NFL and the NFLPA and/or a player concerning a subset of CBA provisions that are central to the NFL’s operations and which invoke antitrust and labor law concerns, including but not limited to the NFL player contract, NFL Draft, rookie compensation, free agency, and the Salary Cap. 2011 CBA, Art. 15, § 1.
This Report is intended to improve the lives and careers of players by protecting and promoting their health. While there are many stakeholders with a role to play in achieving this goal, it is important that players recognize and accept that they are on this list as well, not only with regard to their own health, but also with regard to the health of former, current and future players. Nevertheless, in many cases, players will need support from other stakeholders to fulfill the recommendations made here. In the chapters on the NFL and NFLPA, Contract Advisors, and Financial Advisors, we make recommendations to these stakeholders about how they can assist players.

While all of the recommendations in this Report concern players, certain recommendations directed toward players’ conduct are made in other chapters:

- **Chapter 6: Personal Doctors** — Recommendation 6:1-B: Players should receive a physical from their own doctor as soon as possible after each season.

- **Chapter 12: Contract Advisors** — Recommendation 12:2-C: Players should be given information to ensure that they choose contract advisors based on their professional qualifications and experience and not the financial benefits the contract advisor has or is willing to provide to the player.

- **Chapter 13: Financial Advisors** — Recommendation 13:1-D: Players should be given information to ensure that they choose financial advisors based on their professional qualifications and experience and not the financial benefits the financial advisor has or is willing to provide to the player.

- **Chapter 14: Family Members** — Recommendation 14:2-A: Players should select and rely on professionals rather than family members for managing their business, financial, and legal affairs.

Additional player-specific recommendations are listed here.

**Goal 1: To have players be proactive concerning their own health with appropriate support.**

*Principles Advanced: Health Primacy; Empowered Autonomy; and, Collaboration and Engagement.*

**Recommendation 1:1-A:** With assistance from contract advisors, the NFL, the NFLPA, and others, players should familiarize themselves with their rights and obligations related to health and other benefits, and should avail themselves of applicable benefits.

Our formal interviews, literature review, and other feedback from stakeholders revealed that many players are not sufficiently aware of their rights, obligations, benefits, and opportunities pursuant to the CBA or other programs, or do not take full advantage of them, even if they are aware. There are numerous rights and benefits that are important to a player’s health and he must be aware and take advantage of them to maximize his health. For example, a player is entitled to a second medical opinion, the surgeon of his choice, and may be entitled to tuition assistance, and a variety of injury and disability-related payments.

In Chapter 7: The NFL and NFLPA, Recommendation 7:3-A, we discuss ways in which the NFL and NFLPA have sought to advise players of certain benefits and opportunities. And while the NFL and NFLPA have an obligation to publicize
Recommendations Concerning Players – continued

these benefits and make them as easily accessible and comprehensible to the players as possible, players ultimately have to be the ones to act on the benefits.

This recommendation applies to former players as well. To the extent a former player is unaware of his rights and the benefits available to him, he should consult with his financial advisor and former contract advisor, as well as contact the NFL and the NFLPA, both of whom have staff and resources that can assist the player in understanding and obtaining benefits.

**Recommendation 1:1-B:** Players should carefully consider the ways in which health sacrifices now may affect their future health.

While the health of the average former player is uncertain, there is no doubt that injuries suffered during an NFL career can cause players permanent damage that could make the remainder of their life more difficult. In their desire to win, help their club and teammates, or just remain employed, players routinely play with injuries or conditions even though continuing to play might subject them to further or permanent injury. In so doing, players (like most human beings) exhibit present bias, which is the tendency to make decisions that are beneficial in the short term but are harmful in the long term. It is important for players (with the help of other stakeholders) to recognize the impact of this potential bias on their decision making. Some players may rationally decide that the decisions that they make now may be worth the consequences they suffer later, but it is important that those choices be as informed as possible. Players should pause—or have a support system that can help them pause—and understand the risks and benefits of playing through certain injuries or conditions, with particular emphasis on understanding the long-term implications of the decision.

Relatedly, additional research must be done into ways to effectively communicate the risks and benefits of playing to NFL players. Such research can draw on effective campaigns in other areas of public health, including increased cancer awareness, smoking cessation, and preventing communicable diseases.

**Recommendation 1:1-C:** Players should take advantage of opportunities to prepare for life after football.

One reason that some players may behave in ways that jeopardize their health is because of their strong desire to remain in the NFL given the lack of attractive alternatives available to them outside the sport. The NFL and NFLPA offer a wide variety of programs and benefits to help players prepare for life after football, including educational courses and seminars. These programs are discussed in more detail in Chapter 7: The NFL and NFLPA, Appendix D: Summary of Programs Offered by NFL’s Player Engagement Department and Appendix E: Summary of Programs Offered by NFLPA. As one example, the NFL’s Tuition Assistance Plan reimburses players for tuition costs if they complete their college degrees within four years of leaving the NFL. Unless the player is nearly certain to have a lengthy career in coaching, broadcasting, or something else (all of which are rare), he should take advantage of this opportunity to finish his education at no or little cost. Doing so may somewhat lessen background pressures and influences to sacrifice health.

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a Current Player 10: “Unfortunately, advice from agents and especially the NFLPA in a long meeting with lots of information falls on deaf ears most times. Players don’t care about this information until it pertains to them.”

b Former Player 2: “As stubborn as most of us are, I think the players truly don’t understand the effects it has later in our lives.”

c It should also be pointed out that if the player is considering the possibility of ever coaching in college, he will likely need a college degree. See Brett McMurphy, UK: Steve Masiello Didn’t Graduate, ESPN (Mar. 26, 2014, 4:30 PM), http://espn.go.com/mens-college-basketball/story/_/id/10675532/south-florida-bulls-kill-coaching-deal-steve-masiello-lying-resume, archived at http://perma.cc/V826-JMSZ (discussing requirement of at least an undergraduate degree to be basketball coach at the University of South Florida).
Recommendation 1:1-D: Players should seek out and learn from more experienced players, including former players, concerning health-related matters.

In any line of work, younger employees are well-advised to engage with more experienced colleagues and to ask for their advice and guidance. NFL players are no different. Indeed, the uniqueness of NFL employment makes it even more important that players engage experienced players for advice.

Many of the players we interviewed told us that it took a few years in the NFL for them to learn best how to maximize their health, prepare their bodies for football, and take advantage of and protect their health-related rights, such as seeking a second medical opinion or ensuring they retain a quality financial advisor. Veteran players can provide valuable insights into these issues. Moreover, while a more experienced player may not always be particularly interested in talking with the younger player, the younger player can learn a lot simply by observing.

Players have a variety of options in finding former players with whom to consult. As is discussed in detail in Chapter 10: Club Employees, each club employs a developmental employee who is charged with helping players, particularly rookies, transition to the NFL. Often this developmental employee is a former player. The club might also have former players who visit the club regularly or are involved in informal ways. Moreover, the NFLPA also employs five former players as Player Advocates, charged with serving as “the NFLPA’s first line of defense in explaining and protecting player rights and benefits.” Each Player Advocate is assigned to a set of clubs and is responsible for helping the players on those clubs. Finally, a player could ask his contract advisor about some of the contract advisor’s former clients and reach out to some of them.

No matter the method, players should seek out and seize opportunities to learn from the men that came before them.

Recommendation 1:1-E: Players should take on a responsibility to one another, to support one another’s health, and to change the culture for the better.

Players are in a unique and important position to help one another. There are a variety of aspects of an NFL career that only players can understand, including the incredible pressure to play and succeed and why they might sometimes make decisions that are not in the best interests of their short- or long-term health. With this understanding and the rapport that develops among teammates, players have the credibility to positively influence the decisions players make and to improve the overall culture of player health.

Given the difficult decisions players face when it comes to their careers and health, it would likely be very helpful for players to be able to rely on other players for support and advice. In addition, players can lead by example concerning their own health and the health of other players. Players are more likely able to objectively view situations and prevent players from making decisions that are not in their best interests, for example, returning to play too soon after a concussion or other major injury. At the very least, players can take it upon themselves not to pressure one another to play while injured, either explicitly or implicitly. The NFL appears to agree; as part of the standard training camp PowerPoint presentation, in discussing the importance of mental health, the NFL encourages players to “advocate for a teammate or coach if you are concerned” and declares that “reaching out for assistance is not a sign of weakness but of strength!”

The United States Army can serve as a useful comparison. The Army assigns each soldier a “Battle Buddy.” Battle Buddies help each other through training and then look out for each other physically, emotionally, and mentally when deployed. Moreover, Battle Buddies remain buddies after deployment and help each other deal with the adjustment to

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Current Player 10 explained that “there’s a lot more discussions in the locker room now, especially from older guys to the younger guys just in making sure that everybody’s got all the right information and making sure that everybody’s healthy when they go out on the field.”
civilian life and with post-traumatic stress disorder. A 2002 Army study of the Battle Buddy system found that soldiers overwhelmingly liked the system and found that it helped improve morale.

While playing professional football should not be compared to the risks and tolls of military service, there are certain overlapping ideologies and characteristics that make the Battle Buddies analogy apt on a lesser scale. In sum, players who are well supported by their peers are likely to better handle important health issues and promote an environment in which player health is a priority.

Recommendation 1:1-F: Players should not return to play until they are fit to do so.

As discussed above, players play through all types of injuries to help the team win, protect their position on the team, prove their toughness, etc. Indeed, when a player is “fit” to return is a difficult subjective question and can involve balancing a number of factors, including but not limited to the player’s short- and long-term health, the player’s career goals and status with the club, and the importance of the club’s upcoming games. At least some of the players and contract advisors we talked to believe that club medical staff sometimes encourage players to return to play despite being less than 100% healthy because this will allow the club to more easily terminate the player’s contract or succeed in fighting a potential Injury Grievance. While clubs might not engage in such conduct with their more important players, these situations are a very real concern for many players simply seeking to retain their status on the roster. Some players indicated that they did not realize that the club would do such a thing until they saw it done or were so advised by older players. While we cannot confirm that clubs engage in such behavior, at least some players believe they do, which affects the trust relationship between the player and club medical staff. In sum, players need to understand the full panoply of risks when they make health-related decisions, not only to their own health, but also to their economic interests.

Recommendation 1:1-G: Players should not sign any document presented to them by the NFL, an NFL club, or an employee of an NFL club without discussing the document with their contract advisor, the NFLPA, their financial advisor, and/or other counsel, as appropriate.

As is discussed in more detail in Chapter 2: Club Doctors, players sign collectively bargained forms authorizing club doctors to disclose the players’ medical records and information to club officials, coaches, and many others. A copy of this waiver is included as Appendix L. Additionally, at the NFL Combine, players similarly execute waivers and forms authorizing the disclosure of their medical records and information. The circumstances under which these waivers are executed is an area worthy of additional attention. For example, questions might be raised as to whether the players are providing meaningful and voluntary informed consent in their execution. Indeed, these forms have the potential to effectively strip players of important privacy protections and empower clubs to make adverse employment decisions about players based on the player’s medical information.

As discussed in Chapter 2: Club Doctors, employers are entitled to certain parts of an employee’s medical records under the Health Insurance Portability and Accountability Act, and other state laws, including worker’s compensation laws.

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80. Peer reviewer and former NFL club executive Andrew Brandt indicated he was disappointed with some of the Injury Grievances in which he was involved, especially when players grieved about injuries for which players sought little to no treatment from club trainers or doctors. Andrew Brandt, Peer Review Response (Oct. 30, 2015).

81. Former Player 1: “[T]his is probably the only NFL training camp they’d ever be in, but they get injured and they want to rush back and tried to get back on the field as soon as possible and the first thing that happens as soon as they get out there is the team would cut them. They get them on film running around and that’s it.” Current Player 10: “I think the one concern . . . [is with] young guys that are going to get released . . . . [the medical staff] hurrying to get them back on the field. Them being naïve enough to think they’re getting back on the field for the right reasons and then getting released, so that the clubs don’t have to pay them.”

82. Former Seattle Seahawks doctor Pierce Scranton told this anecdote in his 2001 book: “One team physician complained to me that his club had cut two players after the last exhibition game, on with a ruptured disc in his neck, the other with a posterior cruciate injury to the knee. He called the club to report these injuries when the players came to his office for release physicals. ‘Screw ‘em,’ the general manager said. ‘Let ‘em grieve us if they’re smart enough.’
Nevertheless, the waivers executed by the players are broad and potentially exceed the bounds of the aforementioned exceptions. For example, the waivers permit the player's medical records to be disclosed to and used by numerous parties other than the player's employer, including clubs that do not employ the player. Moreover, the waivers permit the player's medical information to be used for the NFL's publicly released injury report, discussed at length in Chapter 17: The Media, which bear no relevance to the player's ability to perform his job. Players should be careful and as knowledgeable as possible about those rights that they are waiving. Considering the stakes at hand, players would be wise to consult with the appropriate professional and expert advisors before executing any documents provided by the NFL or NFL clubs.

Recommendation 1:1-H: Players should be aware of the ramifications of withholding medical information from club medical staff.

Anecdotal evidence suggests that players routinely hide their medical conditions from the club. Players principally do this to protect their status with the club and fear of being viewed as less tough by the coaches. Players know that their careers are tenuous and also know that if the club starts perceiving a player to be injury-prone, it is often not long before the club no longer employs that player. However, there are serious downsides to players not disclosing medical conditions to club medical staff. As a preliminary matter, not telling the medical staff about a condition he is suffering prevents the player from receiving necessary medical care and risks worsening the condition. Additionally, players should be aware that not advising club medical staff about their conditions might harm their financial interests. As an initial matter, as discussed above, players are obligated by the CBA and their contracts to disclose their medical conditions at certain times. Moreover, if the condition is affecting the player’s performance, it increases the likelihood that the club will terminate the player’s contract, generally without any further obligation to pay the player. Normally, when a player’s contract is terminated because he is physically unable to perform, the club is required to continue paying the player for so long as the player is injured (during the season of injury only) via the Injury Grievance process. But if the player has not advised the club that his diminished performance is the result of an injury, he has undermined his ability to bring an Injury Grievance.

Recommendation 1:1-I: Players should review their medical records regularly.

Beginning with the 2014 season, all 32 NFL clubs use electronic medical records. Players can view their records online at any time after registering with the website. Players should view their records regularly, including specifically at the beginning and conclusion of each season and when they are being treated for an injury or condition. Reviewing the records will ensure that the club’s medical staff is properly documenting the player’s condition and concerns while also helping the player to ensure he is following the proper treatment for the condition. Research has also shown that patients who have access to their medical records feel more in control of their healthcare and better understand their medical issues.

Additionally, in reviewing his medical records and knowing that the club will also review them, a player might become more aware of how his medical conditions or history could adversely affect his employment. For example, the medical records might include a note from the athletic trainer that a player’s knee condition prevents him from cutting and running as he had in the past, leading the club to terminate his contract. In reviewing a draft of this Report, the NFL admitted as much, stating that clubs examine a player’s medical records to “evaluate whether or not a player is healthy enough to practice and play.” Of course, this has implications for the player’s employment status.

Finally, players should also consider enlisting their family members and contract advisors to assist with regular review of medical records.

bd Clubs’ rights of termination are discussed as part of Recommendation 1-D in Chapter 7: NFL and NFLPA.
There are also historical reports of clubs requesting players to fake injuries so that they can be placed on Injured Reserve and remain with the club rather than have their contract terminated. Rob Huizenga, You’re Okay, It’s Just a Bruise 141 (1994) (former Los Angeles Raiders Club doctor stating “I quickly learned that most teams would fake injuries, hiding talented but green prospects on the injured reserve list.”); Pierce E. Scrannton, Jr., Playing Hurt: Treating and Evaluating the Injured Player (2012). So Philly Could Put Him On IR, Deadspin (November 12, 2014, 3:07 PM), www.deadspin.com/so-philadelphia-could-put-him-on-injured-reserve-1570721339 (listing all players to have ever been on an NFL roster for at least three games in at least three seasons).

### Endnotes

1. CBA, Art. 25.
2. See 2011 CBA, Art. 33, § 1 (discussing practice squad limits and also permitting the clubs to change limits from season to season).
3. See 2012 Constitution and Bylaws of the National Football League, § 17.1(A) (discussing the various lists on which players may be placed depending on their status).
4. Id.
5. During week 9 of the 2014 NFL season, the New York Giants listed 76 players on their roster: 53 players on the Active Roster; 11 players on Injured Reserve; 3 players on the Practice Squad; 1 player on the Practice Squad/Injured List; and, 1 player on Injured Reserve—Designated to Return. By contrast, the Denver Broncos only listed 67 players on their roster during week 9: 53 on the Active Roster; 3 on Injured Reserve; 10 on the Practice Squad; and, 1 on Injured Reserve—Designated to Return. There are also historical reports of clubs requesting players to fake injuries so that they can be placed on Injured Reserve and remain with the club rather than have their contract terminated. Rob Huizenga, You’re Okay, It’s Just a Bruise 141 (1994) (former Los Angeles Raiders Club doctor stating “I quickly learned that most teams would fake injuries, hiding talented but green prospects on the injured reserve list.”); Pierce E. Scrannton, Jr., Playing Hurt: Treating and Evaluating the Injured Player (2012). So Philly Could Put Him On IR, Deadspin (November 12, 2014, 3:07 PM), www.deadspin.com/so-philadelphia-could-put-him-on-injured-reserve-1570721339 (listing all players to have ever been on an NFL roster for at least three games in at least three seasons).

6. This figure was obtained from the official NFL and NFLPA playtime figures.
7. These data were derived by reviewing several NFL clubs’ rosters.
12. Id.
14. Id. The Michigan Study population only included players that had vested rights under the NFL’s Retirement Plan, meaning the players generally had been on an NFL roster for at least three games in at least three seasons.
15. Id. at 14.
16. Id.
17. Id.
18. Id.
20. Id.
21. Id.
22. Id.
23. Id.
27. Id.
30. Id.
31. This information was provided by the NFLPA.
34. Id.
35. This information was provided by the NFLPA.
36. Letter from Larry Ferazani, NFL, to authors (July 18, 2016).
37. See 45 C.F.R. § 160.103 (defining the entities required to comply with HIPAA).
39. See 2012 NFL Constitution and Bylaws, § 12.3(E).
41. NFL CBA, Art. 25, § 4.
42. NFL CBA, Art. 25, § 1.
43. See Jim Baumbach, Life After Football, Newsday (Jan. 22, 2015),
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patients’ self-reported symptoms after concussion is likely to result in
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-rules-some-players-sandbag-their-baseline-tests/, archived at http://perma.cc/94KW-SK7W. Experts nonetheless insist that the
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/nfl/information/post/_/id/160927/inside-slang-the-plain-truth-of-nfl-sideline
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independent sideline neurologist Javier Cardenas as saying: “The
[Concussion Protocol] is as good as we have today. We do our best. The
truth of the matter is, this is a two-way street. Of course, not always are
the athletes aware of their injuries. Some of them don’t recognize they
have a concussion, but when they do recognize, the truth is they have a
responsibility to their team, to themselves, to their loved ones of declar
ing that they don’t feel right. The tests are only as sensitive as they can
be. They’re imperfect.”)

Fainaru-Wada supra note 74 at 63–64 (2013); see also Fainaru-Wada
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Jonathan Fanene (CBA Nat’l Football League contract advisor engaged in negotiations for a Player Contract . . . is under an obligation to negotiate in good faith.”)


See 2011 CBA, Art. 4, § 8 (“any Club, any player and any player agent or contract advisor engaged in negotiations for a Player Contract . . . is under an obligation to negotiate in good faith.”)


Columnist Mike Freeman has also written about the challenges in having players accept changes to the game that are for their benefit. See, e.g., Mike Freeman, Two Minute Warning: How Concussions, Crime, and Controversy Could Kill the NFL (and What the League Can Do to Survive) 229 (2015) (recommending that the NFL “Keep pushing the player safety rules no matter how much the players complain.”)


See id. (listing the Clubs for which each Player Advocate is responsible).

The NFL provided us with a copy of the 2016 Training Camp presentation.


See, e.g., Quotes from NFLPA Press Conference, NFLPA (Feb. 4, 2016), https://www.nflpa.com/news/all-news/quotes-from-nflpa-sb50-press-conference, archived at https://perma.cc/ZGZK-FQ37 (quarterback Matt Hasselback: “[Y]ou felt like you were a wimp if you were honest with your team doctor, trainer or a teammate or coach if something was wrong with your head”); Mike Freeman, Two Minute Warning: How Concussions, Crime, and Controversy Could Kill the NFL (and What the League Can Do to Survive) xx, 231 (2015) (mentioning players hiding injuries). See also Mark A. Rothstein, Jessica Roberts, Tee L. Guidotti, Limiting Occupational Medical Evaluations Under the Americans with Disabilities Act and the Genetic Information Nondiscrimination Act, 41 Am. J. L. & Med. 523, 531 (2015) (“In general, employees are reluctant to disclose health information that might result in a limitation on their ability to work.”)

See Rothstein, supra n. 125 (“When employees fail to disclose symptoms or other pertinent medical information, it may impede the physician’s ability to make an accurate assessment of the individual’s risk or fitness for duty.”)

See 2011 CBA, Art. 44 (discussing the Injury Grievance process).

Tom Delbanco et al., Inviting Patients to Read Their Doctors’ Notes: A Quasi-experimental Study and a Look Ahead, Annals of Internal Med. 461 (2012).

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Part 2: **The Medical Team**
Part 2 concerns the various medical professionals who provide healthcare to the players in assorted contexts and circumstances: club doctors; athletic trainers; second opinion doctors; neutral doctors; and, personal doctors. As the players’ healthcare providers, these stakeholders’ actions are crucial components of player health. Some of these stakeholders reside within the club, others within the League, and still others operate outside those systems. But all must work closely with the player if player health is to be protected and promoted to the greatest extent possible.

