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Sports Medicine Conflicts: Team Physicians vs. Athlete–Patients

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SPORTS MEDICINE CONFLICTS: TEAM PHYSICIANS vs. ATHLETE–PATIENTS

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Abstract: Team physicians for professional sports franchises face a conflict of interest created by the competing loyalties they owe to the team that employs them and to the athlete–patient they must treat. Marketing agreements under which physicians pay significant sums of money to be designated as the team's "official healthcare provider" exacerbate this conflict. These marketing arrangements call into question the independent judgment of team physicians and cause players to question the quality of care they receive. This paper explores several solutions to the growing conflicts between athletes and team doctors with the goal of enhancing players' trust in the medical care they receive. First, to remove the dual loyalty problem faced by team physicians, professional sports leagues or players' unions should hire medical providers directly—as opposed to having individual teams employ and provide them. If this fundamental employment change proves impossible, physician groups should enter into explicit agreements with sports franchises that assert the groups' independence, and professional sports leagues should mandate that physicians disclose all potential conflicts of interest to the players they treat. In addition, sports leagues could ban physicians from advertising their affiliation with teams to alleviate the problem of doctors engaging in bidding wars to service athletes at below-market rates in order to gain a "PR" edge on their competition. Finally, states might consider exceptions to the exclusive remedy provisions of workers' compensation laws to ensure that professional athletes have legal recourse when they suffer the deleterious effects of these conflicts.

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INTRODUCTION

Sitting on Bill Stanfill's mantel is a jar filled with a clear solution and small ball sitting at the bottom.[1] It is the ball of his left hip that was removed in 2000 as a result of avascular necrosis, a serious medical condition that occurs when blood circulation to the bone is cut off and the bone dies.[2] At 54, he is not the type of person you expect to see navigating with a walker, but Stanfill is a former professional football player.[3] His hip injury was caused by repeated trauma and, possibly, repeated cortisone injections while he played football.[4] His other hip will likely require surgery in the near future.[5]

Stanfill is one of many professional athletes who suffers from permanent disability as a result of repeated injuries sustained while playing professional sports.[6] Professional athletes face tremendous pressure to get back on the field from coaches, management, and the players themselves.[7] This can lead to serious physical disabilities for elite athletes.

Magnifying the problem are growing conflicts of interest faced by the team physicians who treat these athletes.[8] Physicians confront dual loyalty problems

1. William Nack, *The Wrecking Yard: As They Limp Into the Sunset, Retired NFL Players Struggle with the Game's Grim Legacy: A Lifetime of Disability and Pain*, SPORTS ILLUSTRATED, May 7, 2001, at 60, 68.

2. *Id*.

3. *See id*.

4. *Id*.

5. *See id*. at 69.

6. *See* Gene Wojciechowski & Chris Dufresne, *Life Expectancy Low, Some Say: Football Career is Taking its Toll on NFL's Players*, L.A. TIMES, June 26, 1988, Part III (Sports), at 1 (discussing *Los Angeles Times* survey, which found that 78% of professional football players surveyed suffered some permanent disability). Many of the findings of this 1988 study were replicated by the NFL Players Association in its 2000 survey of players. *See* Gene Frenette & P. Douglas Filaroski, *Medicine and the NFL, an Uneasy Partnership*, FLA. TIMES UNION, Dec. 15, 2002, at A-1.

7. This Paper primarily addresses *external* pressure on athletes to return to the playing field, but we should be careful not to underestimate athletes' internal drive to play even when hurt. One often will hear athletes voice the adage, "no pain, no gain"—reflecting the belief that some degree of suffering is necessary to achieve athletic glory. A powerful recent example is Boston Red Sox hurler Curt Schilling, who pitched his team to the 2004 American League Championship and World Series title despite a ruptured tendon-sheath seeping blood into his shoe. *See* Tyler Kepner, *Red Sox Erase 86 Years of Futility in 4 Games*, N.Y. TIMES, Oct. 28, 2004, at A1. Furthermore, society as a whole often looks upon individuals who have overcome great pain as a marker of heroism. For example, we all admire the suffering endured by former army POW Jessica Lynch and paralyzed actor Christopher Reeve, and many view them as heroes precisely because of what they have undergone. *See, e.g.*, James Dao, *Private Lynch Comes Back Home to a Celebration Fit for a Hero*, N.Y. TIMES, July 23, 2003, at A1; Douglas Martin, *Christopher Reeve, 52, Symbol of Courage, Dies*, N.Y. TIMES, Oct. 12, 2004, at A1.

8. *See* Frenette & Filaroski, *supra* note 6, at A-13 ("Team doctors are left to strike a balance between the interest of the players and the team."). In defining the term "conflict of

stemming from both the employment relationship and marketing arrangements they have entered into with their sports franchise employer. When physicians are hired directly by a team to treat its players (and therefore answer to management), there is often subtle or even overt pressure to return injured athletes to the field prematurely in order to maximize the team's chances of winning.[9] Furthermore, given the marketing edge and prestige associated with being named the "official healthcare provider" for a major athletic franchise, physician groups often compete with each other to offer these services for a reduced fee or for free.[10] As a result, medical decisions may be made that are not in the best interest of the player and his health, but rather which are in the short-run interests of the team. As the doctor's duty to her patient becomes compromised, players' trust in the medical advice being offered by the team physician slowly erodes.

This conflict of interest between team physicians and the athlete–patients they treat must be remedied by aggressively implementing policies and procedures that change the current relationship between healthcare providers, teams, and their players. Part I of this Paper examines the various duties that a team physician owes her athlete–patient. Part II details the nature of the relationship between teams, physicians, and players, and Part III explains how these relationships cause conflicts of interest to arise. Finally, Part IV outlines policy solutions that would remedy the diverging interests that team doctors face.[11]

I. DOCTOR'S DUTY TO HER PATIENT

Physicians operate under a number of professional codes and regulations that delineate their professional responsibilities to their patients. The American Medical Association (AMA) Code of Medical Ethics states that a

interest," the line between potential and actual conflict of interest is a matter of some debate. *See* MARC A. RODWIN, MEDICINE, MONEY, AND MORALS: PHYSICIANS' CONFLICTS OF INTEREST 8–9 (1993). As Rodwin points out, some only use the term "conflict of interest" to refer to situations of tangible acts of disloyal behavior. *Id*. at 9. Similar to Rodwin's definition, for the purposes of this article, conflicts of interest refer to situations that have the capacity to cause harm, rather than solely instances of actual harm. *See id*.

9. *See* Sigmund J. Solares, *Preventing Medical Malpractice of Team Physicians in Professional Sports: A Call for the Players Unions to Hire the Team Physicians in Professional Sports*, 4 SPORTS LAW. J. 235, 236 (1997).

10. Nick DiCello, Note, *No Pain, No Gain, No Compensation: Exploiting Professional Athletes Through Substandard Medical Care Administered by Team Physicians*, 49 CLEV. ST. L. REV. 507, 517 (2001); Twila Keim, Comment, *Physicians for Professional Sports Teams: Health Care Under the Pressure of Economic and Commercial Interests*, 9 SETON HALL J. SPORT L. 196, 215–16 (1999).

