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COMMENTS

TEAM PHYSICIANS: ADHERING TO THE HIPPOCRATIC OATH OR JUST PLAIN HYPOCRITES?

“Into whatever homes I go, I will enter them for the benefit of the sick, avoiding any voluntary act of impropriety or corruption.”¹

- Hippocrates

“I was out of it. I didn’t know anything. I lost coherence. It’s one of those things, you shouldn’t even been able to go back in the game.”²

- Jon Kitna

INTRODUCTION

On a chilled Sunday afternoon, a professional football player tears up-field, protecting the prized pigskin with his full might, thwarting tackles and oscillating his head vigilantly to avoid the opposition. The crowd bustles. What once existed as a low roar has evolved in a matter of seconds to an eruption of noise and cheers and stomping, further fueling his motivation to drive deeper into the opponent’s territory. Fifty thousand rabid spectators rise to their feet. As the player’s destination approaches, his heart palpitates out of control, and his nervous system is jolting with adrenaline as he cuts from left to right. Suddenly, like two trains in the night, it happens – a cataclysmic collision between two highly trained warriors.

1. Greek Medicine, *The Hippocratic Oath*, http://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Feb. 15, 2009) (translated by Michael North, National Library of Medicine). Further, the exact origin of the Hippocratic Oath is unknown, although its namesake, Hippocrates, often gets credit. *Id.* Indeed, some suggest that the Hippocratic Oath was “more strongly influenced by followers of Pythagoras than Hippocrates and is often estimated to have been written in the 4th century B.C.E.” *Id.*

2. Associated Press, *Kitna Says Lions Followed Proper Precautions Before He Returned to Game*, ESPN.COM, Sept. 17, 2007, <http://sports.espn.go.com/nfl/news/story?id=3024381>.

The player awakens a few short seconds later. Now there is a new crowd that concerns him. Surrounding his motionless body are team physicians, team trainers, emergency medical staff, and perhaps most concerning, opposing football players in the background down on one knee, clutching their hands, praying to their God for his safety. After a few seconds, however, he begins to gather your wits. The player's extremities begin to function seemingly fine. His pupils appropriately react to the incessant lights that the physicians are shining in his eyes. He rises and begins to walk to the sideline, this time hearing a more somber applause emanate from the same fans that only just finished screaming his name. On the sideline, the team physician concludes that he just had his "bell rung," a common occurrence in this line of work. The player explains to the team physician that he blacked out for a few seconds, that he is having trouble focusing, and that he feels quite dizzy. After some deliberation, the team physician assures the player that he is fine, slaps him on the helmet and says, "Head back in there and make something happen."

Actually, the player suffered a concussion during the break-neck collision, and unbeknownst to him, the next time he gets his "bell rung" he is at risk of serious injury and possibly death. At any rate, there is no need to worry; in such an event, the player should be able to seek recourse in the form of civil remedies against the team physician for his apparent negligent – and possibly reckless – actions, right? Unfortunately, the opposite is true. Even if the team physician was grossly negligent in allowing the player to continue playing after his injury, the team physician is likely to be completely protected from a medical malpractice claim. This Comment will explore the purported justifications for such an injustice.

The American culture is fraught with avid sports fans, many of whom particularly enjoy contact sports. There is something both stimulating and exhilarating about watching over-sized athletes who are in peak physical condition slam into each other. Whether it is an open-field tackle in football or a blind-side pick in basketball, contact sports have gathered unparalleled acceptance in the United States. Indeed, to the chagrin of many baseball fans, professional American-style football, which is best personified by the National Football League (NFL), is often referred to as America's new pastime.³ The physical nature and, at times, brutal contact is not just a byproduct of the game, but an inherent and necessary component. Consequently, it is well

3. Bryan Curtis, *The National Pastime(s)*, NY TIMES, Jan. 31, 2009, <http://www.nytimes.com/2009/02/01/weekinreview/01curtis.html>. This concept breaks from the long-time tradition and understanding that professional baseball is America's pastime. As evidence, "[t]he 17 most-watched programs in TV history have all been Super Bowl games." *Id.*

known to athletes and spectators alike that with participation in these contact sports, especially at the professional level, comes the risk of injury—often serious or even life threatening. Recognizing this, professional sports organizations employ team physicians to manage and treat any injuries to the athletes.