We acknowledge that there are healthcare professionals other than those discussed in this Part who work with NFL players, including but not limited to physical therapists, massage therapists, chiropractors, dentists, nutritionists, and psychologists. Importantly, each of these groups of professionals has their own set of legal and ethical obligations governing their relationships with players. While a healthcare professional from any one of these groups might play an important role in a player’s health, it is our understanding that their roles are not so systematic and continuous to require in-depth personalized discussion, i.e., they are typically not as enmeshed within the culture of the NFL club to generate some of the concerns that are discussed in this Part. Moreover, the obligations of and recommendations toward these professionals are substantially covered by other Chapters of this Report. To the extent any of these healthcare professionals are employed or retained by the Club, Chapter 2: Club Doctors and Chapter 3: Athletic Trainers are of particular relevance. To the extent any of these healthcare professionals are retained and consulted with by players themselves, then Chapter 6: Personal Doctors is relevant.

Finally, we remind the reader that while we have tried to make the Chapters accessible for standalone reading, certain background or relevant information may be contained in other parts or chapters, specifically Part 1 discussing Players and Part 3 discussing the NFL and NFLPA. Thus, we encourage the reader to review other parts as needed for important context.
Club doctors are clearly an important stakeholder in player health. They diagnose and treat players for a variety of ailments, while making recommendations to players concerning those ailments. At the same time, the doctor has obligations to the club, particularly to advise it about the health status of players. While players and clubs often share an interest in player health — both want players to be healthy so they can play at peak performance — as we discuss in this chapter there are several areas where their interests are in conflict. In these areas, the intersection of the club doctors’ different obligations creates significant legal and ethical quandaries that may threaten player health. Most importantly, even if club doctors are providing the best care they can to the players, the current structure of their relationship with the club creates inherent problems in the treatment relationship. It is this structural problem about which we are most concerned, as discussed below.
Before we begin our analysis, it is important to point out that throughout this chapter we emphasize that the practice of club doctors is likely heterogeneous from club to club at least to some extent. For example, some clubs may be more actively engaged with club doctors, while others may be more hands-off. Nevertheless, we were denied the opportunity to interview club doctors as part of this Report to gain a better understanding of their work. In November 2014, we notified the NFL that we intended to seek interviews with club personnel, including general managers, coaches, doctors, and athletic trainers. The NFL subsequently advised us that it was “unable to consent to the interviews” on the grounds that “the information sought could directly impact several lawsuits currently pending against the league.” Without the consent of the NFL, we did not believe that the interviews would be successful and thus did not pursue the interviews at that time; instead, we have provided these stakeholders the opportunity to review draft chapters of the Report. We again requested to interview club personnel in July 2016 but the NFL did not respond to that request. The NFL was otherwise cooperative. It reviewed the Report and facilitated its review by club doctors and athletic trainers. The NFL also provided information relevant to this Report, including copies of the NFL’s Medical Sponsorship Policy (discussed in Chapter 2: Club Doctors) and other information about the relationships between clubs and doctors.

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

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

( A ) Background

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

- **Club Physicians:** Clubs must retain a board certified orthopedic surgeon and at least one physician board certified in internal medicine, family medicine, or emergency medicine. All physicians hired after execution of the 2011 CBA must also have a Certificate of Added Qualification in Sports Medicine. In addition, clubs are required to retain consultants in the neurological, cardiovascular, nutritional, and, neuropsychological fields.1

- **Physicians at Games:** “All home teams shall retain at least one [Rapid Sequence Intubation] RSI physician who is board certified in emergency medicine, anesthesia, pulmonary medicine, or thoracic surgery, and who has documented competence in RSI intubations in the past twelve months. This physician shall be the neutral physician dedicated to game-day medical intervention for on-field or locker room catastrophic emergencies.”2

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

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

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

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1 The CBA does not define “retain” or otherwise dictate the requisite scope of involvement by the various doctors.
and to provide direction and support for the athletic trainers in charge of the care for these athletes.3 Approximately 175 doctors work with the 32 NFL clubs,4 an average of 5.5 per club. The NFLPS holds annual meetings at the NFL Combine to discuss medical and scientific issues pertinent to its membership.5

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

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

In most of the contracts, the club doctor reports to the club’s general manager, who would have the authority to terminate the doctor.8 The NFL does not have any policies that pertain to supervisory control of medical personnel by coaches or club personnel.9 According to the NFL, there are no clubs in which the club doctor is supervised by the head coach.10 Without being able to independently verify the NFL’s claim, we nonetheless point out that there is no explicit prohibition against a coach having supervisory authority over a club doctor.

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

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

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

![Diagram showing the current structure of club medical staff](image)

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1) THE NFL’S MEDICAL SPONSORSHIP POLICY

The NFL first instituted the Medical Sponsorship Policy in 2004. It prohibited clubs from entering into agreements “under which hospitals, medical facilities or physician groups were designated as club sponsors” and obtained the right to provide various types of medical care to the club’s players and other employees. Although acknowledging that such arrangements had “economic” benefits to the clubs, NFL Commissioner Paul Tagliabue determined it was best to prohibit them in light of “questions raised by players and the NFLPA,” “criticism in both the lay and medical communities,” and reference to them by “plaintiffs’ attorneys in medical malpractice cases.” Additionally, Commissioner Tagliabue noted that such arrangements had resulted in an increase in players obtaining second opinions, “which, because they are paid for by the clubs, erodes the economic benefit to the sponsorship agreements.”

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

The 2004 Medical Sponsorship Policy explicitly permitted clubs to continue to enter into sponsorship agreements with healthcare providers, provided the agreements did not involve the healthcare provider delivering medical services to the club. For example, a hospital could enter into an agreement with the club to advertise itself as the “Official Hospital of [club]” provided that very same agreement did not also call for the hospital to provide medical services to the club. The hospital could have, however, entered into a separate agreement to provide medical services to the club wholly apart from the sponsorship agreement. Last, under the 2004 Medical Sponsorship Policy, clubs were required to submit a copy of any proposed sponsorship agreement with a healthcare provider to the NFL for approval before execution.

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

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

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

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

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b The 2004 Medical Sponsorship Policy did not define “sponsors.”
c Pierce E. Scranton, Jr., Playing Hurt: Treating and Evaluating the Warriors of the NFL 154 (2001) (“Does any Titans player wonder why he is so strongly encouraged to get his operation at Baptist?”).
At its core, the Medical Sponsorship Policy permits clubs to enter into a Sponsorship Agreement with an MSP, but prohibits such agreements that also include the provision of medical services. Stated another way, “[n]o Club may enter into a contract for the provision of medical services to its players that is interdependent with, or in any way tied to a Sponsorship Agreement with a [MSP].” The Medical Sponsorship Policy does not define “interdependent” and instead the NFL reviews the arrangements to ensure there is no interdependence.26

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

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

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

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

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

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

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

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

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.

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

The National Basketball Association (NBA) only prohibits sponsorship arrangements where the selection of healthcare providers is “based primarily on a sponsorship relationship.”

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

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

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d In reviewing this Report, the National Athletic Trainers Association stated that “[p]hysician practices paying clubs to serve as team physicians may result in significant conflicts of interest (COI) in the care of the NFL athlete. Health care should be based on best practices.”
### Table 2-B: Arrangements Permitted by Medical Sponsorship Policy

<table>
<thead>
<tr>
<th>Description</th>
<th>Explanation</th>
<th>Potential Concerns with Practices Still Permitted</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agreement with MSP to pay the club to provide medical services to club on a non-exclusive basis.</td>
<td>Policy does not prohibit MSPs from paying the right to provide medical services.</td>
<td>Club might choose MSP that is willing to pay the most rather than the best MSP.</td>
</tr>
<tr>
<td>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.</td>
<td>Policy does not prohibit MSPs from discounting the costs of their services for the right to provide medical services.</td>
<td>Club might choose MSP willing to charge lowest rates rather than the best MSP.</td>
</tr>
<tr>
<td>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.</td>
<td>Policy expressly permits agreements that permit MSPs to call themselves the “official” doctor or healthcare provider.</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>Policy permits MSPs and clubs to enter into medical services and Sponsorship Agreements so long as they are not “interdependent.”</td>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
<td>Policy expressly permits Sponsorship Agreements with MSPs “so long as these agreements do not involve the provision of medical service to players.”</td>
<td>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.</td>
</tr>
</tbody>
</table>

### B) Introduction to Current Legal Obligations and Ethical Codes

At the outset it is important to restate and clarify the obvious. Club doctors provide care to players while also having some type of contractual or employment relationship with, and thus obligations to, the club. Indeed, club doctors’ principal responsibilities are: (1) providing healthcare to the players; (2) helping players determine when they are ready to return to play; (3) helping clubs determine when players are ready to return to play; (4) examining players the club is considering employing, *e.g.*, at the NFL Combine or as part of free agency; and, (5) helping clubs to determine whether a player’s contract should be terminated because of the player’s physical condition, *e.g.*, whether an injury will prevent the player from playing.32

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

Although it is common to use the word “patient” to describe the player in both of these situations, there are important differences between the Services to Player versus Services to Club setting. The essence of the doctor-patient relationship is the undertaking by a physician to diagnose and/or treat the person being diagnosed or treated with reasonable professional skill. Thus, the doctor-patient relationship is established when the physician undertakes to diagnose, treat, or advise the patient as to a course of treatment. Generally, this is established by mutual consent and can be based on an express or implied contract. However, in the Services to Club situation, there is a limited doctor-patient relationship (or none at all), which will explain the different legal and ethical obligations.

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

### Figure 2-B: The Current Responsibilities of Club Doctors

<table>
<thead>
<tr>
<th></th>
<th>Providing healthcare to the players.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Helping players determine when they are ready to return to play.</td>
</tr>
<tr>
<td>3</td>
<td>Helping clubs determine when players are ready to return to play.</td>
</tr>
<tr>
<td>4</td>
<td>Examining players the club is considering employing, e.g., at the NFL Combine or as part of free agency.</td>
</tr>
<tr>
<td>5</td>
<td>Helping clubs to determine whether a player’s contract should be terminated because of the player’s physical condition, e.g., whether an injury will prevent the player from playing.</td>
</tr>
</tbody>
</table>
Below, we discuss the sources of current legal obligations and current ethical codes and then apply those obligations and codes to both the Services to Player and Services to Club settings. Finally, we conclude this section by discussing some additional ethical considerations.

1) SOURCES OF CURRENT LEGAL OBLIGATIONS

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

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

In determining whether professional misconduct occurred, the medical boards often consult relevant statutes and regulations, as well as codes of medical ethics.

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

2) SOURCES OF CURRENT ETHICAL CODES

There are a wide variety of ethical codes relevant to club doctors, the most prominent of which is the American Medical Association (AMA) Code of Medical Ethics (AMA Code). The AMA is a voluntary organization for doctors with a mission “[t]o promote the art and science of medicine and the betterment of public health.” As a voluntary organization not all doctors are members of the AMA but the AMA Code nonetheless is still very influential. The legal significance of the AMA Code is discussed in Section G: Enforcement.

In addition, NFL clubs retain in some form a wide range of doctors, including but not limited to orthopedists, internists, family medicine specialists, emergency medicine specialists, neurologists, neurosurgeons, cardiologists, and psychologists. Each of these specialties generally has its own professional societies and organizations that might also have ethical codes or practice guidelines relevant to the specialty and thus also to NFL players. In particular, in 2013, the American Academy of Neurology issued guidelines for the evaluation and management of concussions in sports. Similarly, there are also codes of ethics specific to doctors working in occupational settings. For example, the American College of Occupational and Environmental Medicine (ACOEM) has a Code of Ethics as does the International College of Occupational and Environmental Medicine (ACOEM) has a Code of Ethics as does the International Commission on Occupational Health.

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

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f The legal obligations described herein are not an exhaustive list but are those we believe are most relevant to player health.
g Common law refers to “[t]he body of law derived from judicial decisions, rather than from statutes or constitutions.” Black’s Law Dictionary (9th ed. 2009).
in the *Team Physician Consensus Statement* published collectively by the American College of Sports Medicine, American Academy of Family Physicians, American Academy of Orthopaedic Surgeons, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and the American Osteopathic Academy of Sports Medicine.⁵³

The NFLPS confirmed during its review of a draft of this chapter that it does not have a Code of Ethics.¹

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

## C. Current Legal Obligations and Ethical Codes When Providing Services to Player

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

### 1) MEDICAL CARE

#### a) Current Legal Obligations

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

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

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

By virtue of the self-regulatory system, doctors’ statutory obligations concerning medical care are effectively the same as their common law obligations: not to commit professional misconduct as judged by the state medical board. The CBA also speaks to its conception of the club doctor’s standard of care:

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

¹ By contrast, the Professional Football Athletic Trainers Society (PFATS), the professional organization for NFL club athletic trainers, does have a Code of Ethics.
This CBA provision is susceptible to multiple interpretations. On a generous reading (i.e., one that does not give the italicized language any special emphasis), club doctors’ primary duty is to the player at all times. On a less generous reading, the CBA provision demands a primary duty to the player-patient only in situations where the club doctor is “providing medical care,” and thus is inapplicable when the club doctor is rendering services to the club. Importantly, however, the way club doctors are currently situated within the club precludes the two roles from being truly separated, and thereby precludes club doctors from having their exclusive duty be to the players. This is because at the same time that the club doctor is providing care to the player, he is simultaneously performing duties for the club by judging the player’s ability to play and help the club win.

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

Relatedly, the CBA provision also seems to require that the care relationship between players and club doctors be afforded “traditional” confidentiality protections. However, clubs request or require players to execute collectively bargained waivers, effectively waiving this requirement, and players we interviewed indicated that no player refuses to sign the waiver. A copy of this waiver is included as Appendix L. The circumstances under which these waivers are executed is an area worthy of additional attention. For example, questions might be raised as to whether the players are providing meaningful and voluntary informed consent in their execution. Players are being compelled to waive certain legal rights concerning their health without meaningful options. There is no doubt that players execute the waivers because they fear that if they do not, they will lose their job. Indeed, the waivers (which are collectively bargained between the NFL and NFLPA) permit the athletic trainer and club doctors to disclose the player’s medical information to club employees, such as coaches and the general manager. Thus, it is unclear what work this CBA language is doing. Of course, given this communication, it is inevitable that players will be less than forthcoming about their medical needs, lest it negatively affect their career prospects.

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

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

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

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k Current Player 5: “[O]ur first day back in camp, we sign a ton of stuff. I believe one of them is medical release form that allows our team doctors to discuss medical conditions with team officials . . . . I’ve seen some guys question some of the documents we have to sign but when you’re given a stack of papers and it’s you sign this and you play football or you don’t sign it and you don’t, everybody signs it. I don’t know anybody who hasn’t.”
The primary professional duty of all individual health care professionals, such as team physicians, certified athletic trainers/therapists ("ATs"), physical therapists, chiropractors, dentists and neuropsychologists, shall be to the Player-patient regardless of the fact that he/she or his/her hospital, clinic, or medical group is retained by such Club to diagnose and treat Players. In addition, all team physicians who are examining and evaluating a Player pursuant to the Pre-Participation Medical Evaluation (either pre-season and/or in-season), the annual exit examination, or who are making a determination regarding a Player’s fitness or unfitness to play during the season or otherwise, shall be obligated to perform complete and objective examinations and evaluations and shall do so on behalf of the Club, subject to all professional and legal obligations vis-a-vis the Player-patient.62 (Emphasis added.)

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

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

b) Current Ethical Codes

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

(a) Keeping current with best care practices and maintaining professional competence.

(b) Holding themselves accountable to patients, families, and fellow health care professionals for communicating effectively and coordinating care appropriately.

(c) Monitoring the quality of care they deliver as individual practitioners — e.g., through personal case review and critical self-reflection, peer review, and use of other quality improvement tools.

(d) Demonstrating a commitment to develop, implement, and disseminate appropriate, well-defined quality and performance improvement measures in their daily practice.

(e) Participating in educational, certification, and quality improvement activities that are well designed and consistent with the core values of the medical profession.65

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

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

FIMS’ Code of Ethics reiterates these concepts:

The same ethical principles that apply to the practice of medicine shall apply to sports medicine.67 Always make the health of the athlete a priority.68

Never do harm.69

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

2) DISCLOSURE AND AUTONOMY

a) Current Legal Obligations

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

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

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

The patient-based standard, in contrast, measures the physician’s duty to disclose against what a reasonable patient would find material. Information is material when “a reasonable person, in what the physician knows or should know to be the patient’s position, would be likely to attach significance to it.”75 The question of whether a physician disclosed risks that a reasonable person would find material is for the trier of fact, e.g., a jury, and technical expertise is not required.76

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

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

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

Additionally, club doctors are obligated to permit a player to examine his medical records once during the preseason and once after the regular season.80 Club doctors are also obligated to provide a copy of a player’s medical records to the player upon request in the offseason.81

b) Current Ethical Codes

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

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

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1 In 2014, the NFL instituted an electronic medical record (EMR) system, consisting of all of the athletic trainers’ and doctors’ diagnosis and treatment notations, including any sideline examinations performed on the player. The EMR system also includes a player portal that permits the player to access his medical records at any time, including after his career is over. This information was provided by the NFLPA. Thus, the CBA provision requiring that club doctors permit players to examine their medical records once during the preseason and then once after the regular season has become anachronistic.
underlies the patient-physician relationship, and physicians have an obligation to deal honestly with patients at all times, in addition to their obligation to promote patient welfare and safety. Concern regarding legal liability should not affect the physician’s honesty with the patient.\textsuperscript{81}

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

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

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

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

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

3) CONFIDENTIALITY

a) Current Legal Obligations

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

Below we discuss statutory requirements concerning the confidentiality of medical information. As will be explained in more detail below, current practices concerning the confidentiality of player medical information do not appear to violate relevant laws because of waivers executed by the players, and potentially applicable exceptions to the laws. As stated above, clubs request or require players to execute waivers permitting the player’s medical information to be disclosed to and used by a wide variety of parties, including but not limited to the NFL, any NFL club, and any club’s medical staff and personnel, such as coaches and the general manager. These waivers have been collectively bargained between the NFL and NFLPA.\textsuperscript{89} Players sign these waivers without much (if any) hesitation out of fear that behaving otherwise could cost them their job.\textsuperscript{86} Thus, one key aspect of patient confidentiality is rendered moot, at least with regard to club employees, although information must still be protected as against other third parties.

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

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

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

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

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

Club doctors provide healthcare within the meaning of HIPAA and thus must comply with its requirements.

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

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

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

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

Furthermore, despite these common law and statutory obligations, 22 states in which NFL clubs play or practice have statutes that permit healthcare providers to provide employers with an employee’s medical records and/or information. The reasons that disclosure is permitted are generally related to potential or actual workers’ compensation claims and procuring payment. However, the state laws vary as to whether a healthcare provider is permitted to disclose medical information only where a workers’ compensation claim is possible as opposed to already filed. Some states only permit disclosure after a claim has been filed.

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

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

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

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

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\(^{o}\) NFL clubs play in 22 states. Wisconsin is the only state in which an NFL club plays or practices that does not have a statute permitting healthcare providers to provide employers with an employee’s medical records and/or information.

\(^{p}\) Indeed, the waiver indicates that disclosure of the player’s medical information is “[f]or purposes relating only to my actual or potential employment in the National Football League.” See Appendix L. Nevertheless, the waiver permits the use and disclosure of medical information “relating to any injury, sickness, disease, mental health condition, physical condition, medical history, medical or clinical status, diagnosis, treatment or prognosis . . . .” Id.
transmitted diseases or mental health, is football-related and thus available to the club is still questionable.

b) Current Ethical Codes

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

**Opinion 3.1.5—Professionalism in Relationships with Media:** To safeguard patient interests when working with representatives of the media, all physicians should:

(a) Obtain consent from the patient or the patient’s authorized representative before releasing information.

(b) Release only information specifically authorized by the patient or patient’s representative or that is part of the public record.

(c) Ensure that no statement regarding diagnosis or prognosis is made except by or on behalf of the attending physician.

(d) Refer any questions regarding criminal activities or other police matters to the proper authorities.

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

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

b) Current Ethical Codes

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

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

* * *

**Opinion 11.2.2—Conflicts of Interest in Patient Care:** The primary objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may physicians place their own financial interests above the welfare of their patients . . . . Where the economic interests of the hospital, health care organization, or other entity are in conflict with patient welfare, patient welfare takes priority.

* * *

**Opinion 1.1.1—Patient-Physician Relationship:** The relationship between patient and physician is based on trust and gives rise to physicians’ ethical obligations to place patients’ welfare above the physician’s own self-interest and above obligations to others, to [use] sound medical judgment on patients’ behalf, and to advocate for their patients’ welfare.
The AMA Code also contains a sport-specific provision requiring doctors to put the athlete’s interests ahead of their own or anyone else’s:

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

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

In this capacity, physicians should:

(a) Base their judgment about an individual’s participation solely on medical considerations.

(b) Not allow the desire of spectators, promoters of the event, or even the injured individual to govern a decision about whether to remove the participant from the event.112

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

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

(a) Give precedence to their ethical obligation to act in the patient’s best interest.

(b) Exercise independent professional judgment, even if that puts the physician at odds with the employer-supervisee.113

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

- Always make the health of the athlete a priority.114

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

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

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

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

An orthopaedic surgeon shall make a reasonable effort to ensure that his or her academic institution, hospital or employer shall not enter into any contractual relationship whereby such institution
pays for the right to care for patients with musculoskeletal conditions.

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

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

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

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

1) MEDICAL CARE
a) Current Legal Obligations

Courts have generally held that doctors performing medical examinations for non-treatment purposes have a limited patient-physician relationship.122 However, it is also important to note that in the cases analyzing this issue, the doctors performing the medical examinations did not also have a simultaneous treatment relationship with the patient, whereas club doctors generally do have such a treatment relationship with current NFL players (though not at the NFL Combine, as discussed below). Thus, these court opinions do not address or adequately encompass the complexities of the club doctor-player relationship. Nevertheless, in the abstract these rulings are consistent with the AMA Code as is discussed below. In light of the limited relationship, doctors only performing medical examinations, such as those who evaluate fitness-for-play, have duties to exercise care consistent with their professional training and expertise so as not to cause physical harm by negligently conducting the examination.123

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

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

b) Current Ethical Codes

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

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

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

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

(a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.  