11. While this Paper focuses on all professional sports teams, football is prominently featured in the discussions and anecdotes because it creates many serious injuries that have become the source of disputes and litigation.

physician's paramount concern must be the well-being of her patient.[12] Healthcare providers are "bound not to let any other interest interfere with that of the patient in being cured."[13]

Doctors are also bound by the requirements of the Hippocratic Oath.[14] The original version of the Oath stated that physicians must endeavor to prevent "harm and injustice" to their patients.[15] One modern version of the Hippocratic Oath, the Oath of Lasagna, requires that doctors take all necessary measures to heal the sick, while avoiding the "twin traps of overtreatment and therapeutic nihilism."[16]

Given the special risks that participation in sports presents, the AMA also maintains distinct regulations for physicians who treat athletes. AMA Code of Medical Ethics § 3.06 requires that physicians assist players in making "informed decisions about their participation in amateur and professional contact sports which entail risks of bodily injury."[17] A physician's *only* consideration should be the medical care of the participant—the desire of the athlete, the team, or its fans to see the athlete back on the field should not be controlling.[18] The AMA also explicitly obliges physicians to avoid conflicts of interest. AMA Code of Medical Ethics § 8.03 states that "[u]nder no circumstances may physicians place their own financial interests above the welfare of their patients."[19] Moreover, any conflict between a physician's financial interest and her responsibility to the patient must be resolved to the patient's benefit.[20]

Finally, beyond professional regulation, healthcare providers face potential tort liability for the medical services they render, and therefore must follow the relevant standard of care in their treatment of athlete–patients.[21] As Joseph King has outlined, "[T]eam physician[s] should perform with the level of knowledge, skill, and care that is expected of a reasonably competent medical practitioner under similar circumstances, taking into account reasonable limits

12. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS xiv (2004–2005) (Preamble).

13. RODWIN, *supra* note 8, at 8 (quoting Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, 1969 DAEDALUS 219, 238).

14. For a translation of the original Oath, see LUDWIG EDELSTEIN, THE HIPPOCRATIC OATH: TEXT, TRANSLATION AND INTERPRETATION (Henry E. Sigerist ed., 1943).

15. *Id.* at 3.

16. Barbara A. Gabriel, *A Hippocratic Oath for Our Time*, ASSOC'N OF AM. MED. COLLEGES REP. (Sept. 2001), http://www.aamc.org/newsroom/reporter/sept2001/hippocraticoath.htm.

17. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 12, § 3.06.

18. *See id.*

19. *Id.* § 8.03 (outlining conflict of interest rules).

20. *Id.*

21. *See* JOHN C. WEISTART & CYM H. LOWELL, THE LAW OF SPORTS § 8.08 (1979).

that have been placed on the scope of the physician's undertaking."[22] Thus, physicians who treat athletes must be cognizant of a host of relevant professional regulations and common law standards that govern the medical care they provide.

A. Conflict of Interest Defined

While these professional and legal obligations may seem obvious, they are increasingly threatened by conflicts of interest that arise between team physicians and their athlete–patients today. In general, a conflict of interest is considered to exist when competing duties cannot be resolved without compromising known obligations.[23] To rise to this level, physicians' divergent obligations must "compromise their independent judgment or their loyalty to patients."[24] Others define a conflict of interest as existing when a subsystem that is a component of a larger system deliberately enhances its interest to the detriment of the whole.[25] It is not necessary that an actual injury occur as a result of a conflict of interest between a physician and her patient—rather, the creation of the capacity to cause injury and the corresponding erosion of trust between physicians and their patients is harm enough alone. When the interests of doctors and patients are at odds, there is increased risk that the physician may abuse, and eventually lose, the trust of her patient, further jeopardizing healthcare decisions being made.

II. RELATIONSHIPS BETWEEN PHYSICIANS, PLAYERS, AND THE TEAM

A. Employer–Employee Relationship Between Team and Physician

At the heart of the tension facing team physicians is the dual loyalty problem created by their employment relationship with the sports franchise that hires them. All professional sports teams provide for a physician to be available to players, usually through team policy or a collective bargaining agreement.[26] These physicians may be general practitioners, but are often

22. Joseph H. King Jr., *The Duty and Standard of Care for Team Physicians*, 18 HOUS. L. REV. 657, 692 (1981).

23. RODWIN, *supra* note 8, at 9.

24. *Id*.

25. *E.g.*, Joseph M. McGuire, *Conflict of Interest: Whose Interest? And What Conflict?*, *in* ETHICS, FREE ENTERPRISE, & PUBLIC POLICY 214, 216 (Richard T. De George & Joseph A. Pichler eds., 1978).

26. *See, e.g.*, COLLECTIVE BARGAINING AGREEMENT BETWEEN THE NFL MANAGEMENT COUNCIL AND THE NFL PLAYERS ASSOCIATION 2002–2008, art. XLIV (2002), http://www.nflpa.org/Members/main.asp?subPage=CBA+Complete#art44 [hereinafter NFL CBA].

> Each Club will have a board-certified orthopedic surgeon as one of its Club physicians. The cost of medical services rendered by Club physicians will be the responsibility of the

orthopedic surgeons.[27] Within these arrangements, teams directly hire, fire, and pay the doctors to treat their players.[28] Thus, employee-physicians owe allegiance to their employer-teams, while simultaneously owing a duty of loyalty to the athlete–patients they treat on a daily basis.[29] Notably, the AMA requires that any contractual relationship entered into by physicians with teams be free from lay interference in medical matters, and that a doctor's primary responsibility be to her patient.[30] Nevertheless, team management often intervenes in medical decision-making regarding its players, placing the physician in an ethically compromised position.[31] On the one hand, the physician is under a legal and professional duty to provide medical services in the best interests of the athlete–patient. On the other, team management has hired that physician to serve the team's interest, which usually includes getting valuable athletes back onto the playing field sooner rather than later.[32] It is not uncommon, then, that team physicians make decisions that are influenced by

> respective Clubs. If a Club physician advises a coach or other Club representative of a player's physical condition which adversely affects the player's performance or health, the physician will also advise the player. If such condition could be significantly aggravated by continued performance, the physician will advise the player of such fact in writing before the player is again allowed to perform on-field activity.

Id.

27. *See id.* (requiring every NFL team to have an orthopedic surgeon as one of its club physicians); *see also* Matthew J. Mitten, *Emerging Legal Issues in Sports Medicine: A Synthesis, Summary, and Analysis*, 76 ST. JOHN'S L. REV. 5, 10 (2002).

28. Mitten, *supra* note 27, at 8. Complicating these relationships are conflicts of interest that arise when professional teams take bids from medical groups to be the "official" healthcare provider for the team. *See infra* Part III.B.

29. Some have analogized these dual duties to the diverging interests that so-called "company doctors" might have faced in the past—i.e., physicians who were employed by companies to care for the firm's employees. *See, e.g.*, Roger S. Magnusson & Hayden Opie, *HIV and Hepatitis in Sports: An Australian Legal Framework for Resolving Hard Cases*, 5 SETON HALL J. SPORT L. 69, 101 (1995). While there may have been some conflict if management wanted to see a sick employee back at work, the conflict facing company doctors is much more muted than the dilemma facing team physicians. Team physicians must treat patients whose injuries are directly caused by their line of work, unlike company doctors who primarily treated employees for sicknesses unrelated to their job. Compounding the problem is that the "job" of an athlete involves considerably greater risk to health than the risk that most any other company imposes on its employees.

30. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 12, § 8.05.

31. *See, e.g.*, ROB HUIZENGA, YOU'RE OKAY, IT'S JUST A BRUISE: A DOCTOR'S SIDELINE SECRETS ABOUT PRO FOOTBALL'S MOST OUTRAGEOUS TEAM 166 (1994) (describing how Los Angeles Raiders' owner Al Davis sent a message to injured player Marcus Allen ordering him to "take a shot" from the team doctor for his injury).