Normally, when a physician-patient relationship exists and that physician's diagnosis or treatment does not conform to the generally accepted standard within that medical practice field, the physician will be open to civil liability through a medical malpractice action.⁴ In contrast, however, case law has indicated that finding a professional sports team physician civilly liable is next to impossible, primarily because of the co-employee doctrine of workers' compensation law.⁵

This dichotomy will be the focus of this Comment. It will address and reconcile these seemingly inconsistent outcomes, with a specific focus on their application to sports-related concussions. As new research and medical science begins to emerge concerning head trauma, it is indicating a strong causal link between concussions and disorders such as Alzheimer's, Parkinson's, and severe psychological breakdowns including suicide.⁶ In other words, the effects of taking continual or recurring blows to the head can lead to far greater consequences than sounding like a battered Rocky Balboa.⁷

Surprisingly, there is no direct legal precedent assessing team physician liability through the lens of the co-employee doctrine with respect to concussions.⁸ Therefore, this Comment will apply other case law and policy

4. Matthew J. Mitten, *Medical Malpractice Liability of Sports Medicine Care Providers for Injury to, or Death of, Athlete*, 33 A.L.R.5th 619, 628 (1995).

5. Timothy J. Paterick, *Professional Team Physicians Beware! Co-employee Status May Not Ipso Facto Confer Tort Immunity*, SPORTS J. 2007, <http://www.thesportjournal.org/article/professional-team-physicians-beware-co-employee-status-may-not-ipso-facto-confer-tort-immuni>; See discussion *infra* Part II.B.

6. Press Release, *Researchers Find Definitive Proof that Repetitive Head Injury Accelerates the Pace of Alzheimer's Disease*, U. OF PA. HEALTH SYS., Jan. 15, 2002, http://www.uphs.upenn.edu/news/News_Releases/jan02/Alzheimers.html; L. Flemming Fallon Jr., *Concussion Health Article*, HEALTHLINE, 2002, <http://www.healthline.com/galecontent/concussion-2>; Tom Farrey, *Pathologist Says Waters' Brain Tissue Had Deteriorated*, ESPN.COM, Jan. 19, 2007, <http://sports.espn.go.com/nfl/news/story?id=2734941>.

7. See ROCKY III (1982) (starring a poor Philadelphia native boxer, Rocky Balboa, who triumphs throughout a series of prequel and sequel movies by rising from an unknown to become the Boxing Heavyweight Champion of the world – only to find out that the constant and severe hits to his head have caused him brain damage).

8. To be sure, there are several cases involving players, both active and former, or their estates suing various parties, including teams and physicians, for events surrounding injuries and concussions, but this Comment will focus exclusively on the co-employee doctrine used as a liability shield for team physicians. For an excellent analysis of other legal and ethical aspects of sports-related concussions please see Alexander N. Hecht, *Legal and Ethical Aspects of Sports-Related*

considerations to offer an opinion on the possible legal and non-legal consequences of a team physician misdiagnosing or ignoring player concussions. Specifically, this Comment will explore the implications of a team physician allowing an athlete to continue participating in a contact sport⁹ after knowing the likelihood that the player has suffered a concussion, and the consequent liability or lack thereof imposed on that team physician.

Part I of this Comment will describe the general legal duties of a team physician, explain the typical role of a team physician to a professional sports team, and describe the general liability, if any, that attaches to a team physician. Part II will consider the current legal impediments that shield a team physician from being held severally liable for malpractice. Part III will discuss and analyze recent common law trends that hint at the possibility of imposing liability on team physicians in the future. Part IV will provide a medical analysis of concussions, including the various symptoms of concussions, the medical standards used to evaluate such head injuries, the consequences arising from both concussions and their misdiagnosis, and, finally, why concussions are a unique and priority on-field injury. Lastly, Part V will involve a legal and policy analysis of team physician liability with regards to sports-related concussions. This analysis will explore and discuss the team physician's legal accountability to the players, the team physician's fiduciary obligation to the players, the economic pressures and conflicts of interest that exist within the industry, and whether current legislation or collective bargaining agreements (CBA) are protecting the players. Finally, this Comment will offer several solutions to the inequity faced by professional athletes under the current legal regime.