(b) Explain that the physician’s role in this context is to assess the patient’s health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.  

(c) Protect patients’ personal health information in keeping with professional standards of confidentiality.  

(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.  

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

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

The NFL reiterated this CBA provision in its comments, stating that “Club Physicians are required to put the player-patient’s interests first.” In other comments, the NFL proposed that players “principally rely on Club Physicians” for their care “because of the quality of the care they receive from Club Physicians[.]”  

Similarly, in a forthcoming commentary as part of a Special Report to The Hastings Center Report, the NFLPS maintained that “NFL physicians are accomplished medical professionals who abide by the highest ethical standards in providing treatment to all of their patients, including those who play in the NFL.” Given that club doctors are clearly providing care and treatment to player, and statements acknowledging that fact in other places, we find the NFL’s embrace of the ACOEM position perplexing. To be clear, we believe there is a doctor-patient relationship between club doctors and players.

2) DISCLOSURE AND AUTONOMY

a) Current Legal Obligations

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

b) Current Ethical Codes

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

(a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.  

(b) Explain that the physician’s role in this context is to assess the patient’s health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.

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

\[\text{See id., citing the ACOEM Code of Ethics. See also id. at 65–66 ("When the worker is being assessed and treated by the physician for an occupational injury, for example, a physician-patient relationship exists. When that same physician is conducting an evaluation for the employer for fitness to work . . . a physician-patient relationship does not exist, because the service is being performed in the interest of a third party.").}\]
Protecting and Promoting the Health of NFL Players

(c) Protect patients’ personal health information in keeping with professional standards of confidentiality.

(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.138

3) CONFIDENTIALITY

a) Current Legal Obligations

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

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

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

(a) With written or documented consent of the individual (or authorized surrogate); or

(b) As required by law, including workmen’s compensation law where applicable.

When disclosing information to third parties, physicians should:

(c) Restrict disclosure to the minimum necessary information for the intended purpose.

(d) Ensure that individually identifying information is removed before releasing aggregate data or statistical health information about the pertinent population.140

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

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

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

b) Current Ethical Codes

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

The ACOEM declares that while the employer is entitled to the doctor’s professional opinion as to the employee’s “fitness to perform a specific job,” the doctor “should not provide the employer with specific medical details or diagnoses unless the employee has given his or her permission.”
health professionals should recognize that employers may be entitled to counsel about an individual's medical work fitness.”

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

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

b ) Current Ethical Codes
As discussed above, AMA Code Opinion 1.2.6 potentially guides a doctor’s obligations in the Services to Club scenario. In such a situation, the doctor has the following obligations:

(a) Disclose the nature of the relationship with the employer or third party and that the physician is acting as an agent of the employer or third party before gathering health information from the patient.

(b) Explain that the physician’s role in this context is to assess the patient’s health or disability independently and objectively. The physician should further explain the differences between this practice and the traditional fiduciary role of a physician.

(c) Protect patients’ personal health information in keeping with professional standards of confidentiality.

(d) Inform the patient about important incidental findings the physician discovers during the examination. When appropriate, the physician should suggest the patient seek care from a qualified physician and, if requested, provide reasonable assistance in securing follow-up care.

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

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

* * *

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

E ) Additional Ethical Obligations
FIMS’ Code of Ethics declares that “[p]hysicians who care for athletes of all ages have an ethical obligation to understand the specific physical, mental and emotional demands of physical activity, exercise and sports training.”

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

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

Physicians’ fiduciary obligation to promote patients’ best interests and welfare can include consulting other physicians for advice in the care of the patient or referring patients to other professionals to provide care.
When physicians seek or provide consultation about a patient's care or refer a patient for health care services, including diagnostic laboratory services, they should:

(a) Base the decision or recommendation on the patient's medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.

(b) Share patients' health information in keeping with ethical guidelines on confidentiality.

(c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service . . .

* * *

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

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

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

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

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

(F.) Current Practices

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

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

As discussed in the background of this chapter, the NFL denied our request to interview club doctors as part of this Report. Without being able to interview club doctors, where possible, we have supplemented facts discussed in the books written by former club doctors with more contemporary factual accounts, including news reports, academic and professional literature, and formal and informal interviews with NFL and NFLPA representatives, many current and former players, sports medicine professionals, contract advisors, financial advisors, and player family members.

Nevertheless, the limitations discussed above are important ones and we are hopeful that we or others will be provided the necessary access and information in future work to establish a broader set of data on the experience of club doctors.

The first book, “You’re Okay, It's Just a Bruise”: A Doctor’s Sideline Secrets About Pro Football’s Most Outrageous Team, was published in 1994 by former Los Angeles Raiders club doctor Rob Huizenga. Huizenga, who was with the Raiders from 1982 to 1990, was extremely critical of the Raiders’ approach to player medical issues, with particular criticism focused on Raiders’
then-owner Al Davis and the Raiders’ then-orthopedist
and head doctor, Robert Rosenfeld. The title of the book
is something Huizenga claimed Rosenfeld once told a
Raiders player who had recently suffered a neck injury that
had resulted in temporary paralysis, a diagnosis with which
Huizenga and several other doctors disagreed.¹⁵⁴

Rosenfeld, according to Huizenga, downplayed players’
injuries and unabashedly placed the Raiders’ interests ahead
of the players’.¹⁵⁵ As Huizenga put it, “Rosenfeld lived for
the Raider job. I suspected he would do whatever it took to
keep Al Davis happy.”¹⁵³ The book in many respects is an
account of Huizenga’s self-described efforts to balance his
ethical obligations as a doctor and to the players with his
obligations to the Raiders.¹⁵⁷ Ultimately, citing the Raiders’
culture and Rosenfeld’s questionable practices, Huizenga
resigned his position in 1990.¹⁵⁸

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

Scranton also discussed his view of the club doctor’s
obligations to the club and relationship with coaches.
Scranton asserted that “[a] sports-medicine physician must
place the interests of the team above his own. He recognizes
that the team needs instant attention to injuries in order
to be successful.”¹⁶¹ Moreover, Scranton had a close
relationship with and operated on Seahawks head coach
Tom Flores.⁷ Nevertheless, Scranton lamented the control
coaches had over player medical issues, explaining that
coaches would try to exclude doctors from team activities
and make decisions about whether players were medically
cleared to play.” Scranton further claimed that coaches
would direct players not to consult the athletic trainers or
doctors during the game, because “they’ll take you out of
the game.”¹⁶²

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

1) SELECTION AND PAYMENT OF
CLUB DOCTORS

Each NFL club’s medical staff is chosen by the club’s execu-
tives.¹⁶³ Club doctors are affiliated with a wide variety of
private practice groups, hospitals, academic institutions,
and other professional sports leagues. Some of these institu-
tions 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 Synerget, a third-party vendor jointly selected by the
NFL and NFLPA.¹⁶⁴ Synerget provides reports on these
matters to both the NFL and NFLPA.¹⁶⁵ Additionally, of
the NFL’s 32 head club doctors, 2 are employees and 30 are
independent contractors.¹⁶⁶

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

It is difficult to ascertain actual figures and practices of club
doctorn Compensation. 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).x In reviewing a draft of this Report, the NFL stated that this
estimate “grossly underestimates compensation to Head
Team Physicians, Head Team Orthopedists and Head Team
Internists.” Nevertheless, the NFL did not provide alter-
native compensation figures.

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

x In 2001, the Minnesota Vikings paid their three club doctors $4,000, $19,600 and
$47,500 per year, respectively. The amounts varied based on the extent of the
doctors’ obligations. See Memorandum and Order, Stringer v. Minn. Vikings Football

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

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

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

2) THE NFL COMBINE AND DRAFT

Before reaching the preseason or regular season, club
doctors attend the NFL Scouting Combine (Combine).
The Combine is an annual event each February in which
approximately 300 of the best college football players
undergo medical examinations, intelligence tests, interviews
and multiple football and other athletic drills and tests. NFL club executives, coaches, scouts, doctors and athletic
trainers attend the Combine to evaluate the players for the
upcoming NFL Draft (usually in April). The Combine
began in the early 1980s and has been held in Indianapolis
since 1987.

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

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

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

y It is possible that the NFL avoids direct control of the NFL Combine to avoid having
to comply with the Americans with Disabilities Act (ADA). The ADA prohibits pre-emp-
ployment medical examinations to determine whether a prospective employee has a
any “physical or mental impairment that substantially limits one or more major life
activities,” 42 U.S.C. § 12102(1). This definition of disability could arguably include
any prior injury by a prospective NFL player and thus the medical examinations at
the NFL Combine are potentially pre-employment medical examinations which are
barred by the ADA. For more on this and related issues, see our law review article,
Evaluating NFL Player Health and Performance: Legal and Ethical Issues, U. Penn. L.
Polian said that “the one and only reason for the combine is the medical tests.”176 A battery of medical tests are initially performed by doctors affiliated with IU Health,177 a healthcare system affiliated with Indiana University School of Medicine.178 IU Health doctors have been working at the Combine since it moved to Indianapolis in 1987.179 The IU Health doctors perform X-rays and more than 350 magnetic resonance imaging (MRI) diagnostic tests each year.180,2

After the tests are performed by IU Health doctors, “examinations are conducted by the physicians in the NFL Physicians Society.”181 The NFL explained that “Club medical teams each perform one element of a comprehensive evaluation and share their findings with all other clubs. In other words, a combine attendee undergoes one comprehensive examination (performed by different practitioners), not 32 comprehensive examinations.”182 According to the NFLPS, the role of the club doctor at the Combine “is to obtain a comprehensive medical and orthopaedic assessment of every player that is going to be part of the NFL Draft.”183 Also according to the NFLPS, “the team physicians along with their athletic training staff assess every player who is going to be available for the NFL Draft and provide a report back to the scouting department, the head coach, the general manager and the front office about the medical condition of each player. This information becomes very important in a team’s assessment of whether or not a player will be drafted.”184 These examinations might create concerns for club doctors, as discussed below. In particular, the nature and purpose of the doctor’s role might not be clear to the player being examined.2

Former Seahawks club doctor Pierce Scranton discussed the Combine at length in his book. Scranton attended the Combine on behalf of the Seahawks each year to perform medical examinations on prospective NFL players. According to Scranton, “each team relies heavily on doctors in determining that its high picks are healthy and capable of contributing to the team and dominating on the field.”185 Scranton’s description comports with former Los Angeles Raiders club doctor Rob Huizenga’s, who described the Combine examinations as “[d]etective medicine.”186 All indications are that club doctors’ responsibilities at the Combine have not changed since the period described by Scranton and Huizenga.

Scranton expressed misgivings about the Combine. He believed these examinations presented a “moral quandary” for the club doctors on whether to tell a player about medical problems he may have.187 While Scranton felt a “responsibility to protect that athlete’s health and welfare,”188 he believed that his primary responsibility was to make sure players with relatively poor injury histories or medical conditions are not drafted by the Seahawks.2b It is uncertain whether Scranton’s feelings are consistent with those of today’s club doctors. Ultimately, Scranton said he found the “examinations . . . more dehumanizing than interesting.”189

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ae See id. at 39–40 (discussing ‘Buyer-Beware’ Players, including a linebacker that was “[a]n 11-year veteran who is always in the training room,” a punter with “chronic back spasms [and who is] [a]lways in the training room,” and another linebacker who is “[a]lways on injured reserve or on an airplane for a second opinion.”).
4) **GAME DAY DUTIES**

Game days include a wide variety of medical professionals. Each club generally has four athletic trainers, two orthopedists, two primary care physicians and one chiropractor present.\(^{201}\) In addition, pursuant to the Concussion Protocol (see Appendix A), each club is designated an Unaffiliated Neurotrauma Consultant to assess possible concussions.\(^{46}\) In addition, there are a variety of medical professionals available to both clubs, including one independent athletic trainer who views the game from the press box to spot possible injuries (the “spotter”),\(^{\text{ah}}\) an ophthalmologist, a dentist, a radiology technician to handle the stadium’s X-ray machine, an airway management physician, and an emergency medical technician (EMT)/paramedic crew.\(^{\text{ag}}\) The Concussion Protocol does not explain how the Unaffiliated Neurotrauma Consultant is chosen, but requires that the consultant “be a physician who is impartial and independent from any Club, is board certified or board eligible in neurology, neurological surgery, emergency medicine, physical medicine and rehabilitation physician, or any primary care CAQ sports medicine certified physician and has documented competence and experience in the treatment of acute head injuries.” The Unaffiliated Neurotrauma Consultant also prepares a report after each game detailing any examinations performed.

<table>
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<tr>
<th>Table 2-C: Game Day Medical Staff</th>
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<tr>
<td><strong>For Both Clubs</strong></td>
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<tr>
<td>Neurotrauma Consultants (2)</td>
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<tr>
<td>EMTs (2)</td>
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<tr>
<td>Athletic Trainer (1)</td>
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<td>Ophthalmologist (1)</td>
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<td>Dentist (1)</td>
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<td>Radiology Technician (1)</td>
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<td>Airway Management Physician (1)</td>
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In or about 2013, the NFL instituted a new policy requiring the club’s head doctor to meet with the head referee prior to each game so that the referee knows for whom to look and with whom to talk in the event of a major injury.\(^{207}\)

The Concussion Protocol requires that the player undergo a Sideline Concussion Assessment, including the Standardized Concussion Assessment Tool (SCAT3), which consists of a series of scored symptom, cognitive, and physical assessments by the club doctor, with the potential assistance of the unaffiliated neurotrauma consultant assigned to the game.\(^{a1}\) The player’s score on the SCAT3 is then compared to his SCAT3 scores from a preseason baseline examination. Coupled with the doctors’ other professional total, an NFL game generally involves 27 medical personnel on site.\(^{202}\)

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

If the player has suffered a possible concussion in a game,\(^{a1}\) he must go through the Concussion Protocol (see Appendix A) to determine if he can return to play. Generally, the Concussion Protocol requires that the player undergo a Sideline Concussion Assessment, including the Standardized Concussion Assessment Tool (SCAT3), which consists of a series of scored symptom, cognitive, and physical assessments by the club doctor, with the potential assistance of the unaffiliated neurotrauma consultant assigned to the game.\(^{a1}\) The player’s score on the SCAT3 is then compared to his SCAT3 scores from a preseason baseline examination. Coupled with the doctors’ other professional

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\(^{a1}\) The Concussion Protocol includes a list of observable signs or player-reported symptoms that might indicate a player has suffered a concussion. See Appendix A.  
\(^{a}\) The Concussion Protocol is unclear as to whether the unaffiliated neurotrauma consultant must be consulted when a Club doctor is examining a player for a potential concussion.
judgments, a determination is then made as to whether the player has in fact suffered a concussion. If the player has suffered a concussion, he cannot return to the game. The Concussion Protocol declares that “[t]he responsibility for the diagnosis of concussion and the decision to return a player to a game remains exclusively within the professional judgment of the Head Team Physician or the Team physician assigned to managing TBI.” According to the NFL, there have never been any problems or disagreements between club doctors and the unaffiliated neurotrauma consultants.210

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

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

5) RELATIONSHIPS WITH COACHES AND CLUB EXECUTIVES

Based on conversations with sports medicine professionals it is our understanding that there is much variance in the relationships between club doctors and coaches. In general, most medical information concerning a player is passed from the club doctor to the coaching staff through the athletic trainer. Athletic trainers are employees of the club and spend nearly every waking hour with the club. Thus, many club doctors might only meet with the head coach once a week to discuss the health status of players.214 Nevertheless, there are still concerns that some club doctors have much closer relationships with, and sometimes can be pressured by, the coaching staff.

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

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

Because the visiting club’s doctor is often not licensed to practice in the state in which the club is playing, the home club’s doctor is responsible for the visiting player’s care.
during the preseason but otherwise are unlikely to communicate with club executives during the season.

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

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

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

6) RELATIONSHIPS WITH PLAYERS

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

Among the players and contract advisors we interviewed, there was a general consensus that the care provided by club doctors has gradually improved in recent years. Current Player 3 said that “team doctors for the most part . . . do a good job.” Current Players 7, 8 and 10 also thought their club doctors provide good care. As one contract advisor stated, “I think that team doctors more than ever are understanding that they’re an advocate for the player more than they are an advocate for the team.” Another contract advisor explained one reason why he believes the care has improved: “It seems to me that because of the high level of scrutiny involved in the concussion melodrama and drama that’s occurred over the past years that there is now some sense . . . on the part of the trainers and the medical staff, there is extreme pressure on them to not mess it up.” Other people we interviewed confirmed that increased scrutiny about these issues, including from the NFLPA, has likely led club doctors to be more careful about their practices.

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

We also interviewed several former and current players to get a better understanding about NFL player health issues.218 It is important to note that that these interviews were intended to be illustrative but certainly not representative of all players’ views and should be read with that limitation in mind. The players we spoke to generally indicated that the current structure of club medical staff often caused players to distrust club doctors, although this feeling is not universal:

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

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

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

ap It is worth noting that Current Player 1 had only two years of experience in the NFL, and several other current players explained that players become wiser, and thus less trusting, as they get older. Nevertheless, Current Player 10 had played 10 seasons in the NFL and believed he received good care from the club doctors: “[G]enerally, I think I’d go with team doctors if I’m going to do certain surgeries.”
of Can you push through that pain? I think sometimes they want to see those types
it's not going to get any worse if you play. You just have to deal with the pain.
they want to see if you can push through certain pain if the doctor feels like, okay,
Current Player 3 also stated as follows: “Sometimes they want you out there and
things.”
field
good positive vibes from the doctors that have been out on the
“I’ve al
“I’ve seen times when the medical staff
look good.
the team’s interest in mind first before the player’s, but I never
In addition, comments from Calvin Johnson, a perennial
Pro Bowl wide receiver who retired in 2016 after nine sea-
sions, are also informative:
The team doctor, the team trainers, they work
for the team. And I love them, you know. . . .
They’re some good people. They want to see you
do good. But at the same time, they work for the
team. They’re trying to do whatever they can to
get you back on the field and make your team
look good.
On this point, Contract Advisor 4 even stated that when
assessing a player’s injury, “the club doctor has nothing
to do with it . . . the club doctor’s input means nothing
to us.” Moreover, players seem to be increasingly aware
of the potential conflicts of interest club doctors face in
treating players. For example, many question whether
club doctors are telling players everything they are telling
coaches or other club employees, despite an obligation to
do so in the CBA. In addition, players are aware of the
value club doctors receive in being associated with the club;
as one former player said, “I know they can go out making
tremendous amounts of money . . . having that team name
next to their practice.”

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

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**Current Player 2:** “I certainly think that there are a number
of players that do not trust club doctors, and for various
reasons. They feel as though those doctors work for the team
and they do what’s in the best interests of (A) the coach, and
(B), ownership. And I think that a lot of times players feel as
though these doctors maybe don’t disclose the full extent
of their injuries [and] give them a hard time about getting
second opinions.”

**Current Player 3:** “I think that there are some instances
where they don’t trust the team doctors because they don’t
like the team, and the team doctor just wants them to get
back on the field . . . . I think sometimes the doctors may . . .
not tell you the full extent of what’s going on . . . about a
certain injury. [But] I think there is sometimes team doctors
where the players trust them and the doctors are great and
very trustworthy.”

**Current Player 4:** “I do not trust team doctors. I’ve had
multiple occasions where I’ve had a team doctor tell me one
thing and then I go and have a second opinion and I get a
completely different answer . . . . [T]he club doctor has the
same mentality as the club itself. More than anything, they
want a player on the field . . . . I feel like the team doctor only
has the best interest of the team in mind and not necessarily
the player.”

**Current Player 5:** “My trust level with [my former club doctor]
was very high. I know a lot of guys respected him. But I know
there was a number of guys that had disagreements with
him . . . . But I think generally the guys that have a problem
with the doctors are guys that have had some sort of injury
that affects their career and their ability to make money and
support themselves and their families.”

**Current Player 7:** “[T]hey’re doing and saying what’s best to
get you back on the field as soon as possible.”

**Current Player 8:** “I don’t feel like they are diagnosing, or
at least treating us like they would want to be treated or
how they would treat their kids . . . . [T]hey’re going to lean
towards what keeps you on the field.”

**Current Player 9:** “I’ve seen times when the medical staff
has lied about injuries.”

**Current Player 10:** “I’ve always had good relationships and
good positive vibes from the doctors that have been out on the
field . . . . I think players trust them, I think the agents don’t.”

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**Former Player 2:** “[T]hese doctors are good. I wouldn’t say
they are great. You know, at the end of the day . . . the orga-
nizations are paying the doctors . . . . I would say probably 65
percent of the team trusts the doctor and probably 35 percent
of the team does not.”

**Former Player 3:** “My experience has always been very
positive . . . . I know that players are told, or maybe just a little
bit skeptical or suspicious of docs, thinking that they have the
team’s interest in mind first before the player’s, but I never
had an experience where I thought that was the case.”