32. Matthew J. Mitten, *Team Physicians and Competitive Athletes: Allocating Legal Responsibility for Athletic Injuries*, 55 U. PITT. L. REV. 129, 140 (1993). Of course, some teams may "play it safe" and hold elite athletes out of competition until they are 100% certain that the player's injury has healed, but more often the pressure is to get star athletes back on the field instead of keeping them in the training room.

team management in ways contrary to the player's best interests. In sum, the dual loyalty of team physicians under the current employment structure is a recipe for player distrust and skepticism regarding the medical advice being offered by team doctors.[33]

In addition to these pressures from team management, physicians also face pressure from coaches to get their players back on the field. In a deposition for a medical malpractice claim by a player, former Jacksonville Jaguars' head coach Tom Coughlin candidly admitted that he "can and will exert as much pressure on the player and the doctors to get the player [back] on the field."[34] Testimony in the case alleged that Coughlin would walk past injured players in rehabilitation and say derisively, "Oh, look at the sick, lame and lazy."[35] Coaches know that winning is paramount to their success. As one former team physician stated, "There is no loyalty except to winning. In the NFL, owners and coaches can treat employees in ways that would immediately provoke a successful lawsuit in any other business."[36]

B. Marketing Arrangements Between Teams and Healthcare Providers

Complicating the matter today is the emerging practice in sports medicine of auctioning off the right to be a team's "official" medical provider, hospital, or physician-group.[37] The privilege of being selected generally comes with the right to advertise in one's promotional materials that her group has been named the official healthcare provider of a particular professional sports franchise.[38] In return, the team is provided medical care for free or at reduced cost.[39] These entrepreneurial arrangements began in 1995 with the expansion of the NFL into Jacksonville, Florida and Charlotte, North Carolina.[40] The Carolina Panthers' winning bid went to a medical group, Carolinas Medical Center, which was willing to gift the team $400,000 worth of medical supplies and

33. *See, e.g.*, Angelo Cataldi & Glen Macnow, *Team Doctors: A Crisis in Ethics: A Question of Trust for Athletes*, PHILA. INQUIRER, June 19, 1989, at 1-A (describing professional hockey player Mike Robitaille's fear and distrust toward his team doctor as a growing trend among athletes).

34. Selena Roberts, *Coughlin's Biggest Risk is Rejection*, N.Y. TIMES, May 13, 2004, at D1 (detailing a malpractice cause of action brought by Jeff Novak against the Jacksonville Jaguars and team physician Stephen Lucie).

35. *Id*. at D5.

36. PIERCE E. SCRANTON, JR., PLAYING HURT: TREATING AND EVALUATING THE WARRIORS OF THE NFL 153 (2001).

37. *See supra* note 10 and accompanying text.

38. Bill Pennington, *Sports Turnaround: The Team Doctors Now Pay the Team*, N.Y. TIMES, May 18, 2004, at A1.

39. *Id.*

40. Joseph Nocera, *Bitter Medicine: Eager to Hold on to Their Valuable Sideline Practices, Team Doctors All Too Often Strive to Help the Club, Not Heal the Player*, SPORTS ILLUSTRATED, Nov. 6, 1995, at 76, 84.

equipment and further provide medical services at managed care rates.[41] Soon after the New York Yankees won the World Series in 1999, they began to offer the right to be the official team hospital in advertising and marketing.[42] Several hospitals, including the Yankees' longtime healthcare provider, declined to participate, fearing that these arrangements might undermine medical care.[43]

Unfortunately for the state of sports medicine, these marketing agreements provide significant benefits for team physicians, both in terms of clients and prestige. Methodist Hospital, which provides medical services to the NFL's Houston Texans, found that their association with the Texans is the number-one driver of new calls from prospective patients.[44] It is estimated that half of the major sports teams in the United States now have some kind of financial or marketing arrangement to provide medical services.[45] Within a decade, experts believe that number will reach 90%.[46] From both the team's and provider's perspective, these arrangements make sound financial sense. The larger question, however, is at what cost to the athlete's interest and to the doctor–patient relationship do these entrepreneurial agreements come?

C. Team Doctors as Partial Owners of Sports Franchises

In addition to the previously outlined sources of conflicts arising in sports medicine, there exists another, albeit rare, source of physician–patient tension: team doctors who maintain an ownership interest in their team. The classic example is Arthur Pappas, who served as both part owner and team physician for the Boston Red Sox until his resignation in 2002.[47] Pappas' dual relationship led to player and public criticism that he was compromising his

41. Alexander Wolff & Christian Stone, *Scorecard: Hippocratic Oath?*, SPORTS ILLUSTRATED, May 8, 1995, at 12, 12. This type of arrangement also highlights the conflicts inherent in managed care medicine. Physicians are often paid a set capitated fee per patient up front and then run the risk of providing excess care at their own expense. Furthermore, patients must make it past primary care physician "gatekeepers" before they can be referred to a specialist. Not surprisingly, patients often complain that their physicians are incentivized to shortchange them in order to maximize their own profits. *See generally* Steve P. Calandrillo, *Corralling Kevorkian: Regulating Physician-Assisted Suicide in America*, 7 VA. J. SOC. POL'Y & L. 41, 72–77 (1999) (discussing the potential impact of managed care medicine on the physician-assisted suicide debate).

42. William Sherman, *Hospitals Team Up with Yanks*, N.Y. DAILY NEWS, Nov. 5, 2000, at 24.

43. *Id.*

44. Pennington, *supra* note 38, at D4.

45. *Id.*

46. *See, e.g.*, *id.* (quoting Dean Bonham of the Bonham Group, an organization that negotiates and arranges sports sponsorship deals).

47. *See* Joe Giuliotti, *Barrett Awarded $1.7M*, BOSTON HERALD, Oct. 26, 1995, at 101.

athletes' best interests for the short-term benefit of the team.[48] Former pitcher Butch Henry alleged that Pappas ordered him to play, despite a torn anterior cruciate ligament (ACL) in his knee.[49] Henry also claimed that players throughout Major League Baseball were hesitant to play in Boston because of the club's reputation for inadequately caring for injured athletes.[50] As anecdotal evidence, Marty Barrett, former Red Sox second baseman, won a $1.7 million dollar judgment against Pappas after alleging that he failed to disclose the seriousness of Barrett's torn ACL.[51] In his suit, Barrett claimed that Pappas placed team interests in front of Barrett's health,[52] clearing him to play too quickly in the midst of the Red Sox' 1989 pennant chase.[53] Perhaps the most damaging testimony came from former manager Joe Morgan, who recalled a meeting between him and Pappas in which the latter directly admitted, "[B]y the condition of [Barrett's] knee, he would not have a long career."[54] Barrett prevailed on his medical negligence cause of action, but U.S. District Court Judge Nathaniel Gorton found that there was no direct evidence of misplaced interest.[55]

III. THE TEAM PHYSICIAN'S DUAL LOYALTY TO THE EMPLOYER AND TO THE ATHLETE–PATIENT POSES A SERIOUS CONFLICT OF INTEREST

A. Employment Relationship

The fact that physicians are employees of the team whose athletes they treat creates conflicts of interest that are difficult, if not impossible, to satisfy ethically. When a team hires a medical provider, the purpose of that employment relationship is to further the interests of the sports franchise. Not surprisingly, the goal of team management is to run a successful business organization, which generally means maximizing both wins and profit.[56] With

48. *See* Phil O'Neill, *Pappas Resigns Medical Role with Red Sox*, WORCESTER TELEGRAM & GAZETTE, Sept. 17, 2002, at D2.

49. Sean McAdam, *Heaping Dose of Criticism Leaves Sox' Pappas in Guarded Condition*, PROVIDENCE JOURNAL-BULLETIN, Mar. 12, 1999, at D1.

50. *Id*.