Concussions: The Merrill Hoge Story, 12 SETON HALL J. SPORTS L. 17 (2002) (discussing Merrill Hoge's legal pursuit of recourse for his team physicians' failure to inform him of the risk of playing with concussions – Hoge was initially awarded \$1.55 million, but that jury verdict was overturned); Brian Lipsky, *Dealing with the NFL's Concussion Problems of Yesterday, Today, and Tomorrow*, 18 FORDHAM INTELL. PROP. MEDIA & ENT. L.J. 959 (2008).

9. This Comment is meant to apply to a wide variety of professional sports. Although this Comment references "contact" sports on several occasions, it is only in an effort to engage the topic of head-injuries and consequent team physician liability due to misdiagnoses thereof with reference to the sports in which head-injuries and concussions are most common. That said, there are several sports not mentioned herein that this Comment intends to address through parallel analysis to contact sports (such as baseball, soccer, basketball, etc.). As an example, Corey Koskie fell awkwardly attempting to catch a routine popup while playing baseball, a non-contact sport, for the Milwaukee Brewers. Jerry Crasnick, *Koskie's Career Stuck in Limbo Due to Post-Concussion Syndrome*, ESPN.COM, Feb. 2, 2008, http://sports.espn.go.com/mlb/columns/story?columnist=crasnick_jerry&id=3224294. Koskie sustained a concussion, and although Koskie has not given up hope that he may one day safely set foot back on the field, he suffers from post-concussion syndrome as a result of the fall and as such, remains realistic that he may never play again. *Id.* This Comment and its analysis apply directly to any post-concussion medical analysis received from a team physician.

I. THE LEGAL DUTIES, ROLE, AND GENERAL LIABILITY OF TEAM PHYSICIANS

Four general duties apply to team physicians: “[1] protect athletes from injury . . . [2] [o]ffer candid and full disclosure . . . [3] [p]ractice good medicine . . . and [4] [e]nable players to avoid unnecessary risks.”¹⁰ Additionally, it is the fundamental responsibility of a team physician to protect the athlete’s health and well-being even in the face of an abundance of pressure to focus, instead, on the athlete’s ability to perform on the playing field.¹¹ In fact, sports medicine care providers, a term that includes team physicians, must adhere to a certain legal standard of care.¹² Essentially, analogous to the standard imposed in other areas of medicine, sports medicine care providers must conform to the generally accepted standards established within the sports medicine industry.¹³ In other words, a team physician can theoretically be civilly liable, but for the impediments that will be discussed below, if the physician does not adhere to the applicable standards of care within the sports medicine community (e.g., the team physician diverges from the standard evaluation necessary following a concussion, or the team physician fails to relay the possible risks of re-entering play with a concussion).¹⁴

Additionally, a physician has a duty to discover abnormalities and medical problems during an examination; however, the scope of what that examination should entail, along with the expected prognosis therefrom, is primarily determined on a case-by-case basis.¹⁵ In fact, the only standard or common

10. Barry R. Furrow, *Health Law Symposium: The Problem of the Sports Doctor: Serving Two (or is it Three or Four?)*, 50 ST. LOUIS L.J. 165, 172 (2005). Furrow refers to these duties by the acronym “POPE.” *Id.* These duties are designed to limit the possible conflicts of interest posed to team physicians and follow in full:

Protect athletes from injury, re-injury, or permanent disability, placing their welfare over that of the team or other competing interests; [o]ffer candid and full disclosure as to the nature and extent of injuries and the consequences of returning to play; [p]ractice good medicine, as defined by practice guidelines and consensus statements; and [e]nable players to avoid unnecessary risks, both by helping them understand what proper treatment is and what risks are presented by returning to play, and by sharpening the framework for a declaration of ineligibility to play under some circumstances, removing the choice from the player as well as the team and coach.

Id.