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

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

**Contract Advisor 5:** “[T]he younger generation of players absolutely, unequivocally
do not trust [the club doctors].”

**Contract Advisor 6** similarly described the level of
trust between players and club doctors as “close to zero.”
same time, Brandt indicated his belief that this was not the case with at least some NFL clubs.\textsuperscript{220}

Several players told us that players often hide injuries from club medical staff.\textsuperscript{221} They told us that players generally believe that there is no confidentiality between them and the medical staff and that the medical staff would regularly, if not immediately, inform coaches and executives about the injury status of players, which has the potential of negatively affecting the player’s status with the club. Former Player 1:

\begin{quote}
(C)ertainly not like a modern doctor-patient relationship where confidentiality is expected. That’s never going to happen . . . . Ultimately, they had to do their jobs and they had to disclose everything to the higher ups and to the decision makers . . . they’re writing down every single little thing that you do and what happened, everything that you tell him. The first thing they’re doing is sending that email or making the phone call up to the top and telling him what’s going on with this guy and there’s no doubt about what their motives and their intentions are, and I know a lot of it is job security and it’s just part of the business, but, and you know at the end of the day, regardless of how they came across, they were all pretty much doing the same thing, just some went about it in maybe a better fashion.\textsuperscript{222}
\end{quote}

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

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

Some players expressed more concerns about athletic trainers’ practices as compared to club doctors.\textsuperscript{224} Athletic trainers spend significantly more time with players and are directly employed by the club, whereas club doctors are generally independent contractors. One current player described multiple incidents in which an athletic trainer did not disclose a player’s actual diagnosis (in one case a fracture and a torn ligament in another), only to have the diagnosis revealed later by the club doctor.\textsuperscript{225} The same player also indicated that he believes athletic trainers are pressured by the club and coaches to have players on the field.

\textbf{(G) Enforcement of Legal and Ethical Obligations\textsuperscript{ay}}

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

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

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

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

\begin{itemize}
\item \textsuperscript{ax} The same player complained that the athletic training staff uses outdated treatment methods, effectively using ice and electrical stimulation regardless of the injury. The player indicated that, as a result, players are less likely to report injuries so they do not have to report to practice early to undergo a minimally effective treatment they could perform at home.
\item \textsuperscript{ay} Appendix K is a summary of players’ options to enforce legal and ethical obligations against the stakeholders discussed in this Report. In addition, for rights articulated under either the CBA or other NFL policy, the NFLPA and the NFL can also seek to enforce them on players’ behalves.
\end{itemize}
chosen by the NFLPA.224 “The NFLPA shall have the right to commence an investigation before the Joint Committee if the NFLPA believes that the medical care of a team is not adequately taking care of player safety. Within 60 days of the initiation of an investigation, two or more neutral physicians will be selected to investigate and report to the Joint Committee on the situation. The neutral physicians shall issue a written report within 60 days of their selection, and their recommendations as to what steps shall be taken to address and correct any issues shall be acted upon by the Joint Committee.”225

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

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

As a third remedial option, a player could commence a Non-Injury Grievance.228 The 2011 CBA directs certain disputes to designated arbitration mechanisms229 and directs the remainder of any disputes involving the CBA, a player contract, NFL rules, or generally the terms and conditions of employment to the Non-Injury Grievance arbitration process.228 Importantly, Non-Injury Grievances provide players with the benefit of a neutral arbitration and the possibility of a “money award.”229 It is worth emphasizing that in theory a player could bring a Non-Injury Grievance alleging the doctor violated ethical rules. Section 1(c) of Article 39 of the 2011 CBA requires all club medical personnel to “comply with all federal, state, and local requirements, including all ethical rules and standards established by any applicable government and/or authority that regulates or governs the medical profession in the Club’s city.” And Section 1 of Article 43 permits players to bring Non-Injury Grievances concerning any provision of the CBA. Thus, if a club doctor were to violate an ethical rule, he would also be violating Article 39, Section 1(c). Which ethical rules apply has never been litigated and would likely have to be determined by the arbitrator.

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

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

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

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

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

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

226 University of Pennsylvania Law School Professor Stephen B. Burbank.

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

Fourth, it is possible that under the 2011 CBA, the NFL could argue that complaints concerning medical care are designated elsewhere in the CBA and thus should not be heard by the Non-Injury Grievance arbitrator. And as a fifth limitation to Non-Injury Grievances, in practice, pursuing a grievance against a club doctor would likely end the player’s career with that club, and potentially his career altogether.

As a fourth remedial option, and one outside of the CBA process, players can attempt to bring civil lawsuits against NFL club doctors, principally asserting medical malpractice. However, the viability of such claims principally depends on the relationship between the club and the doctor. As discussed above, claims against doctors that are employees of the club are likely to be barred by workers’ compensation statutes. By contrast, for suits against the majority of club doctors who are independent contractors, the CBA potentially presents the biggest obstacle against any medical malpractice claims. This is because the Labor Management Relations Act (LMRA) bars or “preempts” state common law claims, such as negligence, where the claim is “substantially dependent upon analysis of the terms” of a CBA, i.e., where the claim is “inextricably intertwined with consideration of the terms of the” CBA. In order to assess a club doctor’s duty to an NFL player—an essential element of a negligence claim such as medical malpractice—the court may have to refer to and analyze the terms of the CBA, e.g., the club doctors’ obligation, resulting in the claim’s preemption.

In these cases, player complaints must be resolved through the enforcement provisions provided by the CBA itself (i.e., a Non-Injury Grievance against the club), rather than litigation. Thus, preemption may be a problem, although the matter is not crystal clear.

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

Research revealed 13 fully adjudicated cases brought by NFL players (or their kin) against NFL club doctors, discussed in more detail in Appendix H. All of these cases were filed prior to the 2011 CBA which at least partially explains why the claims were not preempted. Nine of these cases resulted either in settlements or jury verdicts in the player’s favor, with several recoveries exceeding $1 million. In two cases, the claims were dismissed on the ground that the doctor was an employee of the club and workers’ compensation laws bar claims against co-employees. Both categories include the Stringer case, in which claims against one doctor were settled while claims against two other doctors were dismissed. Finally, in one case, the doctor was found to have been not negligent, and, in another, a jury verdict was overturned by the judge.
The revisions to the 2011 CBA, and the new Article 39 in particular, increase the likelihood that medical malpractice actions against club doctors will now be held to be preempted. As discussed throughout this chapter, the 2011 CBA is fairly detailed in terms of club doctors’ obligations to players, including an outlined standard of care. It is thus at least plausible that a court would find that analyzing a player’s medical malpractice claim against a club doctor would be “inextricably intertwined with consideration of the terms of the CBA” and thus preempted. However, research has not revealed any player who has sued a club doctor for medical malpractice concerning events that took place after the execution of the 2011 CBA.

Finally, during its review of this Report, the NFL informed us that the NFLPS “has designed and implemented a peer review process through which its membership could investigate and discipline members.” When we asked the NFLPS for more information on its peer review process, the NFLPS explained that it was created in 2014 pursuant to the Healthcare Quality Improvements Act (HQIA). The HQIA was enacted in 1986 to improve healthcare by promoting peer review in the medical setting by immunizing such processes from antitrust scrutiny, and creating a national database of actions taken during such peer review processes called the National Practitioner Data Bank (NPDB). Healthcare organizations can access the NPDB for consideration in making licensing, hiring, and credentialing decisions but the statute also declares that information reported to the NPDB is confidential. However, information that does not reveal the identity of someone is not considered confidential. Based on our understanding of the statute, we informed the NFLPS that our understanding was (1) that the remedial actions available as part of the NFLPS’ peer review process would be limited to evaluating a club doctor’s membership in the NFLPS, and (2) that the NFLPS could disclose to us de-identified aggregate data on the number of enforcement actions the NFLPS had taken under its peer review process.
However, the AMA Council generally does not review complaints submitted by the general public because it believes it “is not in a position to investigation allegations of unprofessional or unethical conduct at the local level.” Instead, complaints referred to the AMA are usually forwarded by state medical societies and national medical societies. If the AMA Council decides the unethical conduct is “greater than local concern,” it may ask the AMA President to appoint an investigating jury to determine whether there is a probable cause of action. Finally, doctors do not need to be members of the AMA to practice medicine.

The AMA Code’s enforcement mechanisms are of little use as remediation to NFL players who received improper care from a team doctor. First, as discussed above, the AMA is unlikely to even review the player’s complaint. Second, the AMA Code does not provide any method by which the injured patient can be compensated.

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

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

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

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

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

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

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

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

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

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

bf Additionally, because the roles of the various doctors with whom a player may consult are so intertwined, all recommendations made in Chapter 4: Second Opinion Doctors, Chapter 5: Neutral Doctors, and Chapter 6: Personal Doctors also can be applied to the club doctors.
Additionally, there have been longstanding concerns about how club doctors are chosen, including the nature of the doctor’s compensation (if any) and whether sponsorship is involved (even if if the sponsorship is part of a separate agreement).

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

*Each 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.*

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

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

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

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

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

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

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**Notes:**

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

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

bi Current Player 2: “I think when it comes down to it, who’s paying you? . . . [A]s long as the teams are paying for [the doctors], they’re going to have to answer to the team; they’re going to have to answer to the coach; they’re going to have to answer to the boss. That’s who is writing their check.”
ethical principles that apply to the practice of medicine shall apply to sports medicine” but later declares that it is “essential” that athletes be informed about a doctor’s responsibilities to the club and that the player authorize the doctor to disclose “otherwise confidential medical information” to certain club officials “for the expressed purpose of determining the fitness of the athlete for participation.” Of course, this dual loyalty is not part of the usual practice of medicine, and so the same ethical principles cannot always apply.

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

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

A. Maintain the status quo with increased reliance on personal and second opinion doctors: Throughout the modern history of the NFL, players have increasingly obtained second opinions to compare against those provided by the club doctor, and have also relied on their own personal doctors for care. Nevertheless, interviews we conducted with players and contract advisors indicated that seeking care from a personal doctor is a burdensome process that players are often reluctant to undertake. It is far easier for players to simply receive healthcare at the club facility where they are already spending a considerable amount of their time than to seek out a personal doctor with an office off premises, and perhaps a less robust understanding of a player’s professional and physical challenges. This is especially true given how much players travel and move during, after, and between seasons. Consequently, many players, particularly the younger ones, continue to rely solely on the medical opinion of and care provided by the club doctor. It is thus uncertain how effective this approach would be. Moreover, it does not resolve the fact that club doctors would remain in a conflicted position.

B. Maintain the status quo without the execution of confidentiality waivers: As discussed above, players execute waivers (which have been collectively bargained between the NFL and NFLPA) permitting the club medical staff to disclose the player’s health information to the club, stripping players of certain protections provided for in relevant laws and ethical codes concerning confidentiality. Players could refuse to execute these waivers and effectively preclude the clubs from knowing the specifics of a player’s

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

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

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

bm This issue is discussed further in Chapter 6: Personal Doctors.
The NFL and NFLPA maintain a jointly compiled list of neutral doctors to assist in Injury Grievances, to hire their own physicians. Each league should hire physicians for the clubs and franchises, with the physicians reporting to a chief medical officer based in the league’s headquarters. The fact that the club pays the doctor (even if only small amounts) to provide services, including treating the player — whose interests may be adverse to the club’s — creates an undeniable conflict of interest. A structure whereby the club doctor is paid equally by the NFL and NFLPA has the potential to remove some of the implicit structural pressures that the club doctor might feel to act in the club’s best interests. However, so long as the club doctor is still chosen and reviewed by the club, and is retained to simultaneously provide services to players and clubs, the doctor is still potentially under pressure to compromise the player’s best interests in favor of the club’s.

C. Pay club doctors from a fund to which the NFL and the NFLPA jointly contribute: The fact that the club pays the doctor (even if only small amounts) to provide services, including treating the player — whose interests may be adverse to the club’s — creates an undeniable conflict of interest. A structure whereby the club doctor is paid equally by the NFL and NFLPA has the potential to remove some of the implicit structural pressures that the club doctor might feel to act in the club’s best interests. However, so long as the club doctor is still chosen and reviewed by the club, and is retained to simultaneously provide services to players and clubs, the doctor is still potentially under pressure to compromise the player’s best interests in favor of the club’s.

D. Choose club doctors, and subject them to review and termination, through a committee of medical experts selected equally by the NFL and the NFLPA: The fact that club doctors are hired, paid and reviewed by the clubs presents the most foundational conflict. One way to avoid this problem is to incorporate the players into the club doctor hiring, review, and termination processes equally with the clubs themselves. A possible approach would be for the NFL and NFLPA to each select three members of a committee, and then have those six members select a seventh neutral member as chair; the committee would be responsible for selection, review, and potential replacement of the club physicians for each of the 32 clubs. Additionally, this committee could be responsible for determining the doctor’s compensation, taking into account the proposed rates by the doctors interested in the position and market rates in the club’s city. The doctor’s compensation would still be paid by the club.

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

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

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

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


The NFL and NFLPA maintain a jointly compiled list of neutral doctors to assist in Injury Grievances, which might be a useful starting point. See 2011 CBA, Art. 44, § 5.
While several of the above scenarios offer improvements over the current situation, each also has deficiencies. Consequently, we believe our recommendation below is the one most likely to promote and protect player health. It combines two of the possible approaches above to achieve an optimal balance. That said, if our preferred recommendation is not adopted, serious consideration should be given to the others listed above, as any would be an improvement over the status quo.\textsuperscript{bp}

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

\textsuperscript{bp} In theory it might be even more desirable to have different teams implement different recommendations, collect data, and then arrive at a more evidence-based recommendation for which possible approach is superior. In practice, though, we think the costs of administering those experiments, concerns about who would without conflict monitor and evaluate those experiments, and the costs of disuniformity for players in the meantime are too high to endorse that approach.
This recommendation is an amalgamation of two of the possible approaches (D and E) discussed above. It is also important to remember that this recommendation encompasses athletic trainers as well, as discussed further in Chapter 3: Athletic Trainers, Section F: Recommendations. Here is how it would work.

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

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

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

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

**The Player Health Report**

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

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

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

bs One possible model for such evaluations come from The Joint Commission, a healthcare accreditation organization, which has in place processes for evaluating the care of doctors called the Ongoing Professional Practice Evaluation (“OPPE”) and Focused Professional Practice Evaluation (“FPPE”). See Robert A. Wise, OPPE and FPPE: Tools to help make privileging decisions, The Joint Comm’n (Aug. 21, 2013), http://www.jointcommission.org/jc_physician_blog/oppe_fppe_tools_privileging_decisions/, archived at http://perma.cc/SBCR-3UBV. This is only one potential model, others are possible, and we do not purport to dictate the specific protocols for these evaluations.
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a legitimate business interest (and indeed in many circumstances a legal right) to know about their employees’ health insofar as it affects their ability to perform the essential functions of their jobs. The Player Health Report would serve this purpose by briefly describing: (1) the player’s condition; (2) the player’s permissible level of participation in practice and other club activities; (3) the player’s current status for the next game (e.g., out, doubtful, questionable, or probable);26 (4) any limitations on the player’s potential participation in the next game; and, (5) an estimation of when the player will be able to return to full participation in practice and games. The Player Health Report would be a summary form written for the lay coaches and club officials, as opposed to a detailed medical document. Generally speaking, we propose that the Player Health Reports be provided to the club before and after each practice and game. Additionally, the club would be entitled to a Player Health Report on days where there is no practice or game if a player has received medical care or testing. The Player Health Reports be provided to the club before and after each practice and game. The Players’ Medical Staff shall complete the Player Health Report in a good faith effort to permit the club to be properly prepared for its next game.26

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

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

As an initial matter, in creating the Player Health Report, it is important that the Head Players’ Doctor take into consideration the player’s desires and not strictly clinical criteria. Players, like all patients, are entitled to autonomy—the right to make their own choices concerning healthcare. Thus, if a player who is fully informed of the risks wishes to play through an injury, the Head Players’ Doctor should take that into consideration in completing the Player Health Report and deciding whether the player can play. Nevertheless, players who have suffered concussions or other injuries that might affect the player’s cognition at the time of decision-making should be given significantly less deference.268

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

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

bt These descriptions match the language historically used on NFL injury reports. However, prior to the 2016 season, the NFL removed the “probable” designation from the injury report and also restricted the use of the “out” designation until two days before the game. Tom Pelissero, Major change to NFL’s injury report will take some getting used to, USA Today (Aug. 21, 2016, 4:33 PM), http://www.usatoday.com/story/sports/nfl/2016/08/21/injury-report-probable-bill-belichick-patriots/89080582/, archived at https://perma.cc/QTC4-MAA6. As discussed in Chapter 17: The Media, the injury report is generally meant to advise the opposing club of the status of a club’s players, while also preventing the possibility of inside information to be used for gambling purposes. Those are different purposes than for which we have contemplated the Player Health Report, which is designed to advise the Club of the health status of its own players. Thus, we think the Player Health Report should be as descriptive as necessary, and does not need to track the language of the NFL’s injury reports.

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

bv Additional logistics of the Player Health Report are detailed in Appendix G: Model Article 39 of the Collective Bargaining Agreement—Players’ Medical Care and Treatment.
between the Club Evaluation Doctor (working solely on behalf of the club as explained below) and the Players’ Medical Staff concerning player health should only be with the Head Players’ Doctor. Beyond these minimal levels of communication, there should be no need for the Players’ Medical Staff (doctors and athletic trainers) to communicate with any club employee, including a coach or general manager. By minimizing the communication in this way, and formalizing it, the goal is to minimize the club’s ability to influence the medical care provided to the player, including more subtle forms of influence, e.g., occasional workplace conversations. We say “minimize” because, as we discuss below, our recommendation does still allow for some communications between the Players’ Medical Staff and the club. We think that this reduced level of communication is necessary and appropriate to protect player health, but nevertheless acknowledge that the existence of any such communications may cause a player to be less forthcoming to the medical staff, even if designated as the Players’ Medical Staff as we recommend.

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

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

The Club’s Access to Player Medical Records

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

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

Providing clubs access to players’ medical records raises additional issues that must be clarified. Athletic trainers are the principal providers of medical care to players under the control of club doctors and also are generally responsible for completing the players’ medical records. Athletic trainers would retain these roles but our important corresponding recommendation is that athletic trainers, like the Head Players’ Doctor and Players’ Medical Staff, be chosen and reviewed by the Medical Committee, and that their principal obligations be to treat the players in accordance with prevailing and
customary legal and ethical standards. The athletic trainers would likely assist the Head Players’ Doctor in creating the Player Health Report but, like the Head Players’ Doctor, should have minimal, if any, other interaction with the coaches or other club officials.

**Club Evaluation Doctors**

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

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

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

**Figure 2-D: Permissible Communications Concerning Player Health**

![Figure 2-D: Permissible Communications Concerning Player Health](image)

**Possible Objections to our Recommendation**

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

\(^{bw}\) To avoid confusion between doctors providing care and performing fitness-for-duty evaluations, it may be appropriate for the doctors not providing care to have some kind of feature distinguishing them from the doctors providing care. See, e.g., Rebecca Dresser, *The Ubiquity and Utility of the Therapeutic Misconception*, 19 Soc. Phil. and Pol’y 271, 293 (2002) (recommending that doctors acting as researchers rather than clinicians wear red coats).
decision to broaden the scope and frequency of permissible communications compared to our original position. On the other hand, some viewed the extent of communication that we allow as too substantial. In this regard, we note that outside of the context of professional sports, personal doctors do occasionally communicate with a patient’s employer in ways sanctioned by that patient (for example, providing information to justify sick leave). Thus, we believe that this final recommendation is the best way to serve the goal of providing players healthcare they can trust from providers who are as free from conflicts of interest as possible, while acknowledging the business realities facing clubs. We recognize that it may need further adjustment as implemented, though we maintain that it is feasible to do so, although perhaps a challenging transition.

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

Possible Objections from a Player-Centric Perspective

We consider five objections from a player-centric perspective.

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

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

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

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

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

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

Possible Objections from a Club-Centric Perspective

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

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

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

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

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

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

\textit{bz} The current CBA describes what player healthcare costs are or are not considered Player Benefit Costs, see 2011 CBA, Art. 12, § 2, and thus count against the player’s share of revenue: “Player medical costs (i.e., fees to doctors, hospitals, and other health care providers, and the drugs and other medical costs of supplies, for the treatment of player injuries) [are considered Player Benefit Costs], but . . . salaries of trainers or other Team personnel, or the cost of Team medical or training equipment” are not considered Player Benefit Costs. 2011 CBA, Art. 12, § 2(a). However, the CBA further states that “player medical costs shall include one-third of each Club’s expenses for tape used on players and one-third of each Club’s player physical examination costs for signed players.” If we thus recognize it would remain to be determined by the NFL and NFLPA whether the costs for the Club Evaluation Doctors would, like some of these other healthcare costs, be part of Player Benefit Costs, and count against the players’ share of revenue.
new structure—one that is necessary to ensure that players receive healthcare that is as unconflicted as realistically possible. Ultimately, the proposed Player Health Report, with the help of existing NFL club doctors and athletic trainers, can be crafted and implemented in such ways as to provide clubs with the information they need to evaluate a player’s fitness to play. Additionally, to the extent clubs believe they need additional clarification, the new Club Evaluation Doctor can communicate with the Head Players’ Doctor or athletic trainers, or examine a player directly, as appropriate.274

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

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

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

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

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

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ca In addition to the above possible concerns, club doctors might also be concerned about how medical malpractice insurance might be affected by our recommendation. Information and data about current club doctors’ medical malpractice insurance arrangements and costs is not publicly available. Consequently, it is difficult to assess how our proposed recommendation might affect those arrangements and costs. However, we acknowledge that it is essential that concerns about insurance coverage or costs (as well as salary and any other monetary issues) do not prevent players from receiving treatment from the best possible medical practitioners, i.e., that the best possible Head Players’ Doctors would not be scared off. Thus, while we are not in a position to conduct such an analysis, medical malpractice insurance and other financial issues must be considered alongside our recommendation.
for the NFL and the NFLPS to suggest that club doctors, who are hired, reviewed, and terminated by the club, and who communicate with and advise the club regularly about player health matters, are not placed in a position that inherently creates a conflict of interest between the interests of the club and the interests of the player. This is the equivalent of asking a single doctor to simultaneously advance the interests of both the organ donor and organ recipient.

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

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

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

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

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What follows are additional recommendations concerning club doctors. Some of these might not be necessary or would need be altered if Recommendation 1-A above were adopted. Nevertheless, we make all recommendations we believe can improve player health under the current structures and set of practices, even if they would become partially redundant or inconsistent if other primary recommendations are adopted.
Recommendation 2:1-B: The NFLPS should adopt a code of ethics.