51. *See* Giuliotti, *supra* note 47, at 101.

52. *See* Nocera, *supra* note 40, at 87.

53. *See id*. Unfortunately, doing so did little to change the Red Sox' fortune, as they failed to make the playoffs, finishing in third place in the American League East. *See* The Baseball Archive Database: 1989 Major League Standings, http://www.baseball1.com/statistics/team/std-1989.html.

54. Nocera, *supra* note 40, at 88.

55. Giuliotti, *supra* note 47, at 101.

56. *See* Hal Lancaster, *Is Sports Just Another Business? One Veteran Says, 'Yes, Mostly,'* WALL ST. J., Aug. 19, 1985, at 17.

some professional sports teams operating as publicly traded companies[57] and others considering the prospect of initial public offerings,[58] the business nature of professional sports is abundantly clear. As former Seattle Seahawks team physician Pierce Scranton bluntly stated in his tell-all exposé, *Playing Hurt*, "The balancing forces are the same in the NFL as in any other industry: fear and greed."[59]

The profit maximization pressures felt by team management are shared by physicians as well, as most play an indirect role in the management of the team by advising coaches regarding who is healthy and whom they should be concerned about. For example, Dr. Scranton detailed his involvement in the organization's process of evaluating who should remain on the team and who he felt was expendable.[60] The fact that physicians are advising coaches about team personnel intertwines doctors and management, and makes a candid relationship between doctors and athletes nearly impossible. Players are incentivized to withhold pertinent health information from the team physician out of fear that the information will be used against them. Further deteriorating the doctor–patient relationship is the reality that team physicians may also be called upon to testify against their patients should a contract dispute arise.[61] In the NFL, when a player is released by his team because he is physically unable to complete his contract, he may file a grievance with the league.[62] The team physician may then be required to testify against the former player, a practice that is unheard of in any other doctor–patient context.[63]

Unlike the team physician's role as an employee in a profit-maximizing venture, the traditional relationship between doctor and patient has very different objectives and expectations. Athlete–patients assume that their treating physician will exercise her best independent medical judgment and be loyal to them in giving medical advice.[64] The AMA Code of Medical Ethics dictates that the patient has a right to be truthfully informed about his medical

57. *See* Brian R. Cheffins, *Playing the Stock Market:"Going Public" and Professional Team Sports*, 24 J. CORP. L., 641, 642 (1999).

58. *See* Sam Walker, *Yankees, Nets May Issue Stock After Merger*, WALL ST. J., Sept. 21, 1999, at B7.

59. SCRANTON, *supra* note 36, at 143.

60. *See id*. at 37.

61. *See* HUIZENGA, *supra* note 31, at 316.

62. *Id*.

63. *Id*.

64. *See* RODWIN, *supra* note 8, at 8. If athletes did indeed possess full information about the conflicts their treating physician faced, one would expect that the risks posed by the conflict would be mitigated by athletes' skepticism about any medical advice offered. While there is growing awareness among athletes of the problem today, players in general would still like to assume that the team physician is relatively loyal to them and aims to effectuate their best medical interests.

care, including the risks and benefits of treatment options.[65] Patients are entitled to be told of any potential conflicts of interest that their physician faces.[66] Patients also have a right to confidentiality that should not be breached absent the patient's consent.[67] Unfortunately, these core elements of the doctor–patient relationship do not exist in the doctor–player relationship. Dr. Scranton opined that as a result of pressure from team management, "[t]he conventional doctor–patient relationship is nonexistent [in sports medicine], and the trust naturally fostered by such a relationship is consciously undermined by the organization."[68] These sentiments are echoed by Dr. Rob Huizenga, former team physician for the Los Angeles Raiders and past president of the NFL Physicians Society.[69] In *You're OK, It's Just a Bruise*, Huizenga details his experience as a team physician and his eventual departure due to poor medical treatment of players and inappropriate interference by management.[70] He reluctantly opined, "I thought I could be a team doctor and rise above the potential game-day pressures and conflict of interest. . . . I was wrong."[71] Such candid testimonials by physicians themselves underscore the serious problems posed by the conflicts inherent in today's employment relationship between teams and physicians. Athletes can no longer reasonably expect that their team doctor's medical advice will be uninfluenced by strong pressures from above.

B. Marketing Arrangements Exacerbate the Problem

A disturbing escalation of the tension created by the employer–employee relationship is the increasing use of innovative marketing arrangements between medical groups and professional sports teams. When physicians bid for the privilege of being named the "official" healthcare provider of a team (in order to gain an advertising advantage on their competition), they face the competing duties of their own financial interest in their agreement versus their overarching commitment to their patients. Rather than receiving payment as they normally would for providing medical services, they are often *paying* for the opportunity to provide the services given the concomitant marketing benefits attached. Such arrangements deepen the dual loyalty problems for team physicians—the pressure to retain the prestigious agreement with the sports franchise creates an incentive to ensure management is happy with the

65. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 12, § 10.01.
66. *Id*.
67. *Id*.
68. SCRANTON, *supra* note 36, at 174.
69. *See* HUIZENGA, *supra* note 31, at 315–17.
70. *See id*. at 263–64.
71. *Id*. at 317.

physician's decision.[72] Not surprisingly, this incentive conflicts with the physician's obligation to ensure the well-being of her patient.[73]

The rise of these marketing deals in recent years has led several team physicians and medical ethicists to cry foul. Dr. Dan Brock, director of Harvard Medical School's Division of Medical Ethics, criticized the arrangements as "unseemly" and lamented the "clear conflict of interest" created.[74] Dr. Andrew Bishop, physician for the Atlanta Falcons, threatened to resign if the team entered a sponsorship agreement with a local hospital.[75] Bishop worried, "The perception is that if this [physician] was so eager to do this he's *willing to pay* to do it, then he's going to do whatever management wants to keep the job he paid for."[76] In addition to physician concerns, players have also expressed their dissatisfaction with these marketing agreements. The chief operating officer of the Major League Baseball Players Association pointedly stated, "Our players do not like this trend in medical-care agreements one bit."[77] Quite reasonably, they believe it harms the trusting relationship between players and doctors, and undermines the credibility of team physicians.[78]

C. Evidence of the Conflict

Limited litigation data and empirical surveys of current and former professional athletes illustrate the existence of serious conflicts of interest faced by team physicians. Unfortunately, there are relatively few lawsuits by professional athletes from which to garner information, primarily because the exclusive remedy provisions contained in many state workers' compensation statutes bar such suits.[79] Nevertheless, the survey results and litigation that do

72. *See* Scott Polsky, Comment, *Winning Medicine: Professional Sports Team Doctors' Conflicts of Interest*, 14 J. CONTEMP. HEALTH L. & POL'Y 503, 515–19 (1998).

73. *See id.* at 519–20.

74. *See* Pennington, *supra* note 38, at D4.

75. *Id.*

76. *Id.* (emphasis added).

77. *Id.*

78. *See id.*

79. *E.g.*, Hendy v. Losse, 819 P.2d 1, 13 (Cal. 1991) (injured professional football player's medical malpractice action barred because workers' compensation is the exclusive remedy for injuries by co-employees). *See generally* DiCello, *supra* note 10, at 526–33 (discussing that under workers' compensation laws, employees (including professional athletes) are generally prohibited from bringing suit against a fellow employee (e.g., team physicians) because the state's workers' compensation system is the exclusive remedy for injuries that occur on the job). There are limited exceptions to the exclusive remedy provisions of workers' compensation, including torts committed by independent contractors, intentional torts, fraud, and injuries that fall under the "dual capacity" doctrine. *See id.* Additionally, a small number of states exclude professional athletes from workers' compensation. *See id.* at 529. However, for the most part, workers' compensation programs have worked to bar recovery for professional athletes for

exist chronicle serious problems caused by conflicts of interest that must be addressed if we are to restore athletes' faith in the medical judgment being rendered by their team physicians.

