The National Football League Physicians Society read with disappointment the article “A Proposal to Address NFL Club Doctors’ Conflicts of Interest and to Promote Player Trust.”¹ In spite of the authors’ suggestions, 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. It defies logic for the authors not to have engaged experienced and active NFL physicians from the very start of their effort to explore, challenge, and recommend significant alterations to the delivery of health care to NFL players.²

As troubling as this article is from so many perspectives, it does represent an opportunity for the NFLPS to set the record straight and call attention to the excellent quality of care NFL players receive. In addition, it represents an opportunity to expose the extraordinarily weak evidence presented in the article and to refute the baseless allegations that challenge the high ethical standards of NFL physicians. Contrary to solid scientific research that starts with a hypothesis based on theory, in this case it seems quite apparent that the authors started with a predetermined conclusion and set out to justify it. Their premise was flawed, and they failed in their execution.

In an effort to provide context, NFL physicians’ training, subspecialty medical and surgical expertise, and reputations in patient care, clinical leadership, and medical professionalism are largely unparalleled in the world of sports medicine. Every NFL physician has been selected because NFL clubs want the best possible physicians to provide care for their players. All NFL physicians are board certified in their specialties, and most are subspecialty certified in sports medicine. Most NFL physicians educate medical students, residents, fellows, and even their physician peers in their areas of expertise across the United States and the world. In addition, many are nationally and internationally renowned researchers who lead the way in seeking to improve the medical care and health of patients.

The NFLPS, created in 1966, is an academic society with a mission to provide excellence in the medical and surgical care of the athletes in the NFL and to provide direction and support for the athletic trainers in charge of caring for these athletes. Combined, NFLPS physicians have authored more than 5,400 scientific articles, presented more than 9,000 scientific presentations, hold more than 130 active academic appointments in prestigious medical centers throughout our country, and care for more than 700 sports teams in professional leagues outside of the NFL. Head medical physicians and orthopedic surgeons of NFL teams have 984 years of combined experience in providing care for NFL players. The NFLPS has published groundbreaking research focused on improving the care and health of NFL players related to heat illness, cardiovascular health of existing and retired NFL players, sleep apnea, playing surfaces, shoe wear, injury protection and prevention, and treatment algorithms. NFL physicians take pride in the standards we have set for professionalism in the world of sports medicine. It is no coincidence that many retired NFL players and their families continue to see their former team physicians as their own personal physicians, a confidence based on the trust and respect established while they were players. Yet, these are the same physicians the authors have indicted on theory alone—without any real data to support their assertions other than interviews.
Contrary to the authors’ allegations, we are physicians who consistently treat all of our patients, including NFL players, with the same uncompromised professional and ethical standards. We do what is in our patients’ best interests. Doing anything less in the NFL environment of high-definition, Uber-scrutiny would not only be immediately recognized and exposed by players, agents, second-opinion physicians, the media, and others but would also be self-defeating. It is not hyperbole to suggest that NFL physicians practice in the most scrutinized environment in medicine. Our patients are protected by a union with its own medical director and medical advisory boards—as well as by a team of lawyers who are not hesitant to voice concerns, where appropriate. Inappropriate medical management (opinions, recommendations, and nonsurgical and surgical treatment) that is not in the best interests of players would quickly damage a physician’s reputation and would result in a very short-lived career as an NFL physician. It is counterintuitive to suggest, as the authors have, that NFL physicians would jeopardize a lifetime commitment to a noble career by practicing in a structure characterized by legal and ethical issues that may threaten player health.

While the premise that NFL physicians have two primary roles is oversimplified, we do not contest it. The foremost responsibility of NFL physicians is to provide medical care for the players. In addition, NFL physicians provide medical information to the club regarding the health status of existing and potentially future players; in fulfilling this role, we are medical messengers. Irrespective of the authors’ theories or opinions, these two roles do not conflict and do not represent a “problem of dual loyalty” (pp. S3, S20). The authors acknowledge that “clubs must have access to some 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 players’ short- and long-term health prospects so that they can make informed decisions about the players’ short- and long-term prospects of assisting the club” (p. S13). As the authors admit, “This is the stark reality of a business driven by physical prowess and ability” (p. S13). Providing appropriate, ethical, moral, and unconflicted care of players is not mutually exclusive to also being medical messengers of factual health information to clubs. Our act of telling a player and a club that the player’s concussion or high ankle sprain may keep him from safely participating in professional football for several weeks is not in conflict with providing the best possible care to that player. The act of providing players’ medical information to clubs, with players’ consent and as collectively bargained between the NFL and the NFLPA, is factual in nature, and under no circumstances do NFL physicians engage in “helping clubs to determine whether a player’s contract should be terminated” (p. S6) or suggest to a general manager that he “consider signing a potential replacement player” (p. S8). Moreover, to suggest that NFL physicians feel “pressure” to try to “please the club in their treatment decisions and information disclosure” (p. S14) ignores the ethical responsibilities and integrity of dedicated physicians.