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

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

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

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

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

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

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

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

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

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

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

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

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

The CBA contains a requirement regarding this issue:

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

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

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

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

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

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

If the incentive exists for MSPs to pay for the right to provide medical services, clubs would likely prefer to sell these services to the highest bidder. This scenario again raises the problematic question of whether clubs might choose MSPs based on their qualifications or instead on the amount they are willing to pay. While the NFLPS says no MSPs are currently paying for the right to provide medical services, we know that the practice existed in the past. Consequently, it is possible that the practice could return or proliferate. To ensure that clubs are choosing MSPs based solely on whether or not they are qualified to provide medical services, the NFLPS must enforce its prohibition against the sale of the right to provide medical services to the club.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medications are generally available in one of two ways: over-the-counter, i.e., by ordinary retail purchase, without the need for a prescription; or, through a prescription from a licensed and authorized medical professional. As will be discussed further below, certain medications meet additional criteria and are classified as “controlled substances” under the Controlled Substances Act (CSA). Nevertheless, many prescription medications are not controlled substances and not all controlled substances are available through a prescription (heroin, for example).

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

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

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

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

It is unclear both historically and currently how much players’ misuse or abuse of medications can be attributed to club doctors. In the past, clubs, through club doctors, provided and prescribed medications, including painkillers, but players could also obtain and abuse medications on their own (and without the club doctor’s knowledge). For
this reason, this issue potentially fits into and could have been featured in several different chapters of this Report. However, because club doctors have many legal obligations concerning medications, we chose to include discussion of the special case of medications as part of this chapter.

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

1) BACKGROUND

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

Over the years, there have been references to a variety of medications being made readily available by NFL clubs and their medical staff to NFL players in “candy jar”-like fashion\(^\text{285}\) — meaning without a specific prescription or individualized access. Although the “candy jar” practice reportedly ceased during the late 1980s and 1990s,\(^\text{286}\) questions about the use of medications in the NFL persisted even recently.\(^\text{287}\)

One important study that attempted to understand the scope of the issue with one particular painkilling medication was conducted by doctors from the United States Air Force and the Denver Broncos (called the “Tokish Study” for lead author, Dr. John Tokish).\(^\text{288}\) The Tokish Study sent questionnaires to every NFL club doctor and head athletic trainer\(^\text{289}\) concerning the club’s use of ketorolac tromethamine, more commonly known by its brand name Toradol, during the 2000 season.

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

The Tokish Study found that in 2000:

- 28 out of the 30 clubs that responded used Toradol;
- Clubs that used Toradol treated an average of 15 players during the season, with a range of 2 to 35;
- 26 out of 28 clubs that responded used Toradol on the day of a game;
- 24 of 27 clubs responding\(^\text{292}\) would allow a player as much as one injection per week throughout the season;
- 13 of 26 clubs responding found that Toradol reduced a player’s pain by 51 percent or greater;
- 13 of 26 clubs responding found that Toradol reduced a player’s pain by 50 percent or less; and,
- Only six clubs reported an adverse outcome related to Toradol usage during the season.

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

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

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

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

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

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

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

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### 2) CURRENT LEGAL OBLIGATIONS CONCERNING MEDICATIONS

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

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

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

As mentioned earlier, the CSA301 “is the statutory framework through which the federal government regulates the lawful production, possession, and distribution of controlled substances.”302 Controlled substances are those drugs that have a “strong potential for abuse.”303 The CSA divides controlled substances into five schedules, depending on the substance’s medical use, potential for abuse, and likelihood of dependence.304 The substances considered the most dangerous are classified as Schedule I, including heroin, marijuana, LSD and ecstasy.305 Schedule V substances, considered the least dangerous, contain limited quantities of certain narcotic and stimulant drugs and include over-the-counter cough medicines such as Robitussin.306
NFL club doctors, like many doctors, prescribe controlled substances—including such powerful painkillers as Vicodin, Percocet and OxyContin (all Schedule II)—and thus must comply with the CSA. The CSA and DEA requirements with which NFL club doctors must comply cover: registration with the DEA; the location of the doctor’s registration; security of controlled substances; recordkeeping of controlled substances; and, dispensing of controlled substances, among other things.

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

3) CURRENT ETHICAL OBLIGATIONS CONCERNING MEDICATIONS

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

4) CURRENT PRACTICES CONCERNING MEDICATIONS

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

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

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

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

One useful change was made beginning with the 2015 season. As of that season, each club is assigned a Visiting Team Medical Liaison, a local doctor who can help prescribe medications as well as advice concerning local medical facilities.
Some of the advances in the NFL’s practices concerning painkillers and prescription medications are likely related to the increased scrutiny of the usage of Toradol (a prescription drug, but not a controlled substance). In 2012, the NFLPS commissioned a study on the use of ketorolac (brand name Toradol) in the NFL. The study stated that since the Tokish Study in 2002, “it is widely believed by NFL team physicians that the use of [Toradol] has increased in prevalence not only in the NFL but also in NCAA Division I football,” though there was no “objective documentation proving this hypothesis.”

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

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

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

“If we do get painkillers, they’re prescribed to us by the doctors. And they definitely go through the whole process . . . they’re not just handing out a bunch of painkillers unnecessarily to guys.”

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

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

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

The DEA has also expressed interest in the administration of painkillers by NFL club doctors. At the 2010 NFL Combine, the DEA advised club doctors that it would be more closely monitoring the use of controlled substances by NFL clubs. Then, during the 2014 season, DEA agents randomly visited several NFL clubs immediately following...
The DEA agents requested to see whether the club doctors were in possession of any controlled substances and the required records. The purpose of the inspections was to determine whether club doctors were prescribing and dispensing controlled substances in states in which they were not licensed to practice (and thus not registered with the DEA), and also to determine whether non-licensed staff members, such as athletic trainers, were handling controlled substances, which would violate the CSA. The selected clubs were found to be in compliance and no further action was taken.

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

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

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

Once in the Intervention Program, the players are referred to the appropriate clinical professionals to develop a treatment plan for the player. The Medical Director must then approve the treatment plan. Additionally, once in the Intervention Program, the player is subject to additional testing at the discretion of the Medical Director.

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

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

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

5) ENFORCEMENT CONCERNING MEDICATIONS

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

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

First, the NFLPA contended the waiver violated Paragraph 9 of the NFL Player Contract. Paragraph 9 provides that if Player is injured in the performance of his services under this contract and promptly reports such injury to the Club physician or trainer, then Player will receive such medical and hospital care during the term of this contract as the club physician may deem necessary[.]” The NFLPA
argued that clubs and club doctors cannot precondition the provision of medical care they deem necessary on the acceptance of waivers.

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

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

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

Finally, we discuss an ongoing lawsuit against the NFL concerning medications. In May 2014, several former players, led by former Chicago Bear Richard Dent, filed a class action lawsuit alleging that the NFL and its clubs and doctors negligently and fraudulently prescribed and administered painkilling medications during their careers.

The lawsuit generally focused on three types of medications: opioids, which “act to block and dull pain”; non-steroidal anti-inflammatory medications, such as Toradol, which have “analgesic and anti-inflammatory effects to mitigate pain”; and, local anesthetics, such as lidocaine.

The former players’ alleged that the doctors’ inappropriate administration of the medications caused them a variety of physical and mental ailments, including heart and kidney damage and drug addiction.

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

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

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

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

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

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

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

Endnotes

1 CBA, Art. 39, § 1.
2 CBA, Art. 39, § 1(e).
5 See Frequently Asked Questions—How Often Do All NFLPS Members Meet?, Nat’l Football League Physician’s Soc’y, http://nflps.org/faq/how-often-do-all-nflps-members-meet/ (last visited Aug. 7, 2015), archived at http://perma.cc/78PS-DROX, Frequently Asked Questions—What Are Typical Topics at Members Meetings?, Nat’l Football League Physician’s Soc’y, http://nflps.org/faq/what-are-typical-topics-at-members-meetings/ (last visited Aug. 7, 2015), archived at http://perma.cc/LR79-9AN3 (“The topics at these meetings vary and address any or all of the potential injuries that a NFL player may experience. This can include orthopaedic injuries such as ACL tears, meniscus tears, cartilage injuries to the knee, multiligamentous injuries to the knee, high ankle sprains, fractures, dislocations, foot injuries, surgical techniques, rehabilitation, hip injuries, arthroscopy of the hip, sports hernia challenges, shoulder injuries such as dislocations or labral tears, rotator cuff problems, elbow dislocation, biceps or triceps injuries, wrist injuries, and hand and finger injuries or dislocations. From a medical standpoint, there has been a recent emphasis on heat-related illnesses, cardiac conditions, MRSA infections, sickle cell traits, concussions and the management of acute blunt trauma to the chest or abdomen.”).
6 This information was provided by NFLPS.
7 Id. Clubs also likely do not directly hire doctors to comply with the corporate practice of medicine doctrine. The corporate practice of medicine doctrine is a state law concept that generally prohibits entities from practicing medicine or employing physicians to provide professional medical services. The prohibitions vary from state to state (with many exceptions to the general rule) and are found in common law, state statutes, regulations, and administrative opinions. See Mary H. Michal, Meg S.L. Pekarske & Matthew K. McManus, Corporate Practice of Medicine Doctrine: 50 State Survey Summary, Nat’l Hospice & Palliative Care Org. & Ctr. to Advance Palliative Care (2006), http://www.nhpco.org/sites/default/files/public/palliativecare/corporate-practice-of-medicine-50-state-summary.pdf, archived at https://perma.cc/G2QD-ZEG8?type=pdf.
8 Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).
9 Id.
10 NFL Comments and Corrections (June 24, 2016).
11 Memorandum from NFL Commissioner Paul Tagliabue to NFL Club Chief Executives and Presidents re: Hospital and Physician Sponsorship (Sep. 7, 2004) (on file with author).
12 Id.
13 Id.
14 Id.
15 Rob Huizenga, You’re Okay, It’s Just a Bruise 74 (1994) (“No wonder that rumors floated, and Sports Illustrated reported that at least one NFL physician was paying the team for the privilege of being team doctor.”); id. at 325 (The NFL Physicians Society is currently trying to fight off an invasion from the big business hospital chains. Turns out some health companies are actually bidding for the right to be the official team doctor/team hospital for NFL teams. The hospitals have presumably calculated that getting their hospital logo next to one of those stadium beer commercials is worth a lot of bucks. It’s rumored the bidding may have reached $1 million.”).
16 Id. See also Sam Effling, Walk It Off, Champ: Why NFL Team Doctors Are Ethically Compromised, Slate.com (Jan. 30, 2013), http://www.slate.com/articles/sports/sports_nut/2013/01/nfl_team_doctors_the_problem_with_pro_football_s_medical_sponsorship_deals.html, archived at https://perma.cc/PL2D-SJHV?type=pdf (quoting Lew Lyon, vice president of the Baltimore Ravens-affiliated MedStar Sports Medicine as saying “If the halo effect is huge . . . [friends] will call me and say, ‘Can you get me into one of the Ravens docs?’”).
19 Memorandum from NFL Commissioner Paul Tagliabue to NFL Club Chief Executives and Presidents re: Hospital and Physician Sponsorship (Sep. 7, 2004) (on file with author).

20 Id.

21 Memorandum from NFL Commissioner Roger Goodell to NFL Club Chief Executives and Presidents re: Hospital and Medical Service Provider Sponsorships (Nov. 2, 2012) (on file with author).

22 Id.

23 Memorandum from NFL Commissioner Roger Goodell to NFL Club Chief Executives and Presidents re: League Policy on Club Medical Services Agreements and Sponsorships (May 2, 2014) (on file with author).

24 Id.

25 E-mail with Larry Ferazani NFL, Vice President, Labor Litigation & Policy (Apr. 15, 2015).

26 Interview with Larry Ferazani, NFL, Vice President, Labor Litigation & Policy (Oct. 6, 2014).

27 Id.

28 Pennington, supra note 18.

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

30 Email from Jon Coyles, MLB Labor Counsel, to Chris Deubert (Oct. 6, 2014, 15:13 EST) (on file with author).

31 NBA CBA, Art. XXII, § 5.

32 Under the 2011 CBA, this responsibility is solely the doctor’s. See 2011 CBA, App. A: NFL Player Contract ¶ 8 (“If Player fails to establish or maintain his excellent physical condition to the satisfaction of the Club physician . . . then Club may terminate this contract.”)


34 LoDiaco v. Caputi, 517 N.Y.S.2d 640 (N.Y. App. Div. 1987); Miller v. Sullivan, 625 N.Y.S.2d 102 (N.Y.App. Div. 1995); St. John v. Pope, 901 S.W.2d 420, 423–24 (Tex. 1995); Gallardo v. U.S., 752 F.3d 865 (10th Cir. 2014) (applying Colorado law) (recognizing that a physician’s duty arises out of an express or implied contractual relationship when a physician undertakes to treat or otherwise provide medical care to another); Smith v. Pavlovich, 914 N.E.2d 1258 (Ill. App. Ct. 2009) (A physician-patient or special relationship may exist even in the absence of any meetings between the physician and patient, where the physician performs services for the patient); Harper v. Hippensteel, 994 N.E.2d 1233 (Ind. Ct. App. 2013) (where doctor does not treat, see, or in any way participate in the care or diagnosis of plaintiff-patient, doctor-patient relationship will not be found to exist such that duty owed by physician would arise); Olson v. Wrenshall, 822 N.W.2d 336 (Neb. 2012) (a physician’s duty to exercise the applicable standard of care arises out of the physician-patient relationship; this relationship is said to arise when the physician undertakes treatment of the patient); Clarke v. Hoek, 219 Cal.Rptr. 845 (Cal. Ct. App. 1985) (finding no doctor-physician relationship established when doctor never entered into any contractual relationship with appellant or the proctored physician.). See also, Rigelhaupt, supra note 33.


38 Barry R. Furrow et al., Health Law 61 (2d ed. 2000).

39 See, e.g., New York State Education § 6530 (defining “professional misconduct” applicable to physicians as, among other things, “practicing the profession with negligence on more than one occasion,” “practicing the profession with gross negligence on a particular occasion,” “[r]eveling of personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the patient, except as authorized or required by law,” and “[i]egating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that such person is not qualified, by training, by experience, or by licensure, to perform them.”)

40 Furrow, supra note 38, at 39. However, “[m]ost boards do not have adequate staff to respond to the volume of complaints and to conduct extensive investigations of unprofessional conduct,” leading consumer groups to complain about the industry’s failure to regulate. Mark A. Hall et al., Med. Liability and Treatment Relationships 137 (2008).

41 Id.

42 Id.


45 See 2011 CBA, Art. 39 § 1(a)-(b) (listing the various types of doctors contemplated or required to be hired by NFL Clubs).


54 See Thierfelder v. Wolfert, 52 A.3d 1251, 1264 (Pa. 2012) (discussing elements of a medical malpractice claim); Hamilton v. Wilson, 249 S.W.3d
This information was provided by the NFLPA.

FIMS Code of Ethics at ¶ 1.


FIMS Code of Ethics at ¶ 4.

Id. at ¶ 5.

Id.

This information was provided by the NFLPA.


97 C.F.R. § 160.103.

96 C.F.R. § 160.103.

95 C.F.R. § 164.512(b)(v).

94 C.F.R. § 164.512(l).

93 C.F.R. § 160.103.

92 C.F.R. § 160.103.

91 “Protected health information means individually identifiable health information . . . that is: (i) Transmitted by electronic media; (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.” 45 C.F.R. § 160.103. “Individually identifiable health information is information that is a subset of health information, including demographic information collected from an individual, and: (1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and (2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (i) That identifies the individual; or (ii) With respect to which there is a reasonable basis to believe the information can be used to identify the individual.” Id.


89 C.B.A. Art. 39, § 1(c).

88 C.B.A. Art. 40, § 2(a).

87 Id.


84 Id.

83 Id.

82 Id.

81 Id.


79 Id. at ¶ 40.

78 This information was provided by the NFLPA.

77 Id.

76 Pedersen v. Vahidy, 552 A.2d 419 (Conn. 1989).

75 King & Moulton, supra note 72.

74 Fuller v. Starnes, 597 S.W. 2d 88 (Ark. 1980).


70 Id. at ¶ 4.

69 This information was provided by the NFLPA.

68 S.B.A. Art. 39, § 1(c).

67 FIMS Code of Ethics at ¶ 1.


65 Id.

64 C.B.A. § 34.1(b).


62 NHL CBA, § 34.1(b).


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

59 This information was provided by the NFLPA.

58 C.B.A. Art. 39, § 1(c).


55 Id.

102 CBA, Art. 39, § 1(c).


105 FIMS Code of Ethics at ¶ 4.

106 Id. at ¶ 11.

107 Id. at ¶ 4.

108 Kloster v. Hormel Foods Corp., 612 N.W.2d 772, 775 (Iowa 2000) (“When a physician acts contrary to the best interests of a patient, these acts or omissions undermine the public trust, and may rise to the level of malpractice.”); Pearce v. Ollie, 826 P.2d 888, 907 (Idaho 1992) (“The physician’s fiduciary duty requires that he act in the best interests of his patient so as to protect the sanctity of the physician-patient relationship”) (citing Petrillo v. Syntex Labs., Inc., 148 Ill. App.3d 581, 594 (Ill. 1986) (“There is an implied promise, arising when the physician begins treating the patient, that the physician will refrain from engaging in conduct that is inconsistent with the ‘good faith’ required of a fiduciary. The patient should, we believe, be able to trust that the physician will act in the best interests of the patient thereby protecting the sanctity of the physician-patient relationship.”).

109 CBA, Art. 39, § 1(c).


114 FIMS Code of Ethics at ¶ 1.

115 Id. at ¶ 3.

116 Id.

117 Id. at ¶ 4.

118 Id. at ¶ 11.


121 See id.


123 Dyer, supra n. 122; Greenberg v. Perkins, 845 P.2d 530, 535 (Colo. 1993) (“physician owes a duty of care to a nonpatient examinee to conduct the examination in a manner not to cause harm to the person being examined.”) (internal quotations and citations removed).

124 Bazakos v. Lewis, 911 N.E.2d 847, 849 (N.Y. 2009) (“an [independent medical examination] is essentially adversarial”); Dyer, 679 N.W. 2d at 315 (independent medical examination “physician often examines the patient under circumstances that are adversarial”); Greenberg, 845 P.2d at 539 (discussing that doctor was acting “in an adversary setting”).


126 See Reed v. Bojarski, 764 A.2d 433 (N.J. 2001) (physician retained to perform a pre-employment physical has a duty to inform the patient of a potentially serious medical condition); Green v. Walker, 910 F.2d 291 (5th Cir. 1990) (holding that, under Louisiana law, a doctor performing an examination on behalf of an employer, had “a duty to conduct the requested tests and diagnose the results thereof, exercising the level of care consistent with the doctor’s professional training and expertise, and to take reasonable steps to make information available timely to the examinee of any findings that pose an imminent danger to the examinee’s physical or mental well-being”).

127 CBA, Art. 39 § 1(c).


129 Id.

130 Id.

131 Id.

132 Tee L. Guidotti et al., Occupational Health Services: A Practical Approach 37 (2d ed. 2013), citing the ACOEM Code of Ethics.

133 NFL Comments and Corrections (June 25, 2016).

134 Id.

135 Id.

136 Dyer, 679 N.W. 2d at 315–17 (collecting cases); Greenberg, 845 P.2d at 535 (Colo. 1993) (“physician owes a duty of care to a nonpatient examinee to conduct the examination in a manner not to cause harm to the person being examined.”) (internal quotations and citations removed).

137 See, e.g., Yoder v. Cotton, 758 N.W.2d 630 (Neb. 2008); Jacobsen-Wayne v. Calvin C.M. Kam, 198 F.3d 254 (9th Cir. 1999) (both affirming granting of defendant physician who had performed independent medical examination summary judgment on informed consent claim by finding that plaintiff had consented to the examination).

143 ACOEM Code of Ethics, Ethical Principle V.

144 Dyer, 679 N.W.2d at 315–17 (collecting cases); Greenberg, 845 P.2d at 535 (“physician owes a duty of care to a nonexistent examinee to conduct the examination in a manner not to cause harm to the person being examined.”) (internal quotations and citations removed).


147 Id. at ¶11.

148 Id. at ¶ 2.


152 Id. at id. at ¶11.

153 Id. at ¶ 2.

154 Id. at ¶ 11.

155 Id. at 21 (Rosenfeld telling player “You’re okay—it’s nothing serious.”); id. at 58 (Rosenfeld telling Huizenga “You’ve got to treat [players] differently from your office patients.”); id. at 147 (Rosenfeld telling player “So you really can’t hurt the joint anymore. We may as well just shoot it up and let you go back out there and play.”). Huizenga also questioned Rosenfeld’s acumen. Id. at 123 (criticizing Rosenfeld for moving the neck of a player with neck pain); id. at 149 (Rosenfeld signing a prescription for anabolic steroids); id. at 256–67 (describing disagreement with Rosenfeld about a player’s condition which led to Huizenga’s resignation); id. at 270–71 (alleging that Rosenfeld and his medical practice had been sued over sixty times, mostly for medical malpractice).

156 Id. at 227.

157 Id. at 57 (“There was a fuzzy boundary between good medicine and good team doctoring.”); id. at 58 (“I was supposed to keep players informed of their health status, not to hide feelings from them. And every doctor knows that his legal and ethical responsibility is to the patient, regardless of who pays the bill.”); id. at 103–04 (describing having player sign waiver that he understood certain risks “to protect the Raiders”); id. at 106 (describing process for having players sign a waiver stating that they were healthy following pre-season physical); id. at 115 (stating to get player off the field for competitive purposes); id. at 125 (declaring “It’s not ethical for me to stay here. I can’t be associated with this kind of medicine.”); id. at 240 (debating the ethics of disclosing players’ medical records).