One of the first important steps in assessing the magnitude of the problem was taken by the *Los Angeles Times*.[80] Its study of all retired NFL players provided a deeper understanding of the physical impact of playing professional football. Shockingly, nearly four-fifths of players surveyed said they suffered permanent physical disabilities directly related to their playing careers.[81] Further, 60% of respondents believed that the NFL did not have their short- or long-term interests in mind.[82] Worse, over half said that their best interests were at one point compromised by a team physician, and 43% would not have chosen the team physician as their own personal doctor if they were given a choice.[83] The NFL Players Association survey of its members in 2000 confirmed these findings, as one of the players' primary concerns was medical treatment and their ability to initiate grievance procedures against team physicians that they felt rendered inappropriate medical advice.[84]

In one of the first successful medical malpractice lawsuits by a player, former San Francisco Forty Niner Charlie Krueger sued the team physician for fraudulently concealing the extent of his injuries and giving him repeated treatments to return him to the playing field.[85] As a result, Krueger now suffers from permanent disabilities, including severe arthritis and crippling degenerative pain that has left him unable to perform simple tasks such as standing, walking, or climbing stairs.[86] After winning his case before the California Court of Appeals, Krueger was awarded $2.3 million as compensation for his injuries.[87] At the time, it was the largest award ever

injuries due to negligent medical care by team physicians. *See id*. at 526. For further reading regarding workers' compensation laws affecting professional athletes, see Teresa Herbert, *Are Player Injuries Adequately Compensated?*, 7 SPORTS LAW. J. 243, 263–75 (2000); Mitten, *supra* note 27, at 36–37.

80. *See* Wojciechowski & Dufresne, *supra* note 6, at 1; *see also* Frenette & Filaroski, *supra* note 6, at A-13 (replicating many of the findings of the 1988 *Los Angeles Times* survey).

81. *See* Wojciechowski & Dufresne, *supra* note 6, at 1.

82. *Id*. at 13 (table of survey questions and responses).

83. *Id*.

84. *See* Frenette & Filaroski, *supra* note 6, at A-13 (including a team-by-team breakdown of the percentage of players who believe their team's medical care was good or better and the percentage of players who believe it is important to institute mandatory second opinions).

85. *See* Krueger v. S.F. Forty Niners, 234 Cal. Rptr. 579, 580, 582 (Cal. Ct. App. 1987) (depublished).

86. Jennifer Lynn Woodlief, *The Trouble with Charlie*, 9 ENT. & SPORTS LAW. 3, 4 (1991).

87. *Id*. at 3; *see Krueger*, 234 Cal. Rptr. at 585 (reversing, finding that the lower court decision was not based on substantial evidence and that Krueger established the required elements of his claim for fraudulent concealment of medical services). On remand from the California Court of Appeals, the trial court awarded Krueger $66,000 in special damages and $2.3 million in general damages. Woodlief, *supra* note 86, at 3. After the California Supreme Court denied

against a professional sports team and the first time a player was successful in suing his team on the grounds of inappropriate medical treatment.[88] However, the California Supreme Court denied review and decertified the Court of Appeals opinion without issuing a written opinion.[89] This removed the decision as precedent and led to an out-of-court settlement, reportedly for greater than $1 million.[90] In the depublished Court of Appeals decision, the judge noted, "[I]n its desire to keep [Krueger] on the playing field, [the team] consciously failed to make full, meaningful disclosure to him respecting the magnitude of the risk he took in continuing to play a violent contact sport with a profoundly damaged left knee."[91]

Another high-profile NFL case involved injuries sustained by Merril Hoge while a fullback for the Chicago Bears.[92] In 2000, Hoge was awarded $1.55 million for negligent treatment in response to a concussion that ended his football career.[93] A jury found that the doctor treating him did not properly inform him of the dangers of returning to play too soon after an earlier concussion.[94] Hoge continued to play without knowledge of the risk and suffered another concussion that led to the end of his playing career.[95]

Conflicts involving medical care rendered by team physicians are not limited to the NFL, however. Dave Babych of the National Hockey League's Philadelphia Flyers fractured a bone in his left foot during a game in 1998.[96] Unfortunately, it was never properly set and he was given pain killers that allowed him to return to play too quickly, resulting in a career-ending injury.[97] Babych was successful in his medical malpractice cause of action against the team, winning a jury verdict of $1.37 million, but did not prevail on his charge of fraud against the team physician.[98]

further review of the case and ordered the California Court of Appeals decision decertified and unpublished without a written opinion, Krueger settled with the team for between $1 million and $1.5 million. *Id*.

88. Woodlief, *supra* note 86, at 3.

89. *Krueger*, 234 Cal. Rptr. at 579.

90. Woodlief, *supra* note 86, at 3.

91. *Krueger*, 234 Cal. Rptr. at 584.

92. *See* Mitten, *supra* note 27, at 28.

93. *Id*. at 28–29.

94. *Id*.

95. *See id.* Unfortunately, a new trial had to be ordered on appeal because Hoge's trial attorney violated discovery rules by failing to provide the defendant with a letter from one of Hoge's doctors. *Id*. at 29; *see also $1.55M Verdict Against a Football Doctor Reversed*, NAT'L L.J., Apr. 2, 2001, at A12.

96. *Treatment Cut Hockey Player's Career Short*, NAT'L L.J., Nov. 18, 2002, at B2.

97. *Id*.

98. *Id*.

One might reasonably query why athletes continue to suit up knowing that they are injured. In addition to strong personal drive to return to the game,[99] players face severe penalties for refusing to play when they have been cleared medically.[100] Hakeem Olajuwon was suspended by the NBA's Houston Rockets for refusing to play injured after doctors gave him approval to do so.[101] The team physician claimed his injury was healed, while Olajuwon believed the opposite to be the case.[102] Olajuwon further alleged that the physician was influenced by the loyalty he owed to team management, while the team countered that Olajuwon's refusal was just a ploy in his contract negotiations.[103] In addition to possible suspensions or fines, players who resist playing hurt due to pain also face scrutiny from management and coaches. Jacksonville Jaguars head coach Tom Coughlin was heard to call injured athletes "[t]he sick, lame and lazy."[104] Dr. Huizenga of the L.A. Raiders detailed the constant pressure that owner Al Davis placed on running back Marcus Allen to take shots in order to return to the field despite his injuries and pain.[105] This pressure is difficult to resist for any player, especially those who lack the star status of Allen and risk being released from their team if they do not follow the doctor's or coach's orders.

The scope of conflicts due to physicians' dual loyalty to both the athlete–patient and to the team includes not only treatment of player injuries, but also pain management. One of the earliest player lawsuits on this matter was brought by Dick Butkus, former linebacker for the Chicago Bears.[106] Butkus alleged that the weekly pain-killing injections he received for a knee injury were administered without adequate informed consent regarding the complications.[107] He settled his lawsuit for $600,000 in 1976 and still suffers from permanent injuries today as a result of his treatment.[108] In a 1978 lawsuit against the team physician for the Portland Trailblazers, Bill Walton similarly alleged that the doctor had injected heavy painkillers into his injured feet before games and failed to inform him of the risks associated with continuing

99. This attitude is summed up by the often-cited battle cry, "no pain, no gain." Virtually all professional athletes would prefer to play rather than sit in the trainer's room. A prominent recent example is the pain endured by Boston Red Sox pitcher Curt Schilling as he carried his team to the American League Pennant and World Series title despite playing with a torn tendon-sheath in his ankle. *See supra* note 7 and accompanying text.