There must be a factual basis to support an allegation of a “conflict of interest.” Just because an individual may fulfill two different roles that could theoretically be in conflict does not mean that conflicts actually occur. Physicians deal with inherent theoretical conflicts of interest in their professional lives every single day. The very best surgeons who recommend a surgical approach to their patients are theoretically conflicted, as reimbursement will be greater for their surgical management. The most respected oncologists have a theoretical conflict of interest if they recommend a chemotherapeutic regimen to their patients. Examples are endless. Rather than discussing or even considering a theoretical conflict of interest, the premise throughout this article—“Club Doctors’ Conflicts of Interest”—is presented as a statement of fact. It is clear that the authors, without even the most basic data to back up their assertions, have concluded that NFL physicians have an absolute conflict of interest in treating NFL players. They do not interview any of the health care professionals whose conduct they question, and they do not provide any real data to support their conclusion that the conflict of interest they describe as “inherent” (p. S4 and passim) actually exists.

The evidentiary base for the alleged lack of trust that the authors contend NFL players have in their team physicians is severely lacking. The authors rely on only two data sources to document a lack of trust between players and team physicians: thirty-minute interviews with a “convenience sample” of ten players active in the 2015 season (which represents 0.5 percent [10 out of 856] of active players) and three former players, and a 2016 Associated Press survey of one hundred players that was designed for a different purpose and was described as “nonscientific” by the AP itself. The AP posed five questions to three members of each NFL team for the purposes of gauging attitudes and anxieties about football,” not to come to any scientifically definitive conclusion related to the trust between players and team physicians.

Instead of documenting that NFL players distrust club physicians, the eleven sets of quotations provided in the article (with no explanation of why the other two interviewees’ responses are not included) document that six of the eleven interviewees expressed trust in club physicians. Yet the authors state that “[m]ost of the players we spoke
to said that the current structure of the club medical staff generated distrust of club doctors.” It is also interesting to note that a current player with only two years of NFL experience and another with ten seasons in the NFL both describe very positive relationships with their club physicians. However, the authors suggest that “players become wiser—and thus less trusting—as they get older” (p. S22, note 22).

The 2016 AP survey that the authors also cite as addressing the issue of players’ distrust in club physicians found that forty-seven of one hundred respondents agreed that “NFL teams, coaches and team doctors have players’ best interests in mind when it comes to injuries and player health,” while only thirty-nine disagreed and fourteen either were not sure or did not respond to the question. These responses certainly do not provide evidence of an overwhelming player distrust of their club doctors; the majority of responders, in fact, express trust in teams, coaches, and team physicians when it comes to their health. Should trust become an issue, players have a right to a second opinion (encouraged and often facilitated by NFL physicians) as well as a right to the surgeon of their choice (paid for by their clubs)—a fact that the authors acknowledge only in a footnote.

Although the authors examine existing sets of contractual vehicles, professional codes, and case law and conclude that they are all deficient, their own analysis actually shows the strengths of these protective measures. They cite the collective bargaining agreement’s provision regarding the standard of care that doctors must follow, the essential meaning of which is very clear in acknowledging physicians’ responsibilities. They extensively cite the American Medical Association’s Code of Medical Ethics on the responsibilities of physicians to their patients. When they cite relevant law, they conclude that “NFL clubs’ practices concerning confidentiality of player medical information seem to comport with the relevant law.” They cite the waivers, agreed to by the NFL and the NFL Players Association and executed by players, as being consistent with federal privacy protections in the Health Insurance Portability and Accountability Act, privacy laws in the twenty-two states where teams play or practice, and common law and statutory confidentiality requirements. Yet after noting the applicability of all of these provisions, instead of emphasizing the comprehensive nature of these standards and how they work together to guard players’ health, the authors somehow conclude that “the existing ethical codes and legal requirements are not adequate to ensure that players receive health care they can trust from providers who are as free from structural conflicts of interest as is realistically possible” (p. S13). It is unclear how this conclusion follows from the strengths of the protections that the authors cite.

The authors call for a sweeping change in the way health care is delivered to NFL players and how information regarding player health is conveyed to NFL clubs based on an unsubstantiated set of premises that is flawed in concept and would not work in reality. And they have done so without any prospective input from the people who know the NFL health care structure best—existing NFL physicians with nearly one thousand years of combined experience. Furthermore, the authors’ recommendation disregards the vast implications to physician-patient relationships in comparable settings (Major League Baseball, the National Basketball Association, the National Hockey League, other professional sports with team physicians, United States Olympics teams, college sports, high-school sports, U.S. military physicians, and others). There is no evidence that a successful multiple-physician health care panel such as the authors propose has ever before been created. Thus, their recommended new, untested health care structure would be a risky and ill-conceived experiment with the health care of all NFL players in the balance.