158 Id. at 266–67.


160 Id. at xi.

161 Id. at 32.

162 Id. at 170.


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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

190 NFL Comments and Corrections (June 24, 2016).
Legal and Ethical Issues, Univ. Penn. L. Rev. (forthcoming
NFL Comments and Corrections (June 24, 2016).

See Do team physicians have their own practices, or do they work for the clubs full-time?, Nat’l Football League Physicians Soc’y, http://nffps.org/faqs/do-team-physicians-have-their-own-practices-or-do-they-work-for-the-clubs-full-time, archived at http://perma.cc/Y535-ZM2M (last visited Aug. 7, 2015) (stating that Club doctors “have [their] own private or university practices, in addition to [their] work as team physicians.”)


NFL Constitution and Bylaws, § 220.

This information was provided by the NFLPA.


Id.

Id.

Siebert, supra note 201.

Id.

NFL Constitution and Bylaws, § 17.3.

Siebert, supra note 201.

Id.

Id.

NFL Comments and Corrections (June 24, 2016).


Id.


Siebert, supra note 201.


233 See Jackson v. Kimel, 992 F.2d 1318, 1325 n.4 (4th Cir. 1993) (collecting cases holding that employees that are not signatories to the CBA cannot be sued for violations of the CBA).

234 See 2011 CBA, Art. 2, § 2 (generally discussing CBA’s binding effect on NFL, NFLPA, players and Clubs but no other party).

235 CBA, Art. 43, § 2.

236 This information was provided by the NFLPA.

237 The Non-Injury Grievance arbitrator has the authority to determine whether a complaint against a doctor fit within his or her jurisdiction under Article 43. See 2011 CBA, Art. 43, § 1 (discussing scope of Non-Injury Grievance arbitrator’s jurisdiction).


242 (Das, Arb. Mar. 25, 2008). For a more complete discussion of Jeffers, see Chapter 8: NFL Clubs.

243 See Hendy, 819 P.2d 1; Pam Louwagie & Kevin Seifert, Stringer Claims Against Vikings Dismissed, Newspaper of the Twin Cities (Minneapolis, Apr. 26, 2003), available at 2003 WLNR 14250471.


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


249 Id.

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

251 Id.

252 This information was provided by the NFLPA.


255 Mark A. Hall et al., Health Care Law and Ethics 137 (2003).


258 Id.

259 Id.


261 CBA, Art. 39, § 1(c).


264 FIMS Code of Ethics at ¶ 1, ¶ 4.


267 CBA, Art. 39, § 1(c).


269 See 2011 CBA, Art. 15, § 6; Art. 16, § 7; Art. 66, § 1.

270 See, Robertson et al., supra n 263; Kesselheim and Orentlicher, supra n. 263.

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


274 See, e.g., Uniform Anatomical Gift Act (2006), § 14(b) (“Neither the physician who attends the decedent at death nor the physician who determines the time of the decedent's death may participate in the procedures for removing or transplanting a part from the decedent.”); Ethical Controversies in Organ Donation After Circulatory Death, Am. Acad. of Pediatrics (2013), http://pediatrics.aappublications.org/content/131/5/1021, archived at https://perma.cc/NN9V-7RKK.
NFL Comments and Corrections (June 24, 2016).

This information was provided by the NFLPA.

CBA, Art. 39, § 1(c).

See Christopher Tarver Robertson, Biased Advice, 60 Emory L.J. 653, 666–68 (2011) (explaining study showing that disclosing parties “apparently felt that the disclosure gave them a ‘moral license’ to be even more biased” and that the people to whom biases are disclosed “failed to effectively use the disclosure to adjust for the inaccuracy of the given advice.”); Omri Ben-Shahar & Carl E. Schneider, The Failure of Mandated Disclosure, 159 U. Penn. L. Rev. 647 (2011); I Robert Gatter, Communicating Loyalty: Advocacy and Disclosure of Conflicts in Treatment and Research Relationships, in The Oxford Handbook of U.S. Health Law (I. Glenn Cohen, Allison K. Hoffman, William M. Sage eds. 2015–2016).

NFLPA’s position “that lawsuits by players against club doctors are [not] ‘admissible malpractice lawsuit against a Club doctor’”; and, acknowledging that malpractice suits against Club doctors “regularly are brought to vindicate and persecute Club physicians.”


This information was provided by the NFL and NFLPS.

This information was provided by the NFL.

See Complaint, Dent v. Nat’l Football League, 14-cv-2324 (N.D. Cal. May 20, 2014), ECF No. 1, ¶ 203 (“amphetamine in the form of yellow and purple pills were available in jars in the locker room for any and all to take as they saw fit”); Sally Jenkins & Rick Maese, Pain and Pain Management in NFL Spawn a Culture of Prescription Drug Use and Abuse, Wash. Post, April 14, 2013, available at 2013 WLNR 9074933 (William Barr, the director of New York University’s Langone Medical Center, and a concussion consultant for the New York Jets from 1995 to 2004 describing a “huge candy jar of Toradol”); see Rob Huizenga, You’re Okay, It’s just a Bruise 13 (1994) (former Raiders Club doctor describing the safe door where prescription medications were kept as “wide open”); id. at 40 (players complaining that Huizenga had removed the “candy jar”); Scratton, Pierce E. Scratton, Jr., Playing Hurt: Treating and Evaluating the Warriors of the NFL 27 (2001) (providing evidence for the anesthetic Marcaine so that players could make it through the game; and providing Vicodin or Percocet after the game for pain management).

See Complaint, Dent v. Nat’l Football League, 14-cv-2324 (N.D. Cal. May 20, 2014), ECF No. 1, ¶ 204 (alleging that jars of amphetamines were removed after the death of NFL safety Don Rogers and NBA prospect Len Bias in 1986); Whatever It Takes: To Stay In The Game, Tampa Tribune (FL), Dec. 30, 2007, available at 2007 WLNR 25835392 (NFL player Brad Culpepper: “It’s not like there’s a giant candy jar out in the field where prescription medications are kept as ‘wide open’”); id. at 40 (players complaining that Huizenga had removed the “candy jar”’s); Scatton, Pierce E. Scatton, Jr., Playing Hurt: Treating and Evaluating the Warriors of the NFL 27 (2001) (providing evidence for the anesthetic Marcaine so that players could make it through the game; and providing Vicodin or Percocet after the game for pain management).

Indeed, even if a “jar” was no longer available, Former Player 1, who retired in 2010, said Club doctors would provide “painkillers and anti-inflammatories . . . like candy.” Additionally, Former Player 1 said that the Club doctors never discussed any of the risks or benefits of the painkillers with the players.


of the then 31 NFL Clubs responded to the survey.

Id. at 21.


It is unclear what group the Washington/ESPN study refers to. There are various unofficial groups of former NFL players with a variety of monikers, but research has not revealed any group using the name “Retired NFL Football Players Association.”

The Washington/ESPN study adopted the definition of “misuse” from the U.S. National Survey on Drug Use and Health, meaning “use without a prescription or use simply for the experience or feeling the drug causes.”


What are over-the-counter (OTC) drugs and how are they approved? F.D.A., http://www.fda.gov/AboutFDA/Transparency/Basics/ucm194951.htm (last visited June 17, 2016), archived at https://perma.cc/C6U2-3Q2X.


DEA Practitioner’s Manual at 6 (describing Schedules of controlled substances).

Id. at 4.

See 21 U.S.C. § 844 (prescribing criminal penalties for possession of a controlled substance without a prescription); 21 U.S.C. § 829 (prohibiting the dispensing of Schedule II, III or IV controlled substances without a prescription).
310 Vicodin, Percocet, and OxyContin are brand names for certain types of opioid pain medications. Opioids are Schedule II controlled substances. 21 U.S.C. § 812(c).

311 “The term ‘distribute’ means to deliver (other than by administering or dispensing) a controlled substance or a listed chemical. The term ‘distributor’ means a person who so delivers a controlled substance or a listed chemical.” 21 U.S.C. § 802(11).

312 “The term ‘dispense’ means to deliver a controlled substance to an ultimate user or research subject by, or pursuant to the lawful order of, a practitioner, including the prescribing and administering of a controlled substance and the packaging, labeling or compounding necessary to prepare the substance for such delivery. The term ‘dispenser’ means a practitioner who so delivers a controlled substance to an ultimate user or research subject.” 21 U.S.C. § 802(10).

313 C.F.R. § 1301.11.


315 In considering whether someone is qualified to be registered to distribute Schedule I or II controlled substances, the DEA considers: “(1) maintenance of effective control against diversion of particular controlled substances into other than legitimate medical, scientific, and industrial channels; (2) compliance with applicable State and local law; (3) prior conviction records of application under Federal or State laws relating to the manufacture, distribution, or dispensing of such substances; (4) past experience in the distribution of controlled substances; and (5) such other factors as may be relevant to and consistent with the public health and safety.” 21 U.S.C. § 823(b).

316 See Cal. Health & Safety Code § 11150 (West 2014 (“[n]o person other than a physician, dentist, podiatrist, or veterinarian, or naturopathic doctor . . . or pharmacist . . . shall write or issue a prescription”); see Cal. Health & Safety Code § 11153 (West 2014) (“[a] prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice”); N.Y. Public Health Law § 3331 (“[a] practitioner [or veterinarian], in good faith, and in the course of his or her professional practice only [in the course of the practice of veterinary medicine only], may prescribe, administer and dispense [scheduled substances] or he may cause them to be administered by a designated agent under his direction and supervision”); Tex. Health & Safety Code Ann. § 481.061 (“[e]xcept as otherwise provided by this chapter, a person who is not a registrant may not manufacture, distribute, prescribe, possess, analyze, or dispense a controlled substance in this state”); Tex. Health & Safety Code Ann. § 481.002 (“[p]ractitioner means: (A) a physician, dentist, veterinarian, podiatrist, scientific investigator, or other person licensed, registered, or permitted otherwise to distribute, dispense, analyze, conduct research with respect to, or administer a controlled substance in the course of professional practice or research in this state . . . ‘Prescribe’ means the act of a practitioner to authorize a controlled substance to be dispensed to an ultimate user.”

317 See also DEA Practitioner’s Manual at 47–51 (attaching DEA Form 224, Application for Registration, which requires the applicant to identify his or her “business activity” from a finite list of medical professions, and requires the applicant to provide his or her state license number).

318 C.F.R. § 1301.12; see also U.S. v. Clinical Leasing Service, Inc., 925 F.2d 120 (5th Cir. 1991) (statute requiring registration of physicians who distribute controlled substances at “each principal place of business” was not unconstitutionally vague).

319 C.F.R. § 1301.71(a).


321 This information was provided by the NFL and NFLPS.

322 This information was provided by the NFL.

323 Letter from Larry Ferazani, NFL, to authors (July 18, 2016).

324 This information was provided by the NFL.

325 Letter from Larry Ferazani, NFL, to authors (July 18, 2016).

326 Id.

327 Id.

328 Id.


330 Id.

331 Matthew Matava et al., Recommendations of the National Football League Physicians Society Task Force on the Use of Toradol Ketorolac in the National Football League, 4 Sports Health 377 (2012). At the time, Matava was the St. Louis Rams Club doctor, and co-authors Gritter and Heyer were Carolina Panthers Club doctors, Schlegel was a Denver Broncos Club doctor, and Yates was a Pittsburgh Steelers Club doctor.

332 Id. at 378.

333 Id. at 382.

334 Letter from Tim English, Staff Counsel, NFLPA, to Dennis Curran, Senior VP of Labor Litigation & Policy, NFL (Dec. 11, 2012), available as Exhibit 18 to the Declaration of Dennis L. Curran in Support of Defendant National Football League’s Motion to Dismiss Second Amended Complaint (Section 301 Preemption), Dent v. Nat’l Football League, 14-cv-2324 (N.D. Cal. Sep. 24, 2014), ECF No. 73.


338 Id.

339 Id.

340 Outside the Lines Discussion: Prescription Medication in the NFL, supra note 337.

341 NFL Substance Abuse Policy, General Policy, n. 1.

342 NFL Substance Abuse Policy at p. 1.

343 Id.

344 NFL Substance Abuse Policy, § 1.4.1.

345 NFL Substance Abuse Policy, § 1.5.1(a).

346 Id.

347 Id.

348 NFL Substance Abuse Policy, § 1.5.1(b).

349 Id.

350 NFL Substance Abuse Policy, § 1.5.2(a).

351 NFL Substance Abuse Policy, § 1.5.2(d).

352 Id.
Letter from Tim English, Staff Counsel, NFLPA, to Dennis Curran, Senior VP of Labor Litigation & Policy, NFL (Dec. 11, 2012), available as Exhibit 18 to the Declaration of Dennis L. Curran in Support of Defendant National Football League’s Motion to Dismiss Second Amended Complaint (Section 301 Preemption), Dent v. Nat’l Football League, 14-cv-2324 (N.D. Cal. Sep. 24, 2014), ECF No. 73.

This information was provided by the NFLPA.

E-mail with Larry Ferazani NFL, Vice President, Labor Litigation & Policy (June 1, 2016). As discussed earlier, in 2012, one club doctor did require players to sign a waiver before administering Toradol.


Id. at ¶ 15. In addition to state law claims sounding in fraud and negligence, the plaintiffs alleged the NFL violated several statutes. For example, the plaintiffs allege that the NFL violated: “the Controlled Substances Act’s requirements governing the acquisition, storage, provision and administration of, and recordkeeping concerning, Schedule II, III and IV controlled substances”; the Food, Drug, and Cosmetic Act’s “requirements for prescriptions, warnings about known and possible side effects, and proper labeling, among other violations”; and, “state laws governing the acquisition, storage and dispensation of prescription medications.” Id. at ¶¶ 354–57.

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

Specific duties of the athletic trainer include but are not limited to:

(a) Supervision of the selection, fitting, and maintenance of protective equipment;
(b) Provision of assistance to the coaching staff in the development and implementation of conditioning programs;
(c) Counseling of athletes on nutrition and hygiene;
(d) Supervision of athletic training facility and inspection of playing facilities;
(e) Selection and maintenance of athletic training equipment and supplies;
(f) Instruction and supervision of student trainer staff;
(g) Coordination with a team physician to provide:
   i. pre-competition physical exam and health history updates,
   ii. game coverage or phone access to a physician or paramedic,
   iii. follow-up injury care,
   iv. reconditioning programs, and
   v. assistance on all matters pertaining to the health and well-being of athletes.
(h) Provision of on-site injury care and evaluation as well as appropriate transportation, follow-up treatment and rehabilitation as necessary for all injuries sustained by athletes in the program;
(i) With a physician, determination of when an athlete may safely return to full participation post-injury; and
(j) Maintenance of complete and accurate records of all athletic injuries and treatments rendered.11

Generally, state licensing statutes and regulations require athletic trainers to work under the direction of a licensed physician.12 Indeed, all club athletic trainers work under the supervision of a club doctor and it is important that athletic trainers act within the scope of their practice. Nevertheless, athletic trainers are often the first and most consistent source of medical care provided to players. Club doctors generally only visit practice for a few hours a few times per week (see Chapter 2: Club Doctors, Section F: Current Practices), as players’ conditions are unlikely to change much on a day-to-day basis. Thus, during the week, athletic trainers are responsible for treating ongoing injuries by all available methods, including, for example, ice, heat, ultrasound, massage, and stretching. The athletic trainer and club doctor remain in contact about players’ conditions during the week and the club doctor directs the athletic trainer as to how treatment should proceed.13

Additionally, athletic trainers prepare players for each practice by taping, bracing, and padding various joints and body parts. Athletic trainers must also be prepared to respond to any new injuries that occur. Each day, athletic trainers, in consultation with the club’s coaches and management, complete the daily Injury Report (discussed at length in Chapter 17: The Media), describing a player’s practice participation level.14

Game days proceed similarly, only with the likelihood of injury significantly increased.15 Athletic trainers assist in the evaluation of injuries, including the performance of relevant diagnostic testing. In so doing, athletic trainers work closely with the various club doctors present on game days.16

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

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

c According to the NFLPS, “[t]he athletic trainer is often the first person to see an injured player at the game, practice, training camp, mini-camp, etc. The trainer must be accurate in the identification of injuries and must communicate (sic) well with the team physician. There is a constant source of dialogue between the athletic trainers and the team physicians in all aspects of the player’s care, whether it’s preventative care, managing current injuries or medical problems, or the entire rehabilitation process.” Frequently Asked Questions: NFLPS, http://nflps.org/faqs/how-do-nflps-physicians-collaborate-with-team-trainers-to-ensure-optimum-health-for-players/ (last visited Aug. 7, 2015), archived at http://perma.cc/8FL2-F54H.
medical
will feel pressure from the athletic trainer concerning certain
the club doctor, there is the possibility that the club doctor
has the authority to terminate the club’s relationship with
not extend to medical issues. However, if the athletic trainer
of a club doctor must be merely administrative and should
club’s outside medical providers.24 As a matter of law
responsible for determining and communicating with the
athletic trainers of NFL clubs.26 “[M]embership in
PFATS is an organization that represents
the athletic trainers of NFL clubs.26 “[M]embership in
PFATS is limited to those professionally certified in ac-
cordance with the most current NFL Collective Bargaining
Agreement and who are employed full-time as head or
assistant athletic trainers by any of the 32 NFL fran-
chises.”27 PFATS’ mission statement is as follows:

The Professional Football Athletic Trainers Society
(PFATS) is a Professional Association represent-
ing the athletic trainers of the National Football
League. We serve the players of the NFL, the
member Clubs, and other members of the commu-
nity. 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 educa-
tion and research. The Society is founded on the
professional integrity and the ethical standards
of our members and the fellowship that exists
among us.28

In addition to PFATS, it is likely that many club athletic
trainers are also members of NATA, mentioned above
in the CBA provision. NATA is a voluntary professional
membership association for certified athletic trainers across
all levels of competition.29 NATA’s stated mission “is to
enhance the quality of health care provided by certified
athletic trainers and to advance the athletic training profes-
sion.”30 NATA informed us that 0.38 percent of its 32,651
members (equal to 124) work in the NFL.31 At a mean of
3,875 per club, it appears almost every NFL athletic trainer
is a member of NATA.

The CBA’s requirement that athletic trainers be certified by
NATA is actually in error and a requirement with which
athletic trainers cannot comply. NATA is a voluntary pro-
fessional association but does not certify athletic trainers.
Athletic trainers are certified by the BOC.32 The BOC used
to be part of NATA, but split from the voluntary associa-
tion in 1989.33 Fortunately, the error has no impact, as all
NFL athletic trainers are BOC-certified.34 Nevertheless,
to ensure players are being treated by the highest quality
athletic trainers, the CBA should be amended to require
the correct certification, the Board of Certification for the
Athletic Trainer.

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

(B) Current Legal Obligations

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

The legal obligations described herein are not an exhaustive list but are those we
believe are most relevant to player health.
Athletic trainers also have legal obligations consistent with their licensure. As discussed above, the vast majority of states require athletic trainers to be licensed. Generally, each state’s governing act and/or related regulations also includes standards of professional conduct with which athletic trainers must comply. Many of the standards are similar to those of other licensed or certified professionals, such as prohibitions against false statements and discrimination against protected classes.

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

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

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

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

Below we discuss statutory requirements concerning the confidentiality of medical information. As briefly discussed in the introduction to this chapter, an athletic trainer’s conflicting interests can create complications concerning the treatment of player medical information. Indeed, in Section D: Current Practices, we provide the thoughts of some current players about these conflicts. However, before discussing the statutory requirements, it is important to first state that clubs request or require players to execute waivers permitting the player’s medical information to be disclosed to and used by a wide variety of parties, including but not limited to the NFL, any NFL club, and any club’s medical staff and personnel, such as coaches and the general manager. A copy of this waiver is included as Appendix L. The circumstances under which these waivers are executed is an area worthy of additional attention. For example, questions might be raised as to whether the players are providing meaningful and voluntary informed consent in their execution, even though these waivers have been collectively bargained between the NFL and NFLPA.

Nevertheless, the federal Health Insurance Portability and Accountability Act (HIPAA) likely governs athletic trainer’s requirements concerning the confidentiality of player medical information. HIPAA requires healthcare providers covered by the law to obtain a patient’s authorization before disclosing health information protected by HIPAA. Covered entities under HIPAA include: “(1) A health plan[,] (2) A health care clearinghouse[,] and[,] (3) A health care provider who transmits any health information in electronic form.”

Athletic trainers likely meet the third criteria to be considered a covered entity under HIPAA. A “[h]ealth care provider” is defined by HIPAA as anyone who “furnishes . . . health care in the normal course of business.” And “health care means care, services, or supplies related to the health of an individual” including “[p]reventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body.” Moreover, athletic trainers enter players’ health information into EMRs that are accessed by doctors. Athletic trainers thus appear to provide healthcare within the meaning of HIPAA and thus must comply with its requirements.

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

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On a related point, it is not clear whether clubs would be considered covered entities under HIPAA. See Memorandum Opinion and Order, In re: Nat’l Hockey League Players’ Concussion Injury Litigation, 14-md-2551 (D. Minn. July 31, 2015), ECF No. 196 (discussing, but not resolving, whether NHL clubs were covered entities under HIPAA).
3. National Athletic Trainers Association Code of Ethics:
The most current version of the Code of Ethics on the National Athletic Trainers Association (NATA) shall be deemed to be incorporated by reference as part of this Code of Ethics as if fully set forth herein.

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

5. Responsibility of the Certified Athletic Trainer to the Medical Staff:
   a. It should be remembered that the role of the certified athletic trainer is that of a paramedical person, and that diagnosing of injuries/illnesses and prescribing remedial exercise and medication is the job of the physicians employed.
   b. The certified athletic trainer shall honor the standing operating procedures established by the team physicians in the physicians’ absence, and shall care for the athletes in compliance with standing orders until such time that the athletes can be seen by physicians.