100. *See Olajuwon Seeks Way to Protest Suspension*, CHI. SUN TIMES, Mar. 25, 1992, at 105.

101. *Id*.

102. *Id*.

103. *Id*.

104. Roberts, *supra* note 34, at D5.

105. *See* HUIZENGA, *supra* note 31, at 165–69.

106. Polsky, *supra* note 72, at 521.

107. *Id*.

108. Nocera, *supra* note 40, at 84.

to play.[109] Moreover, in response to concerns about the long-term effects of heavy painkillers in treating injuries, the Cincinnati Bengals recently stopped using such medications on the field.[110] The common sense rationale for the decision was that using these masking agents during a game could conceal serious injury that was in need of treatment.[111] Simply killing the pain can lead to a player further injuring himself, jeopardizing his long-term health and career.

In addition to survey data and litigation, there is further evidence of player concern regarding decisions made by team physicians.[112] Quite tellingly, players are increasingly taking medical care into their own hands. They are seeking second opinions more often, and all major players' unions are now encouraging and helping to facilitate the practice.[113] In fact, the NFL Players Association website today posts a list of doctors who are available to render second opinions for players on every team.[114] The most recent Major League Baseball and National Football League collective bargaining agreements both provide that players have the "right" to second medical opinions.[115] The NFL Players Union has also attempted to change their collective bargaining agreement to provide for greater independence to team physicians.[116] Some players are eschewing team doctors entirely—Barry Bonds, for instance, hires

109. Polsky, *supra* note 72, at 521; Nocera, *supra* note 40, at 84. The case settled out of court. Nocera, *supra* note 40, at 84.

110. Ken Gordon, *Bengals Trainer Disdains Needle and Damage Done*, COLUMBUS DISPATCH, Nov. 15, 2002, at 2D.

111. *See id.*

112. *See, e.g.*, Lotysz v. Montgomery, 766 N.Y.S.2d 28, 28 (N.Y. App. Div. 2003). In Lotysz's medical malpractice action against team physicians, amicus briefs were filed in Lotysz's favor by the National Football League Players Association, Major League Baseball Players Association, National Basketball Players Association, National Hockey League Players Association, and Professional Hockey Players Association. *Id.*

113. *See* Frenette & Filaroski, *supra* note 6, at A-13.

114. NFL PLAYERS ASSOCIATION SECOND OPINION LISTING (2005), http://www.nflpa.org/Members/main.asp?subPage=Second+Opinions.

115. *See* MAJOR LEAGUE BASEBALL PLAYERS ASSOCIATION, 2003–2006 BASIC AGREEMENT 45–46, http://mlbplayers.mlb.com/pa/pdf/cba_english.pdf [hereinafter MLBPA BASIC AGREEMENT] (requiring at Article XIII(D) that teams provide players with an accepted list of specialists that they may see as part of their contract); NFL CBA, *supra* note 26, at art. XLIV (permitting a player to seek a second opinion; but requiring the player to consult the team physician prior to doing so, and entitling the team physician to issue her own report concerning the findings of the second physician).

116. Gene Wojciechowski & Chris Dufresne, *Delicate Procedures: NFL Team Physicians Must Provide Proper Care to Injured Players and Please Management at Same Time*, L.A. TIMES, June 26, 1988, Part III (Sports), at 12.

his own trainer to help with his back pain instead of relying on the San Francisco Giants' staff of medical care providers.[117]

Moreover, doctors themselves have expressed concern over management involvement in decisions regarding player care. Dr. Huizenga, former president of the NFL Physicians Society, has aggressively argued that steps must be taken to remove management pressures on medical decisions.[118] Dr. Michael Lawhon, team doctor for the Cincinnati Reds, resigned from the organization in 1991 saying that he could not "continue to engage in a situation that has a front office which does not consider the medical team and its players' health a priority."[119] Lawhon urges that reforms need to be made to combat "a lack of support and honesty from the front office, continued second-guessing and misleading reports about injuries."[120] Dr. Arthur Caplan, director of the University of Pennsylvania's Center for Bioethics, also laments the dual loyalty problems confronted by team physicians and advocates for change.[121] Caplan argues that physicians cannot meet their obligation to look after the welfare of their patients when their interests are also inextricably linked to the needs of their employer and the franchise.[122] John Cadigan, former team physician for the New England Patriots, decries the erosion of trust that has resulted from players viewing doctors as part of the team's management, rather than as advocates for the athlete's best medical interests.[123] He proposes fundamental alterations to the employment relationship between teams and doctors as a sensible response to today's conflicts.[124]

Finally, mounting evidence exists that due to the pressures that team physicians face, they are increasingly engaging in unethical behavior when it comes to designating players eligible for injured reserve.[125] Because the NFL limits the number of players who can remain on their team's active roster, physicians sometimes coach athletes to fake injuries.[126] By doing so, the

117. *See* Ken Daley, *A Bonds Primer: How He's Making History: Several Factors Propelling the Drive for 70*, DALLAS MORNING NEWS, Oct. 2, 2001, at 5B.

118. *See* HUIZENGA, *supra* note 31, at 316–17.

119. *Doctor for Reds Quits*, N.Y. TIMES, Dec. 4, 1991, at B19.

120. *Id*. For example, another physician, Dr. Arthur Caplan, urges that *Miranda*-style warnings disclosing the conflicts that doctors face be given to athlete–patients. *See infra* notes 151–52 and accompanying text.

121. Sabin Russell, *Rice's Injury Puts Spotlight on Team Doctors: Pressure to Win Conflicts with Players' Need to Heal*, S.F. CHRON., Dec. 18, 1997, at A1.

122. *See id*. at A8. Caplan adds that it is highly unusual for doctors to practice medicine in the face of such significant economic pressures adverse to independent medical judgment. *Id.*

123. *See* Hal Habib, *When Injuries Rob Athletes, Who's to Blame?*, PALM BEACH POST, June 16, 2002, at 1C.

124. *See id*. at 14C; *see also infra* Part IV.A (recommending that physicians be hired by the league rather than by individual teams).

125. *See, e.g.*, SCRANTON, *supra* note 36, at 54–55.

126. *See id*.

player can be placed on injured reserve and avoid being released from the team.[127] One team referred to the practice as providing "rookie scholarships," under which a player would fake an injury, receive his full salary, and then attempt to make the team the following season.[128] Team doctors are pressured to enable this fraudulent practice by pretending to treat the uninjured player. As a rationalization, one team physician clearly revealed the conflict of interest he faced, stating: "We were hired to protect the players' health and to [simultaneously] look out for the team's interests, and that's exactly what we did."[129] Fortunately, the NFL has attempted to curtail these rookie scholarships in recent years by limiting the number of players permitted on injured reserve.[130] Nevertheless, if a physician were to coach a patient to feign an injury in any other context (such as a court trial), she would be in outright violation of AMA medical ethics guidelines and face serious consequences.[131] Again, however, we witness the toll of the employment conflicts on team doctors, pressuring them to compromise medical ethics in order to achieve the goals of their employer.