NFL medical physicians and NFL orthopedic surgeons have different clinical roles and responsibilities related to NFL player health care that do not overlap. Thus, the authors’ proposal, in reality, would require the addition of at least sixty-four physicians (“Players’ Medical Staff” to include one player’s orthopedic doctor and one player’s medical doctor per team) to the NFL health care structure. This redundancy would assuredly have its own set of potential conflicts of interest, complexity, and challenges that would predictably not achieve the authors’ stated objectives. Having the Club Evaluation Doctors report with the health care of all NFL players in the balance.

Based on the proposed structure, the Players’ Medical Staff and Club Evaluation Doctors would, by definition, not be collaborating. Who could possibly endorse the creation of a new medical plan that mandates lack of collaboration and lack of communication?
a “reduced level of communication is necessary and appropriate to protect” (p. S16) a patient’s health.

Written summaries, as recommended in the Player Health Report, are poor, inadequate, and impossibly impractical substitutes for collegial discussion of the complex medical situations that naturally occur in medicine and in football. Based on the structure as proposed, the Players’ Medical Staff and Club Evaluation Doctors would, by definition, not be collaborating.7 Who could possibly endorse the creation of a new medical plan that mandates lack of collaboration and lack of communication?

It is difficult to imagine the game-day interplay—when decisions are made in real time—between two Players’ Doctors, two Club Evaluation Doctors, the head athletic trainer (who, as defined, is a players’ athletic trainer and therefore cannot communicate with coaches or other club personnel), the player, and the head coach in a setting where there is a mandate for limited communication.

Even more troubling is the authors’ recommendation that if a Players’ Doctor states in the Player Health Report that a player cannot play, then that player may seek a second opinion from a physician unaffiliated with either the Players’ Medical Staff or the Club Evaluation Doctor, and if that second-opinion doctor states that the player can play, then the player himself should be allowed to make the decision to play. How is this process one in which the player’s health and safety can be ensured by either the Players’ Medical Staff or the club itself?

Furthermore, members of the Players’ Medical Staff would not be able to have a traditional, concomitant medical or orthopedic practice in conjunction with their NFL positions given the authors’ requirement that they attend all practices and games and provide “a regular written report . . . about the status of any player currently receiving medical treatment” (p. S16) before and after each practice and game. The Players’ Medical Staff would have to be fully employed by the club. Thus, this position would likely attract physicians no longer at the peak of their professional careers. The end result may very well be a decrease in the quality of care for players.

The NFL physicians view this limited response to the authors’ accusations as an opportunity to state unequivocally that we are true to our professional and ethical standards and to the Hippocratic Oath in treating all of our patients, including those who happen to work within the confines of the NFL, with the utmost of professional integrity. There is no person, club, structure, or entity that can or will successfully challenge our duty and obligation to do what is best for our patients. We as physicians effectively deal with theoretical conflicts of interest on a daily basis in providing the highest quality of care to our patients. We do not accept the authors’ unsubstantiated opinion that a theoretical conflict of interest by definition represents a real conflict that destroys players’ trust in their team physician and jeopardizes patients’ health.


2. The first the NFLPS heard of this article was on April 8, 2016, in the form of an email from the article’s authors asking us to provide a commentary to their completed work yet limit our response to two to three pages and to do so within a month of receipt of the article. This request was after the authors spent over two years and significant funding from the NFL Players Association on their project that produced an approximately five-hundred-page report, a second one-hundred-sixty-page document, and a third twenty-three-page “spin-off” derivative that is the subject of this response. They chose not to contact the NFLPS directly before or during the creation of their reports, and by the time they did, their work was nearly completed.


4. Ibid.


6. See Fendrich and E. Pells, “AP Survey: NFL Players Question Teams’ Attitudes on Health,” which cites this question asked of NFL players: “Do you think NFL teams, coaches and team doctors have players’ best interests in mind when it comes to injuries and player health?”

7. The authors suggest that the presence of the unaffiliated neuromusculoskeletal consultant in the concussion protocol is justification for their proposed drastic changes to the entire NFL health care structure. It is important to note that the role of the UNC evolved to provide transparency to all parties as well as an additional, collaborative source of expertise for potentially complex sideline concussion evaluations. In the last two years, there have been 390 preseason and regular-season game concussions in the NFL. Of these, there were no instances (0 out of 390, or 0 percent) where the UNC disagreed with the team physician regarding whether or not a potentially concussed player should return to play. Not only have UNCs corroborated the real-time decisions of team physicians, but they have also done so in an open, transparent, and collaborative manner (which is in stark contrast to the recommended structural changes proposed by the authors).