6. Responsibility of the Certified Athletic Trainer to the Club:
   a. The certified athletic trainer is a professional member of the NFL Club that is his employer and should be completely loyal to the Club.
   b. Different Clubs and Coaches have different methods and philosophies. The certified athletic trainers are expected to provide their best professional services within the framework of the existing Club and coaching policy but should never violate professional ethics based on purported “Club Policy.”

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

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

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

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

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

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

1: Members shall respect the rights, welfare and dignity of all.

1.3: Members shall preserve the confidentiality of privileged information and shall not release such information to a third party not involved in the patient’s care without a release unless required by law.

2.1: Members shall comply with applicable local, state, and federal laws and institutional guidelines.

3.2: Members shall provide only those services for which they are qualified through education or experience and which are allowed by their practice acts and other pertinent regulation.

4: Members shall not engage in conduct that could be construed as a conflict of interest or that reflects negatively on the profession.
The above-stated principles leave significant room for interpretation and debate and NATA does not make any enforcement decisions public. Consequently, it is difficult to know how these principles are applied in practice.

In addition, NATA issues a variety of “Position Statements,” “Official Statements,” “Consensus Statements” and “Support Statements” on a variety of topics related to the health of athletes generally, including treatment of various medical conditions and issues including but not limited to concussions, psychological issues, cardiac arrest, ankle sprains, performance-enhancing drugs, nutritional supplements, and weight loss and eating disorders.56

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

The BOC’s Standards of Professional Practice also include several relevant directives, with which all certified athletic trainers must “agree to comply,”62 including:

- **Standard 1**: The Athletic Trainer renders service or treatment under the direction of a physician.
- **Standard 2**: Prevention: The Athletic Trainer understands and uses preventive measures to ensure the highest quality of care for every patient.

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

Nevertheless, the above Code provisions are generalized and thus difficult to apply to NFL athletic trainers without more guidance. According to the BOC’s Professional Practice and Discipline Guidelines and Procedures, it is “standard procedure” to publicly release any discipline imposed on an athletic trainer.63 However, despite closing 304 disciplinary cases in 2015,64 the BOC’s database of disciplinary decisions only contains 63 cases from 2015,
and only 99 in total, dating back to 2002. Moreover, the 63 cases in 2015 that are publicly available are not helpful in interpreting the BOC’s Standards of Professional Practice: 44 concern failure to receive continuing education credits; 11 concern practicing without a license; 7 concern criminal conduct; and 1 concerns voluntarily surrendering a license. The BOC stated that “most of our disciplinary cases were private censures and those are not public.”

### Current Practices

Players and contract advisors we interviewed confirmed that athletic trainers are generally the player’s first and primary source of medical care. Club doctors are only with the club sporadically during the week of practice, while 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. Current Player 1:

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

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

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

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

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

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

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

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

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

l To repeat information provided in the Introduction, we conducted approximately 30-minute interviews with 10 players active during the 2015 season and three players who recently left the NFL (the players’ last seasons were 2010, 2012, and 2012 respectively). The players interviewed were part of a convenience sample identified through a variety of methods—some were interested in The Football Players Health Study more generally, some we engaged through the Law and Ethics Advisory Panel (LEAP), and Football Players Health Study Player Advisors, and some interviews were facilitated by a former player now working for the NFLPA. The players interviewed had a mean of 7.5 seasons, with a range of 2 to 15 seasons, and for a mean of between 3 and 4 different clubs (3.4 clubs), with a range of 1 to 10 clubs. In addition, we interviewed players from multiple positions: one quarterback; two fullbacks; one tight end; three offensive linemen; two linebackers; one defensive end; two safeties; and a special teams player (not a kicker, punter, or long snapper). We aimed for a racially diverse set of players to be interviewed: seven were white and six were African American. Finally, the players also represented a range of skill levels, with both backups and starters, including four players who had been named to at least one Pro Bowl team. These interviews were not intended to be representative of the entire NFL player population or to draw scientifically valid inferences, and should not be read as such, but were instead meant to be generally informative of the issues discussed in this Report.

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

n Current Player 1: “If you trust the doctors. But I think it’s more the trainers that they don’t trust as much.” Current Player 2 described the lack of trust in athletic trainers as “even more so than the doctors.” Current Player 10: “I think there’s less trust in the trainers than the team doctors.”

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

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

q Current Player 4 also explained “I’ve had trainers try to convince me not to have a second opinion.”
Although we recognize that players may not be experts in treatment methods, multiple players we interviewed also complained that athletic trainers utilize outdated treatment methods:

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

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

Multiple current players explained that their concerns about athletic trainers and the club’s healthcare operations caused them to self-treat or to seek care and treatment outside of the club, both during the season and in the offseason:

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

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

( E ) Enforcement of Legal and Ethical Obligations

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

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

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2 Appendix K is a summary of players’ options to enforce legal and ethical obligations against the stakeholders discussed in this Report. In addition, for rights articulated under either the CBA or other NFL policy, the NFLPA and the NFL can also seek to enforce them on players’ behalves.
designee), the NFLPA Executive Director (or his designee), and six additional members “experienced in fields relevant to healthcare for professional athletes,” three appointed by the Commissioner and three by the NFLPA Executive Director.75 “[T]he complaint shall be referred to the League and the player’s Club, which together shall determine an appropriate response or corrective action if found to be reasonable. The Committee shall be informed of any response or corrective action.”76 There is thus no neutral adjudicatory process for addressing the player’s claim or compensating the player for any wrong suffered. The remedial process is left entirely in the hands of the NFL and the club, both of which would have little incentive to find that a club medical official acted inappropriately and to compensate the injured player accordingly.

Second, a player could request the NFLPA to commence an investigation before the Joint Committee on Player Safety and Welfare (Joint Committee). The Joint Committee consists of three representatives chosen by the NFL and three chosen by the NFLPA.77 “The NFLPA shall have the right to commence an investigation before the Joint Committee if the NFLPA believes that the medical care of a team is not adequately taking care of player safety. Within 60 days of the initiation of an investigation, two or more neutral physicians will be selected to investigate and report to the Joint Committee on the situation. The neutral physicians shall issue a written report within 60 days of their selection, and their recommendations as to what steps shall be taken to address and correct any issues shall be acted upon by the Joint Committee.”78 While a complaint to the Joint Committee results in a neutral review process, the scope of that review process’ authority is vague. The Joint Committee is obligated to act on the recommendations of the neutral physicians, but it is unclear what it means for the Joint Committee to act and there is nothing obligating the NFL or any club to abide by the neutral physicians’ or Joint Committee’s recommendations. Moreover, there is no indication that the neutral physicians or Joint Committee could award damages to an injured player.79

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

Third, a player could try to commence a Non-Injury Grievance.82 The 2011 CBA directs certain disputes to designated arbitration mechanisms83 and directs the remainder of any disputes involving the CBA, a player contract, NFL rules or generally the terms and conditions of employment to the Non-Injury Grievance arbitration process.84 Importantly, Non-Injury Grievances provide players with the benefit of a neutral arbitration and the possibility of a “money award.”85

However, there are several impediments to pursuing a Non-Injury Grievance against an athletic trainer (or any club employee). First, athletic trainers are not parties to the CBA and thus likely cannot be sued for violations of the CBA.86 Instead, the player could seek to hold the club responsible for the athletic trainer’s violation of the CBA.87 Second, Non-Injury Grievances must be filed within 50 days “from the date of the occurrence or non-occurrence upon which the grievance is based,”88 a timeframe that is much shorter than your typical statute of limitations. And third, players likely fear that pursuing a grievance against an athletic trainer could result in the club terminating him. Current Player 8 stated as much: “You don’t have the gall to stand against your franchise and say ‘They mistreated me.’ . . . I, still today, going into my eighth year, am afraid to file a grievance, or do anything like that[.]”89

While it is illegal for an employer to retaliate against an employee for filing a grievance pursuant to a CBA,89 such litigation would involve substantial time and money for an uncertain outcome. Moreover, given the precarious nature of players’ employment and the considerable discretion the club has over the roster, any such retaliation would be challenging to prove.

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

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

First, in 1989, former Seattle Seahawks safety Kenny Easley sued the Seahawks, the Seahawks doctor and athletic trainer, and Whitehall Laboratories, a maker of Advil, alleging that Easley’s use of Advil had caused him kidney damage necessitating a transplant.93 Easley alleged the Seahawks medical staff negligently provided him with large doses of the drug and did not tell him when he developed kidney problems.94 Easley ultimately reached
an undisclosed settlement with the doctor and Whitehall Laboratories in 1991. The result of the case as against the athletic trainer is unclear. News reports discussed a pending workers’ compensation case, which suggests that Easley’s case against the athletic trainer, a co-worker, was dismissed.

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

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

The Minnesota Court of Appeals determined that the athletic trainers against whom appeal was sought did owe a personal duty to Stringer but affirmed judgment in their favor by finding that they were not grossly negligent as a matter of law.\(^v\)

The Supreme Court of Minnesota affirmed the decisions in favor of the athletic trainers and held that they did not owe a personal duty to Stringer.\(^v\) Under Minnesota law, an employee owes a personal duty to an injured employee only where the employee acts “outside the course and scope of employment.”\(^v\) Because the Vikings’ athletic trainers were acting within their scope of their employment when treating Stringer, they did not owe Stringer a personal duty and thus any claims against them were barred by workers’ compensation laws.\(^v\)

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

The CBA also presents a potential obstacle against any such claim. This is because the Labor Management Relations Act (LMRA)\(^v\) bars or “preempts” state common law claims, such as negligence, where the claim is “substantially dependent upon analysis of the terms” of a CBA, i.e., where the claim is “inextricably intertwined with consideration of the terms” of the CBA.\(^v\) In order to assess an athletic trainer’s duty to an NFL player, an essential element of a negligence claim, the court may have to refer to and analyze the terms of the CBA, resulting in the claim’s preemption.\(^v\)

Preemption occurs even though athletic trainers are not parties to the CBA and thus likely cannot be a party in any CBA grievance procedure. So long as the player’s claim is “inextricably intertwined with the CBA, it will be pre-empted. In these cases, player complaints must be resolved through the enforcement provisions provided by the CBA itself (i.e., a Non-Injury Grievance against the club), rather than litigation.

PFATS’ Code of Ethics also provides two purported enforcement mechanisms. First, according to PFATS, its “Constitution expressly authorizes disciplinary action against members for violations of the Constitution,” of which the Code of Ethics is part.\(^v\) However, “[d]isciplinary action for alleged violations of the PFATS Code of Ethics can only be initiated by the Executive Committee.”\(^v\) PFATS’ Code of Ethics also provides two purported enforcement mechanisms. First, according to PFATS, its “Constitution expressly authorizes disciplinary action against members for violations of the Constitution,” of which the Code of Ethics is part.\(^v\) However, “[d]isciplinary action for alleged violations of the PFATS Code of Ethics can only be initiated by the Executive Committee.”\(^v\)

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

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

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

\(^x\) Stringer’s estate did not appeal the trial court’s decision with respect to one of the athletic trainers. See Stringer v. Minn. Vikings Football Club, 705 N.W.2d 746, 748 n.1 (Minn. 2005).
Athletic trainers are the player’s principal source of healthcare. For this reason, it is important that they hold player health as their paramount responsibility and act in accordance with their legal and ethical obligations at all times. Nevertheless, as discussed above in the Current Practices Section, some players expressed concerns about athletic trainers’ practice because of their close relationship to the club. To address this concern, we make the below recommendations.

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

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

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

**Recommendation 3:1-A:** The current arrangement in which club (i.e., “team”) medical staff, including doctors, athletic trainers, and others, have responsibilities both to players and to the club presents an inherent conflict of interest. To address this problem and help ensure that players receive medical care that is as free from conflict as possible, division of responsibilities between two distinct groups of medical professionals is needed. Player care and treatment should be provided by one set of medical professionals (called the “Players’ Medical Staff”), appointed by a joint committee with representation from both the NFL and NFLPA, and evaluation of players for business purposes should be done by separate medical personnel (the “Club Evaluation Doctor”).

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

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

*z Current Player 10: “If protecting the health of players always takes precedence, as Roger Goodell has stated, then trainers need to have players’, not owners’, best interests in mind at all times.”*
transmitted to the club through a Player Health Report completed by the Players’ Medical Staff." Additional logistics concerning the recommendation are discussed in Chapter 2: Club Doctors and Appendix G: Model Article 39 of the Collective Bargaining Agreement – Players’ Medical Care and Treatment. Nevertheless, most importantly, the proposed structure removes any conflict of interest in the care being provided to players by athletic trainers and other medical staff. This recommendation concerns both club doctors and athletic trainers and is an important recommendation for the improvement of player health. Like club doctors, athletic trainer best practices include the avoidance and minimization of conflicts of interest. Indeed, in reviewing a draft of this chapter, NATA described this recommendation as “possibly controversial,” but “sound.” One positive sign as to the feasibility of our recommendation is that PFATS did not express any opposition to this recommendation when it reviewed a draft of this chapter.

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

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

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

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aa As explained in Chapter 2: Club Doctors, Recommendation 2:1-A, The Player Health Report would briefly describe: (1) the player’s condition; (2) the player’s permissible level of participation in practice and other club activities; (3) the player’s current status for the next game (e.g., out, doubtful, questionable, or probable); (4) any limitations on the player’s potential participation in the next game; and (5) an estimation of when the player will be able to return to full participation in practice and games. The Player Health Report would be a summary form written for the lay coaches and club officials, as opposed to a detailed medical document. Generally speaking, we propose that the Player Health Reports be provided to the club before and after each practice and game. Additionally, the club would be entitled to a Player Health Report on days where there is no practice or game if a player has received medical care or testing.


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

9 Map of State Regulatory Agencies, supra note 7.

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

11 ILCS 5/3.

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


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


16 This information was provided by the NFLPA.

17 Id.

18 Id.

19 Id.

20 Id.

21 Id.

22 Id.


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


31 NATA Comments (July 14, 2016).

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


34 This information was provided by PFATS.


36 Id. at 2.

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


CBA, Art. 39, § 3(a).
CBA, Art. 39, § 3(d).
CBA, Art. 50, § 1(a).
CBA, Art. 50, § 1(d).
In Stringer v. Nat’l Football League, the court also expressed concerns about the effectiveness of the Joint Committee: “While the NFL is required to give ‘serious and thorough consideration’ to recommendations of the Joint Committee, the CBA imposes no independent duty on the NFL to consider health risks arising from adverse playing conditions, or to make recommendations for rules, regulations or guidelines for the clubs to follow.” 474 F.Supp.2d 894, 896 (S.D. Ohio 2007).

This information was provided by the NFLPA.

Id.

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

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

See 2011 CBA, Art. 43, § 1.

Id. at § 6 (discussing constitution of Arbitration Panel); Id. at § 8 (discussing Arbitrator’s authority, including to grant a “money award”).

See Jackson v. Kimel, 992 F.2d 1318, 1325 n.4 (4th Cir. 1993) (collecting cases holding that employees that are not signatories to the CBA cannot be sued for violations of the exclusive scope of the System Arbitrator, 2011 CBA, Art. 15, currently University of Pennsylvania Law School Professor Stephen B. Burbank.

See 2011 CBA, Art. 2, § 2 (generally discussing CBA’s binding effect on NFL, NFLPA, players and clubs but not other party).

CBA, Art. 43, § 2.


Id.

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


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

Id. at 754.


Stringer, 705 N.W.2d 746.

Id. at 757–58.

Id. at 761–63. The result would likely have been the same under other states’ workers’ compensation laws. See Hendy v. Loss, 819 P.2d 1 (Cal. 1991) (NFL player’s medical malpractice claim against Club doctor barred by workers’ compensation statute where Club doctor was co-employee and acting within scope of employment); Macchirole v. Giamboli, 782 N.E.2d 346 (N.Y. 2001) (co-employee’s negligence claims barred by worker’s compensation statute where co-employee was acting within scope of employment).


See, e.g., Givens v. Tennessee Football, Inc., 684 F.Supp.2d 985 (M.D. Tenn. 2010) (player’s tort claims against Club arising out of medical treatment preempted); Williams v. Nat’l Football League, 582 F.3d 863 (8th Cir. 2009) (players’ tort claims arising out of drug test preempted). However, for reasons that are not clear, LMRA preemption was not cited by any of the Minnesota state court decisions in the Stringer case.

This information was provided by PFATS.

Id.

PFATS Code of Ethics, Art. X.

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

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

This information was provided by PFATS.

Id.


See id.


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


E-Mail from NATA representative to author (May 20, 2016, 11:46 PM) (on file with author).
“Second opinion doctors” is a generic term for doctors whom players may consult concerning an injury or medical condition to compare or contrast that opinion to that of the club doctor. In addition, some might be the players’ primary caregiver or “personal doctor,” as discussed in detail in Chapter 6, and thus fall under the same recommendations we make there. Second opinion doctors are an important component of a player’s healthcare protected by the CBA. That said, second opinion doctors’ care of players does not include the same type of structural conflicts that potentially hinder the care provided by club doctors, so our recommended changes as to them are more sparing.
FIMS’ Code of Ethics obligates “[t]he team physician [to] explain to the individual athlete that he or she is free to consult another physician.”3

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

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

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

(a) Base the decision or recommendation on the patient’s medical needs, as they would for any treatment recommendation, and consult or refer the patient to only health care professionals who have appropriate knowledge and skills and are licensed to provide the services needed.

(b) Share patients’ health information in keeping with ethical guidelines on confidentiality.

(c) Assure the patient that he or she may seek a second opinion or choose someone else to provide a recommended consultation or service . . . .

* * *

Physicians may not terminate a patient-physician relationship solely because the patient seeks recommendations or care from a health care professional whom the physician has not recommended.4

Similarly, the American Board of Physician Specialties obligates doctors to “[c]ooperate in every reasonable and proper way with other physicians and work with them in the advancement of quality patient care.”5

D | Current Practices

Second opinion doctors play a role in player health largely as a result of contract advisors.6 While recognizing that there may be some variation in their usage, of the six contract advisors we interviewed, five stated that they obtain a second opinion every time or nearly every time a player is significantly injured, while the sixth stated he obtains a second opinion about 50 percent of the time.

The reasoning behind obtaining the second opinions ranges from general to specific distrust of club doctors.7 Current Player 9 described the advantages of second opinion doctors:

I feel like they don’t have any vested interest in keeping you on the field; their main job is that you’re healthy and they check your medical condition, whatever that may be. And they don’t have pressure coming from the coach or the GM [general manager] or the owner to get guys out there quickly . . . . What you have to understand is that the trainer’s and the doctor’s job is to get you on the field. Once you’re part of the organization, it’s their job to put you on the field.8

Similarly, some contract advisors indicated that by almost always obtaining a second opinion, it removes any concern that the club doctor might have been making a recommendation that was in the club’s interest and not the player’s.9 One contract advisor even stated that when assessing a player’s injury, “the club doctor has nothing to do with it . . . the club doctor’s input means nothing to us.”9 Some contract advisors also indicated that their experience with, and the reputation of, a particular club or club medical staff will color the decision of whether to obtain a second opinion or to proceed with the club doctor’s recommended course of treatment.10 Indeed, club doctors often serve as second opinion doctors for other clubs’ players, often at the recommendation of contract advisors. Nevertheless, in such situations there is less concern about a structural conflict of interest since the club doctor is only serving as a second opinion doctor and not also providing advice to the club employing the player.

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c Current Player 2: “I think that agents do a good job of helping players with . . . seeking second opinions[.]”

d Former Player 2: “Most of the time when I saw guys going to get second opinions . . . was because something had happened or something we heard about or the player had a multi-year contract and wanted to make sure that his diagnosis was correct.”

e Current Player 10: “[P]layers have the right to get a second or third medical opinion which I think is smart to do.”

f Contract Advisor 1: “I’ve effectively removed any of that [concern]. I’ve said okay, where I feel like I need to get a second opinion almost every time, I get a second opinion. So it’s become a nonissue.” Contract Advisor 5: “I’m always concerned that the doctor is involved because he’s, you know, an employee of the club.”

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

h Contract Advisor 2: “[I]t depends sometimes on the organization that we’re dealing with.”
The second opinion doctor’s recommended course of treatment is almost always the one taken in today’s NFL.

If the second opinion doctor’s diagnosis or recommended treatment plan does differ, a decision then must be made as to which course of treatment to pursue and which doctor will perform the surgery (if necessary). In some cases, the contract advisor might arrange for the second opinion doctor to talk with the club doctor to see if a consensus can be reached. Sometimes a third doctor will provide an opinion. Nevertheless, the prevailing sentiment among the contract advisors interviewed is that when there is a conflict, the second opinion doctor’s recommended course of treatment is almost always the one taken in today’s NFL. As discussed above, some contract advisors’ regard the club doctor’s opinion as meaningless, and others believe that in recent years clubs and club medical staff have resigned themselves to doing what the average patient might only seek a second opinion about serious diagnoses.

In talking with players and contract advisors, most believed that club doctors are generally, but not always, cooperative with players obtaining second opinions, a marked departure from historical practice and even just 5 to 10 years ago. Nevertheless, former NFL club executive Andrew Brandt in his peer review comments noted his belief that clubs and club doctors maintain some level of inherent distrust of second opinion doctors chosen by contract advisors and the NFLPA; much in the same way that players and the NFLPA maintain a level of inherent distrust of club doctors. For example, clubs might believe the second opinion doctors are not sufficiently qualified to treat the player.

The second opinion doctor typically only reviews the records, X-rays, and/or MRI films but occasionally will request to see the player in person if the doctor believes it is necessary. Contract advisors’ estimates of how often a second opinion doctor’s diagnosis differed from the club doctor’s diagnosis were generally low (“10 to 20 percent,” “as much as 20 percent,” “about a third of the time,” “not incredibly often”). In fact, those rates (while not necessarily representative) are slightly lower than the general population. According to the Patient Advocate Foundation, 30 percent of patients who sought second opinions for elective surgery found the two opinions differed. However, it is difficult to compare the figures because, as discussed above, players obtain second opinions almost as a matter of course while the average patient might only seek a second opinion about serious diagnoses.