IV. POTENTIAL SOLUTIONS

A. Eliminate the Team Physician Entirely and Hire Doctors Through the League or Players Union

Given the perils and incentives created by the conflicts of interest detailed above, we must consider policy options that would mitigate or remove the problem entirely. Fundamentally restructuring the current employment relationship between teams, physicians, and players is in the best interest of all three parties. Players would benefit because they would know their best interests were now being held paramount by their treating physician, which in turn would increase their confidence and trust in the medical advice being offered. Players could further expect to be provided with complete information about the potential complications of treatment options, and at the same time, would be more willing to reveal all information relevant in treating them.[132] Ideally, this would lead to an overall improvement in long-term

127. *See id.*

128. HUIZENGA, *supra* note 31, at 199.

129. SCRANTON, *supra* note 36, at 55.

130. *See id.*

131. *See* COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, *supra* note 12, at xiv (Preamble) ("A physician shall uphold the standards of professionalism, be honest in all professional interactions, and strive to report physicians deficient in character or competence, or engaging in fraud or deception, to appropriate entities.").

132. Under the current system, one might reasonably speculate that if a player knows his doctor is advising his coach on which athletes he thinks can perform well versus those he feels

player health and the doctor–patient relationship. Doctors would benefit from an employment restructuring because they would no longer be placed in the ethically uncomfortable situation of being pressured by management to make medical decisions that could be adverse to a player's best interests. Moreover, physicians may even be able to lower their malpractice costs by avoiding lawsuits that allege fraudulent medical care on the theory that the doctor's loyalty was not with the player.[133] Finally, sports franchises would reap long-term benefits because their players would be in better health and ideally be able to extend their playing careers.[134]

The most obvious method to fundamentally change the physician's employment relationship would be to no longer have teams hire physicians. The players' unions and the professional sports leagues are the most obvious organizations that could take over this responsibility.[135] Both players[136] and physicians[137] have reasonably proposed such a move. Players' unions only represent the interest of the athletes that comprise their membership. Thus, physicians hired by the union would owe their loyalty solely to the players they treat. In this manner, a far more traditional doctor–patient relationship would be created in which an athlete could trust that his physician had only his well-being at heart.[138] Today's dual loyalty that physicians owe to both players and organizations—and the corresponding conflict of interest created—would be eliminated. Furthermore, if the players' union hired physicians, then they could be categorized as independent contractors, which would in turn remove workers' compensation law as the exclusive remedy for injuries.[139] Players would be permitted to bring negligence suits for medical malpractice against

cannot, that player would be apt to conceal adverse health information for fear of losing playing time.

133. *See supra* notes 85–98 and accompanying text (detailing malpractice litigation against team physicians).

134. Obviously, this is a benefit only if teams care about the long-run horizon. Presumably, if they did, they might institute some of the reforms suggested in this Paper on their own. The fact that teams have generally not done so may be evidence that providing healthcare free from conflicts of interest may indeed be less than profit maximizing.

135. *See* Solares, *supra* note 9, at 249–53; Justin P. Caldarone, Comment, *Professional Team Doctors: Money, Prestige, and Ethical Dilemmas*, 9 SPORTS LAW. J. 131, 150 (2002); DiCello, *supra* note 10, at 534–35.

136. *See* Frenette & Filaroski, *supra* note 6, at A-13.

137. *See* Habib, *supra* note 123, at 14C (noting that former team physician for the New England Patriots recommended that the league be responsible for hiring team physicians, rather than individual teams).

138. *See* Herbert, *supra* note 79, at 257–58.

139. *Id*. at 275.

the doctors they hire, thereby incentivizing physicians to offer the best medical care and advice possible.[140]

The collective bargaining agreements for the professional players' unions provide an excellent vehicle to create these new relationships between players and their physicians. The NFL collective bargaining agreement expires in 2007,[141] the NBA's expired after the 2005 season,[142] and the Major League Baseball collective bargaining agreement is set to end in December of 2006.[143] Through these collective bargaining negotiations, players' unions have the ripe opportunity to alleviate the longstanding tension between players and doctors and to remove the conflict of interest that team physicians confront.[144] In fact, leaders of the NFL Players Union have already expressed a desire to discuss long-term consequences of medical decisions in their next collective bargaining agreement.[145] The Union has understandably made healthcare a priority concern after its 2000 survey revealed concerns with medical care by team physicians and demonstrated that players strongly believe that second medical opinions should be mandatory.[146] The Union is currently considering what proactive steps can be taken, including instituting a grievance procedure against doctors.[147] Of course, the superior option would be to end the grievances once and for all.

Besides using the collective bargaining process, a second option to restructure the employment relationship of team physicians would be to require the professional sports league itself to hire the doctors rather than its players

140. *Cf*. Lotysz v. Montgomery, 766 N.Y.S.2d 28 (N.Y. App. Div. 2003); Hendy v. Losse, 819 P.2d 1, 13 (Cal. 1991) (prohibiting negligence claims of professional athletes from proceeding because workers' compensation is the exclusive remedy for those injured by a co-employee physician acting in the scope of employment).

141. Frenette & Filaroski, *supra* note 6, at A-13.

142. *NBA Extends Deal with Players Union*, BOSTON GLOBE, Dec. 9, 2003, at E2. The NBA recently reached a new collective bargaining agreement with players that was ratified this summer. *See* Associated Press News Service, *League, Players Get New CBA Done Before Lockout*, CBS SPORTSLINE.COM, June 21, 2005, http://cbs.sportsline.com/nba/story/8584282. While salary cap and revenue sharing remained dominant issues, little was done to remedy conflicts of interest faced by team physicians. *See id*.

143. *See* MLBPA BASIC AGREEMENT, *supra* note 115, at 119. At the time this Paper was authored, the National Hockey League was under a lockout due to disputes over its collective bargaining agreement. *See* Joe Lapointe, *N.H.L. and Union Reject Proposals*, N.Y. TIMES, Dec. 15, 2004, at D6.

144. *See* Pennington, *supra* note 38, at A1 (describing the longstanding tension between players of professional sports teams and team doctors because of the employment relationship between the doctor and the team). Of course, some may possess a less optimistic view of the ability of labor unions to effectuate players' interests in this regard, especially if leadership is "captured" by league or team management.

145. Frenette & Filaroski, *supra* note 6, at A-13.

146. *See id*.

147. *Id*.

union.[148] John Cadigan of the New England Patriots recently called for such a reform, proposing that the NFL hire doctors directly rather than the teams.[149] This alternative would similarly remove the pressures placed by management on physicians and would return the distorted doctor–athlete relationship back to the realm of a more traditional doctor–patient relationship.[150] Ultimately, however, players might still be skeptical of league involvement in light of the close relationship between leagues and the individual teams that comprise them. If this is a significant concern, having the players' union hire physicians directly would be the superior reform to eliminate both actual and perceived conflicts of interest.

B. Mandatory Conflict Disclosure

If a radical employment change proves too difficult to negotiate, team doctors should at the very least be required by law and league policy to affirmatively disclose their financial relationships and conflicts of interest to players.[151] This disclosure would include any ownership interests held by the physician, the products endorsed by the team or her medical group, and whether the physician made contributions to the team in exchange for being named the "official" healthcare provider.[152] The purpose of mandating conflict disclosure would be to inform athletes of all relevant information regarding their healthcare choices and to promote trust and openness in what many see as a damaged relationship.

Dr. Arthur Caplan of the University of Pennsylvania's Center for Bioethics has expanded upon this disclosure principle. In light of the team physician's conflict of interest, Caplan believes there should be a "*Miranda*-style warning [given] to every player informing him that he not only has the right but the *obligation* to get his own personal physician."[153] He added that "[n]o professional athlete should ever have to depend solely on the team doctor for his medical treatment."[154]

148. *See* DiCello, *supra* note 10, at 535.

149. Habib, *supra* note 123, at 14C.

150. *See id.*

151. *See* Keim, *supra* note 10, at 223–24.

152. *See id.*

153. Wolff & Stone, *supra* note 41, at 12 (referencing the Supreme Court ruling in *Miranda v. Arizona*, 384 U.S. 436 (1966), requiring that police inform arrestees of certain rights before questioning) (emphasis added). An interesting analogy could be made in the attorney–client privilege context. When a lawyer is hired by a corporation to represent the organization, she is required to disclose to individual corporate officers that she represents them in their capacity as representatives of the corporation (i.e., not as individuals), and that in litigation between the two, none of what is said is privileged. *See* Nancy J. Moore, *Expanding Duties of Attorneys to "Non-Clients": Reconceptualizing the Attorney–Client Relationship in Entity Representation and Other Inherently Ambiguous Situations*, 45 S.C. L. REV. 659, 678 (1994).

154. Wolff & Stone, *supra* note 41, at 12.

While such a warning would promote candor and be a step in the right direction, the mere existence of mandatory disclosures would not remove the underlying conflict of interest problem. A warning would directly acknowledge the issue and raise athletes' awareness, but would not implement the fundamental change in the physician's employment relationship necessary to remove the divergence of interests that she must satisfy.[155]

C. Physician Agreements to Assert Independence

Some sports medicine followers have proposed that physicians enter into agreements with team management under which they explicitly assert their authority to make decisions free from team interference.[156] This type of agreement would ensure that the physician's relationship with the franchise is purely professional, and that the doctor was not considered "part of the team."[157] Moreover, such agreements should include the elimination of incentives witnessed today for team physicians based on a successful season, such as the championship rings and financial bonuses based on wins.[158] These agreements must also prohibit physicians from being involved in questionable behavior such as inappropriately placing players on injured reserve.[159] If such contracts could be reached, they might mitigate the concern that physicians who are emotionally or financially invested in the team might lose their objectivity when making medical decisions.[160]

However, much like proposed "*Miranda* warnings" to players, this prophylactic measure would not fundamentally alter the physician's relationship to the team in such a way as to remove the conflict of interest. Even if these agreements existed, the potential for implicit interference from management in daily medical decisions would create the same dual loyalty problems for doctors as those seen today. Furthermore, the growing prevalence of marketing agreements between teams and their medical providers—under which physicians *pay* significant sums of money for the *privilege* of providing healthcare services—makes it unlikely that physicians possess the bargaining clout necessary to assert their independence and their complete control over medical decisions affecting athletes.[161]

155. There is additional cause to be skeptical of the effect that mandatory disclosures would have. In the criminal law context, for example, studies have shown that Miranda warnings have had relatively little inhibiting effect on suspects' willingness to talk to the police. *See* Stephen J. Schulhofer, *Reconsidering Miranda*, 54 U. CHI. L. REV. 435, 456 (1987).

156. *See* Keim, *supra* note 10, at 220–21; Caldarone, *supra* note 135, at 150.

157. *See* Caldarone, *supra* note 135, at 150.

158. *Id.*; DiCello, *supra* note 10, at 535.

159. *See supra* notes 125–31 and accompanying text; *see also* Polsky, *supra* note 72, at 526.

160. *See* Caldarone, *supra* note 135, at 150–51.

161. *See* Polsky, *supra* note 72, at 525.

D. Ban Advertising of Physicians' Relationship with Teams

The dramatic rise of marketing arrangements between teams and physician groups over the last decade leads a reasonable mind to conclude that the primary value of being named a team's official healthcare provider is the public relations benefit, not the compensation received for rendering medical services. In turn, doctors may become so preoccupied with preserving the marketing edge associated with being a team's official provider that their medical care decisions suffer.[162] One potential method of alleviating this growing problem (short of the more fundamental solutions above) would simply be to ban advertising that highlights physicians' relationships with teams. If the marketing edge that physician groups now enjoy was strictly prevented by league policy, doctors would no longer engage in bidding wars to win the right to service athletes at below-market rates (or for free). Moreover, their healthcare advice and decision-making would not be influenced by the pressure to keep the position as a way of attracting future clients. Thus, merely limiting the "PR" use of having a healthcare contract with a team would go a long way towards eliminating some conflicts that physicians face.

E. Modify Workers' Compensation Laws

Finally, some critics of the current legal liability regime (or lack thereof) support the notion that workers' compensation statutes should be reconsidered to meet the goals that they were originally created to satisfy.[163] Traditionally, these statutes offered protections to employees injured on the job that they might not otherwise be able to negotiate or receive on their own. In the professional sports context, however, they serve primarily to shield teams and their physicians from medical malpractice liability while simultaneously offering dramatically inadequate compensation to reimburse an injured player for his expected loss.[164] By modifying these statutes to exempt professional sports franchises, athlete-employees would regain the necessary leverage afforded by the threat of litigation against team physicians who do not hold the player's interest first and foremost in their healthcare decisions.[165] In this manner, the spirit of workers' compensation laws—that employees be adequately compensated for their injuries—would be satisfied, and teams and

162. *See* Pennington, *supra* note 38, at D4 (discussing Dr. Andrew Bishop's concern that "if this [physician] was so eager to do this he's *willing to pay* to do it, then he's going to do whatever management wants to keep the job he paid for") (emphasis added).

163. *See* Herbert, *supra* note 79, at 276–77; Michael Landis, *The Team Physician: An Analysis of the Causes of Action, Conflicts, Defenses and Improvements*, 1 DEPAUL J. SPORTS L. & CONTEMP. PROBS. 139, 157 (2003).

164. *See* Herbert, *supra* note 79, at 276.

165. *See id*. at 276–77.

their physicians would no longer be able to hide under the shield of legislation that was never intended to deprive athletes of just compensation.[166]

CONCLUSION

Unfortunately, it has become increasingly clear that team physicians in professional sports face serious conflicts of interest created by their competing loyalties to both the athlete–patient that they treat and to the team that employs them. The conflict is compounded by the recent rise of marketing agreements whereby physician groups pay significant sums of money in order to have the right to be designated the official healthcare provider of a prestigious sports franchise. In response, professional sports leagues and their players must adopt measures that would alleviate the worsening conflicts and enhance protections for athlete–patients. Most fundamentally, the character of the current employment relationship between teams and their physicians must be drastically altered by requiring doctors be hired directly by the players' union or by the league itself. In this manner, the dual loyalty problem that team physicians face today (i.e., Do they serve the interests of the team which employs them or the welfare of the player-patient they treat?) would be removed. Physicians could then resume a more traditional and trusting doctor–patient relationship with the athletes they see, and players' confidence in the medical decisions being rendered would rise significantly. If such a change proves politically impossible to institute, at the very least physicians should be required to disclose the conflicts of interest they face to their athlete–patients.

In addition, reputable physician groups should insist on negotiating healthcare provision agreements that stress the independence of their medical judgment from the other interests being sought by team management. Moreover, banning the ability of physicians to advertise their affiliation with a sports franchise would substantially cut down on the willingness of medical groups to defer to team management simply to preserve the "PR" benefit of their relationship. Finally, state legislatures might consider amending workers compensation statutes to remove coverage of professional sports teams, because in this unique arena, such laws actually work to hurt the employee (athlete) that they were originally intended to protect. In the final analysis, I believe the best hope lies with players and their league to use the collective bargaining process to reform physicians' employment relationship with teams, and to ensure that the medical care being provided to athletes who risk serious

166. *See id*. However, since workers' compensation is the exclusive remedy for most workplace injuries, many observers are not convinced that there is a clear public policy rationale justifying a special exception solely for the benefit of professional athletes. Moreover, if the league or players union hired doctors directly, they could hire physicians as independent contractors, which would remove the problem of workers' compensation exclusive remedy provisions. *See id*. at 276.

injury on a daily basis is never again compromised in the interest of financial gain.