A second opinion doctor, just like any doctor, is obligated to provide care to his or her patients within an acceptable standard of care in the medical community or potentially be subject to a medical malpractice claim. The extent of these obligations is discussed in much greater depth in Chapter 2: Club Doctors, Section (C)(1)(a). In brief, though, the general elements of a medical malpractice claim are: (1) a standard of care owed by the doctor to the plaintiff; (2) a breach of that standard of care by the doctor; and, (3) the breach was the proximate cause of the plaintiff’s injury.

While medical malpractice liability potentially exists, our research has not revealed any cases in which an NFL player has sued a doctor from whom he obtained a second opinion.

The CBA does not provide players with any grievance or arbitration mechanism by which players could pursue claims against second opinion doctors. Second opinions are available to players at the club’s expense under the CBA, but the CBA does not in any way dictate the second opinion doctor’s obligations to the player.

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j Contract Advisor 1: “I will say there was a lot more pushback early in my career about second opinions and going somewhere else.”

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

l Many states require a doctor with the same board certification or similar expertise as the doctor against whom the claim is brought to opine as to the appropriate standard of care. See Benjamin Grossberg, Uniformity, Federalism, and Tort Reform: The Erie Implications of Medical Malpractice Certificate of Merit Statutes, 159 U. Pa. L. Rev. 217 (2010) (identifying 25 states with statutes that require certificates of merit by another doctor for a medical malpractice claim). Thus, in the event a second opinion doctor was sued for medical malpractice, the claim likely could not proceed without a similarly qualified doctor — whether it be an orthopedist, neurologist or a doctor specializing in sports medicine — opining that the second opinion doctor deviated from the standard of care.
Recommendations Concerning Second Opinion Doctors

Second opinion doctors are important advocates for players’ health and do not suffer from the inherent structural conflicts of interest, faced by club doctors. While we do not have recommendations directed specifically toward second opinion doctors, we do have recommendations concerning how other stakeholders can promote and support the good work of these doctors.

**Goal 1: To help players obtain the best possible healthcare.**

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

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**Recommendation 4:1-A:** Clubs and club medical staff should support players in their right to receive a second opinion.

The right to and value of a second medical opinion is well accepted in our society, particularly for serious conditions. This right to a second opinion is all the more important for NFL players considering that their careers depend on their health and the complexity of their conditions. Consequently, no matter the club doctor’s best intentions or practices, players should regularly obtain second opinions and clubs and club medical staff should support them in exercising that right. It would be advisable that club medical staff advise players of their right to obtain a second opinion at the beginning of training camp (a right of which the NFLPA should also be advising players at the same time). Supporting a player’s right to a second opinion means, among other things, advising the player of his right to a second opinion, not resisting a player’s desire to obtain a second opinion, and cooperating with the second opinion doctor by providing the necessary medical records and other information in a timely fashion. Indeed, AMA Code Opinion 1.2.3 requires such cooperation. Accepting a player’s right to obtain a second opinion and cooperating with that right is important for players to receive the best possible healthcare. For this reason, the parties should also consider whether this recommendation should be included in the CBA.

**Recommendation 4:1-B:** In the event that club medical staff diagnose or treat a player for an injury that is beyond a threshold of severity, the medical staff should remind the player of his right to obtain a second opinion at the club’s expense.

As discussed above, a player’s right to a second opinion is important to his health. Nevertheless, many players, particularly younger players, do not avail themselves of this right. Some players might not be aware that they have the right in the CBA to a second opinion at the club’s expense or are worried about offending the club doctor and thus the club. By requiring club medical staff to advise players of their right to a second opinion in more serious situations, it is likely that players will increasingly take advantage of this right and thus also protect their own health. When a player misses a game or a week of practice it might indicate a sufficiently severe injury to trigger this obligation. Again, a player’s right to receive a second opinion is important for players to receive the best possible healthcare and thus the parties should also consider whether this recommendation should be included in the CBA.

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In reviewing a draft of this report, the NFL claimed that “[t]hese recommendations are already incorporated in Article 39 of the CBA.” While it is true that Article 39 does provide a right to a second opinion, our recommendation is not about that specific right, but about club medical staff assisting players in obtaining a second opinion. We do not read Article 39 to include these recommendations and thus believe they are important to make.
In the NFL, a third kind of doctor, what the CBA describes as a “neutral”
doctor, is sometimes used when there are conflicting opinions or
interests. Neutral doctors, particularly when providing care, can be an
important component of a player’s healthcare. As with second opinion
doctors, neutral doctors’ responsibilities do not include the same
type of structural conflicts that potentially hinder the care provided
by club doctors. Consequently, our recommendations as to them are
more sparing.

While in other chapters we provided the stakeholder an opportunity to
review a draft of the relevant chapter(s) prior to publication, because
there is no well-defined representative for neutral doctors, no one
reviewed this chapter on behalf of neutral doctors prior to publication.
(A) Background

The 2011 CBA demarcates three situations where neutral doctors are required. Preliminarily, it is important to note that in each of these situations, the neutral doctor is usually a different person, i.e., there is not one neutral doctor who serves in each of these situations.

First, Article 39, § 1(e) concerns neutral doctors at NFL games. Section 1(e) requires that “[a]ll 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.” As far as we can ascertain, there has never been a “catastrophic emerg[ency]” requiring intubation or similar emergency care.

Second, Article 44 enlists the neutral doctor in the Injury Grievance mechanism. “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.” Pursuant to Article 44, the player is entitled to a neutral arbitration to determine whether the player was physically unable to perform at the time his contract was terminated. A neutral doctor plays an instrumental role in the outcome of the arbitration:

The player must present himself for examination by a neutral physician in the Club city or the Club city closest to the player’s residence within twenty (20) days from the date of the filing of the grievance. This time period may be extended by mutual consent if the neutral physician is not available. Neither Club nor player may submit any medical records to the neutral physician, nor may the Club physician or player’s physician communicate with the neutral physician. The neutral physician will not become the treating physician nor will the neutral physician examination involve more than one office visit without the prior approval of both the NFLPA and Management Council. The neutral physician may not review any objective medical tests unless all parties mutually agree to provide such results. The neutral physician may not perform any diagnostic tests unless all parties consent. The neutral physician is required to submit to the parties a detailed medical report of his examination.2

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The arbitrator will consider the neutral physician’s findings conclusive with regard to the physical condition of the player and the extent of an injury at the time of his examination by the neutral physician.3

Third, Article 50, § 1 concerns the Joint Committee on Player Safety and Welfare (Joint Committee), which also makes mention of the neutral physician. The Joint Committee consists of members from both NFL clubs and the NFLPA and is designed to discuss “the player safety and welfare aspects of playing equipment, playing surfaces, stadium facilities, playing rules, player-coach relationships,

We recommend that if the Unaffiliated Neurotrauma Consultant diagnoses a player with a concussion, the player cannot return to the game.
The NFLPA shall have the right to commence an investigation before the Joint Committee if the NFLPA believes that the medical care of a team is not adequately taking care of player safety. Within 60 days of the initiation of an investigation, two or more neutral physicians will be selected to investigate and report to the Joint Committee on the situation. The neutral physicians shall issue a written report within 60 days of their selection, and their recommendations as to what steps shall be taken to address and correct any issues shall be acted upon by the Joint Committee.  

In addition to these CBA provisions requiring a neutral doctor, the NFL and NFLPA have agreed on protocols regarding the diagnosis and management of concussions (“Concussion Protocol,” see Appendix A). The Concussion Protocol requires an “Unaffiliated Neurotrauma Consultant” to be assigned to each club for each game. The Unaffiliated Neurotrauma Consultant must “be a physician who is impartial and independent from any Club, is board certified or board eligible in neurology, neurological surgery, emergency medicine, physical medicine and rehabilitation physician, or any primary care CAQ [Certificate of Added Qualification] sports medicine certified physician and has documented competence and experience in the treatment of acute head injuries.” The Unaffiliated Neurotrauma Consultant is present on the sideline during the game and “shall be (i) focused on identifying symptoms of concussion and mechanisms of injury that warrant concussion evaluation, (ii) working in consultation with the Head Team Physician or designated TBI team physicians to implement the Club’s concussion evaluation and management protocol (including the Sideline Concussion Assessment Exam) during the games, and (iii) present to observe (and collaborate when appropriate with the Team Physician) the Sideline Concussion Assessment Exams performed by Club medical staff.”

Despite the important role of the Unaffiliated Neurotrauma Consultant, “[t]he responsibility for the diagnosis of concussion and the decision to return a player to a game remains exclusively within the professional judgment of the Head Team Physician or the Team physician assigned to managing TBI [traumatic brain injury].” In Chapter 2: Club Doctors, Recommendation 2:1-D, we recommend that this be changed and that if either the Unaffiliated Neurotrauma Consultant or club doctor diagnoses a player with a concussion, the player cannot return to the game.  

(B) Current Legal Obligations

The neutral doctor’s role is different in each of situations described above. As a game-day doctor under Article 39 or as the Unaffiliated Neurotrauma Consultant, the neutral doctor is actually treating the player. As part of an Injury Grievance, the neutral doctor is examining, but not treating, the player. And finally, in conducting an investigation at the behest of the Joint Committee, the neutral doctor’s role is less clear as the doctor might examine the player but seems unlikely to treat him.

The different contexts create different obligations on the neutral doctor.

Where the neutral doctor is treating the player, the doctor’s first and only loyalty should be to the player and the doctor is thus bound to provide care within an acceptable standard of care, as discussed in Chapter 2: Club Doctors, Section (C)(1)(a).

Where the neutral doctor is evaluating the player, the doctor’s obligations are the same as if the doctor were performing a fitness-for-play examination. As discussed in Chapter 2: Club Doctors, Section (D)(1)(a), doctors performing such evaluations have a limited patient-doctor relationship that obligates them to exercise care consistent with their professional training and expertise so as not to cause physical harm by negligently conducting the examination.

If the neutral doctor conducting an investigation on behalf of the Joint Committee actually examines a player, then the neutral doctor will have the same obligations as if the doctor were performing a fitness-for-play evaluation as discussed above. However, if the neutral doctor does not examine (or treat) the player in any way as part of the investigation, the neutral doctor will not develop any legal responsibilities toward the player as a result of the doctor’s role with the Joint Committee.

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a In the explanation for this recommendation, we acknowledge that because the club doctor is likely to have greater familiarity with the player, he or she might be able to better determine whether a player has suffered a concussion. Nevertheless, we believe this recommendation is a common sense protection that errs on the side of player health.

b The legal obligations described herein are not an exhaustive list but are those we believe are most relevant to player health.
Many states require a doctor with the same board certification or similar expertise as the doctor against whom the claim is brought to opine as to the appropriate standard of care. Thus, in the event a neutral doctor were sued for medical malpractice, the claim likely could not proceed without a similarly qualified doctor—whether it be an orthopedist, neurologist or a doctor specializing in sports medicine—opining that the neutral doctor deviated from the standard of care.

The CBA may limit players bringing a medical malpractice claim against a neutral doctor. This is because the Labor Management Relations Act (LMRA) bars or “preempts” state common law claims, such as negligence, where the claim is “substantially dependent upon analysis of the terms” of a CBA, i.e., where the claim is “inextricably intertwined with consideration of the terms of the” CBA. In order to assess the neutral doctor’s duty to an NFL player—an essential element of a negligence claim such as medical malpractice—the court may have to refer to and analyze the terms of the CBA, e.g., the neutral doctors’ obligation, resulting in the claim’s preemption. Preemption occurs even though the neutral doctors are not parties to the CBA and thus likely cannot be a party in any CBA grievance procedure. So long as the player’s claim is “inextricably intertwined” with the CBA, it will be preempted. In these cases, player complaints must be resolved through the enforcement provisions provided by the CBA itself (i.e., a Non-Injury Grievance against the NFL), rather than litigation. Nevertheless, research has not revealed any litigation between a player and a neutral doctor so how a court would resolve these issues is unclear.

The player could also consider bringing a Non-Injury Grievance relating to the neutral doctor’s care pursuant to the CBA. The 2011 CBA directs certain disputes to designated arbitration mechanisms and directs the remainder of any disputes involving the CBA, a player contract, NFL rules, or generally the terms and conditions of employment to the Non-Injury Grievance arbitration process. Importantly, Non-Injury Grievances provide players with the benefit of a neutral arbitration and the possibility of a “money award.” However, Non-Injury Grievances must be filed within 50 days “from the date of the occurrence or non-occurrence upon which the grievance is based.” Additionally, it is possible that under the 2011 CBA, the NFL could argue that complaints concerning medical care are designated elsewhere in the CBA and thus should not be heard by the Non-Injury Grievance arbitrator.

A player could conceivably bring a medical malpractice claim against a neutral doctor who examined the player as part of an Injury Grievance or for the Joint Committee. However, such a claim would be limited to whether the neutral doctor exercised care consistent with the doctor’s professional training and expertise so as not to cause physical harm by negligently conducting the examination. Additionally, the claim might be preempted by the LMRA, as discussed above.

Research has not revealed any litigation between a player and a neutral doctor.

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

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

g For example, Injury Grievances, which occur when, at the time a player’s contract was terminated, the player claims he was physically unable to perform the services required of him because of a football-related injury, are heard by a specified Arbitration Panel. 2011 CBA, Art. 44. Additionally, issues concerning certain Sections of the CBA related to labor and antitrust issues, such as free agency and the salary cap, are within the exclusive scope of the System Arbitrator. 2011 CBA, Art. 15, currently University of Pennsylvania Law School Professor Stephen B. Burbank.
Neutral doctors play a limited but important role in player health. Perhaps most importantly, the Unaffiliated Neurotrauma Consultants are crucial to the effective operation of the Concussion Protocol, a signature component of player health. There is no indication that neutral doctors have done anything other than perform the roles assigned to them by the CBA and Concussion Protocol. Consequently, we make no recommendations concerning neutral doctors. Indeed, as the prior chapters suggest, the neutrality of these doctors is a positive benefit to players, and we should look for additional opportunities to have more neutral doctor input and involvement.

There are additional recommendations relevant to the work conducted by neutral doctors that are made in other chapters:

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

- **Chapter 7: The NFL and NFLPA**—Recommendation 7:4-A: The NFL and NFLPA should continue and intensify their efforts to ensure that players take the Concussion Protocol seriously.
Endnotes

1 CBA, Art. 44, § 1.
2 CBA, Art. 44, § 4(a).
3 CBA, Art. 44, § 4(d).
4 CBA, Art. 50, § 1.
5 CBA, Art. 50, § 1(d).
7 Id.
8 Id.
9 See Chapter 1: Players, Table 1-F.
15 CBA, Art. 44, § 5. The list requires “at least two orthopedic physicians and two neuropsychologists in each city in which a club is located.” Id.
16 Id.
17 This information was provided by the NFLPA.
18 Id.
20 Id.
25 See 2011 CBA, Art. 43, § 1.
26 See 2011 CBA, Art. 43, § 6 (discussing constitution of Arbitration Panel); 2011 CBA, Art. 43 § 8 (discussing Arbitrator’s authority, including to grant a “money award”).
27 CBA, Art. 43, § 2.
28 The Non-Injury Grievance arbitrator has the authority to determine whether a complaint against a doctor fit within his or her jurisdiction under Article 43. See 2011 CBA, Art. 43, § 1 (discussing scope of Non-Injury Grievance arbitrator’s jurisdiction).
In addition to being seen by club doctors or obtaining a second opinion in response to a club doctor, players might have a personal doctor they see as a primary care physician or for other specific ailments. Personal doctors have no relationship with the NFL or NFL clubs and thus their only concern should be for the player’s health. Consequently, to the extent players choose to utilize the services of their own doctor (maybe even for a second opinion), these doctors too are an important stakeholder in ensuring and promoting player health.

Additionally, in discussing personal doctors, we recognize of course that different doctors have different specialties. Thus, when discussing personal doctors in this chapter, we expect and intend players will seek out the appropriate specialist for their ailment. We intend this chapter to cover all of the various specialists (e.g., internists, orthopedists, neurologists) with whom players may consult.
Finally, while in other chapters we provided the stakeholder an opportunity to review a draft of the relevant chapter(s) prior to publication, because there is no well-defined representative for personal doctors, no one reviewed this chapter on behalf of personal doctors prior to publication.

[A] Background

Players’ use of personal doctors is not generally discussed by the CBA. Personal doctors are not provided any rights under the 2011 CBA other than the right to, “upon presentation to the Club physician of an authorization signed by the player, inspect the player’s medical and trainers’ records in consultation with the Club physician or have copies of such medical and trainers’ records forwarded to such player’s personal physician.”

[B] Current Legal Obligations

While controversy exists about the role of club doctors, the responsibilities of a player’s personal doctor are clear. A player’s personal doctor’s first and only loyalty is to the player and the doctor is thus bound to provide care within an acceptable standard of care, as discussed in Chapter 2: Club Doctors, Section (C)(1)(a).

[C] Current Ethical Codes

As discussed in Chapter 2: Club Doctors, Section (C) (1)(b), doctors treating players, such as personal doctors, are obligated by the AMA Code and the FIMS Code of Ethics to provide care that is in the player-patient’s best interests.

[D] Current Practices

Personal doctors might be the least utilized of the doctors discussed in this Report. Players principally rely on club doctors and second opinion doctors for their care. In our discussions with players, including the interviews discussed herein, several indicated that the frequent moves from city to city, the convenience of receiving healthcare at the club facility, and their busy schedules made finding and seeing a personal doctor problematic. In addition, some players also do like and prefer the care they receive from club doctors. In some circumstances, a second opinion doctor might also be or become the player’s personal doctor. Current players discussed players’ non-use of personal doctors:

- **Current Player 4:** “I do not have a primary care physician, no. I think most players are the same way.”
- **Current Player 5:** “I only use doctors that are in the system . . . . I know other players will have other doctors that they used in college or whatever. But as far as routine check-ups, not much. I don’t know if I’ve ever heard of that.”
- **Current Player 8:** “I wouldn’t think the majority of guys have a primary care physician.”
- **Current Player 10:** “I don’t think there’s a whole lot of players that have their own personal doctors in whatever city they’re in.”

Former Player 3: “I had never gone to the doctor. If I ever had to, I would just use our team’s physician.”

In any event, there are circumstances in which players see their own personal doctors outside of the healthcare structure dictated by the CBA, particularly in the offseason. If a player sees a personal doctor, the cost of that visit would likely be covered by the player’s health insurance policy provided through the club, as described in Appendix C: Summary of Collectively Bargained Health-Related Programs and Benefits.

If a player’s personal doctor discovers an injury, the player is required to report it to the club. The 2011 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. Nevertheless, we know that players routinely withhold injuries and medical conditions from the club medical staff for a variety of reasons, including protecting their spot on the roster and to not be viewed by the club in a negative way.

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a The legal obligations described herein are not an exhaustive list but are those we believe are most relevant to player health.
Considering the perceived downsides of disclosing every injury, a $1,770 fine seems trivial and is unlikely to influence players’ injury reporting behavior.

Players are also obligated to disclose their medical conditions in certain situations by their contract. The Standard NFL Player Contract obligates players to undergo a physical examination by the club doctor as a condition of the contract during which a player must “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.” If the player does not advise the club doctor about a condition diagnosed by his personal doctor during the course of a club physical, the player might be in violation of his contract. Violating this provision carries much more serious consequences than failing to report an injury as described above. If a player fails to disclose all medical conditions during a club physical, the club may terminate the contract. For an example of a club’s attempts to void a player’s contract under such circumstances, see Chapter 1: Players, Section D, Enforcement of Legal and Ethical Obligations.

As is discussed in more depth in Chapter 2: Club Doctors, Section (C)(1)(a) and in greater depth in many other places, personal doctors have the same obligations to players as any other doctor to any other patient. In brief, a doctor is obligated to provide care to his or her patients within an acceptable standard of care in the medical community or potentially be subject to a medical malpractice claim. Generally, the elements of a medical malpractice claim are: (1) a standard of care owed by the doctor to the plaintiff; (2) a breach of that standard of care by the doctor; and (3) the breach was the proximate cause of the plaintiff’s injury.

Many states require a doctor with the same board certification or similar expertise as the doctor against whom the claim is brought to opine as to the appropriate standard of care. Thus, in the event a player’s personal doctor were sued for medical malpractice, the claim likely could not proceed without a similarly qualified doctor—whether it be an orthopedist, neurologist, or a doctor specializing in sports medicine—opining that the doctor deviated from the standard of care.

The CBA does not provide players with any grievance or arbitration mechanism by which players could pursue claims against their own doctors. Players may choose to see doctors on their own but the CBA does not in any way dictate that doctor’s obligations to the player.

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e Peer reviewer and doctor for college sports teams Cindy Chang informed us that she has seen NFL players return to their college medical staff for treatment so that the care would not be known by the club. Cindy Chang, Peer Review Response (Dec. 28, 2015).

f Appendix K is a summary of players’ options to enforce legal and ethical obligations against the stakeholders discussed in this Report. In addition, for rights articulated under either the CBA or other NFL policy, the NFLPA and the NFL can also seek to enforce them on players’ behalves.
the player was injured. The club’s season-end physical might describe the player as healthy. However, unless the player obtains a physical that disagrees with the club’s findings around the same time as the club’s season-end physical, it will be difficult for the player to dispute the club’s assertion that he was healthy at the time his contract was terminated. The player’s personal doctor, via a season-end physical, might provide a medical opinion that supports the player’s position.

Endnotes

1 CBA, Art. 40, § 2(a).
2 CBA, Art. 42, § 1(a)(iii).
4 Id.
5 See, e.g., Barry R. Furrow et al., Health Law Ch. 6 (2d ed. 2000) (discussing doctors’ obligations to patients); Mark A. Hall et al., Medical Liability and Treatment Relationships (2d ed. 2008) (same).
7 Id.
9 See 2011 CBA, Art. 44 (discussing the Injury Grievance process).