11. *Id.* at 173 (quoting Twila Keim, *Physicians for Professional Sports Teams: Health Care Under the Pressure of Economic and Commercial Interests*, 9 SETON HALL J. SPORT L. 196, 213-14 (1999)).

12. Mitten, *supra* note 4, at 627.

13. *Id.* at 627-28.

14. *Id.*

15. *Id.*

thread among the applicable cases seems to be a requisite duty of the physician to conform to "good and accepted standards of medical care" when diagnosing or treating sports injuries.¹⁶

Another consideration is that of the relationship between the physician and the player. The courts require that a physician-patient relationship exist between an athlete and the associated physician before a medical malpractice suit will be heard.¹⁷ In the context of this Comment, however, the patient-physician relationship will rarely be at issue because team physicians supervising players, especially on the sidelines of games when most concussions are first assessed, are retained for the exact purpose of making initial diagnoses of injury while on the sideline or in the locker room.¹⁸

As mentioned above, an area in which a player may find mercy from the court is that of disclosure. Indeed, team physicians have a duty to fully disclose to an athlete any injuries suffered by that athlete and the consequences of returning to play.¹⁹ So rather than bringing a civil action for malpractice, an athlete may have a course of action under state law for fraud or deceit.²⁰ In *Krueger v. San Francisco Forty Niners*, a team physician "failed to tell Krueger about possible adverse effects of steroid injections, the nature and extent of his left knee damage, and the extent of damage revealed by x-rays of his left knee."²¹ The court held that the physician's failure to notify and properly disclose to the player the severity of his injury and the consequences of further playing on the injured knee was more than enough evidence to find that the physician and the team fraudulently concealed the player's condition.²²

Krueger represents an "end-around" to many impediments presented in

16. *Classen v. Izquierdo*, 520 N.Y.S.2d 999, 1002 (N.Y. Sup. Ct. 1987). For several cases showing various analyses and applications of the *Classen* standard please see also *Rosensweig v. State*, 5 A.D.2d 293 (N.Y. App. Div. 1958); *Mikkelsen v. Haslam*, 764 P.2d 1384 (Utah Ct. App. 1988).

17. *Mitten*, *supra* note 4, at 627.

18. *But see* *Murphy v. Blum*, 160 A.D.2d 914, 915 (N.Y. App. Div. 1990); *Martin v. Niagara Frontier Hockey Corp.*, 177 A.D.2d 1006, 1009 (N.Y. App. Div. 1991). For a much more explanatory and in-depth analysis of the patient-physician relationship as it relates to sports, *see* *Lipsky*, *supra* note 8, at 976-81.

19. *Furrow*, *supra* note 10, at 176.

20. *See generally* *Krueger v. S.F. Forty Niners*, 234 Cal. Rptr. 579 (Cal. Ct. App. 1987); *but see also* *Gambrell v. Kansas City Chiefs Football Club*, 562 S.W.2d 163 (1978) (holding that the Workers' Compensation Act precluded a fraud and deceit action brought by an athlete against his employer because the nature of the plaintiff's injury, not the nature of the defendant's act are controlling, and holding that the nature of the plaintiff's injuries were accidental bodily injuries, which are covered by Workers' Compensation statutes).

21. *Furrow*, *supra* note 10, at 176 (citing *Krueger*, 234 Cal. Rptr. at 582-83).

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

finding a team physician liable in tort for medical malpractice. This is particularly applicable to concussions because team physicians must not only disclose to athletes that they may have suffered a concussion or that they are exhibiting symptoms of concussions, but athletes must also be made aware of the possible consequences of premature reentry onto the field of play.²³ This course of action presents its own burdens, however, as proving fraud will often require physician misrepresentation of a material fact, knowledge of said misrepresentation, desire that the athlete believe the falsity, athlete reliance on the misrepresentation, and ensuing damages.²⁴

II. THE LEGAL ISSUES IMPEDING RECOVERY BY INJURED ATHLETES

To circumvent the impediments to imposing civil liability on team physicians through malpractice actions, injured athletes must overcome several legal issues. First, an athlete must consider the workers' compensation laws applicable to the jurisdiction, especially because most collective bargaining agreements (CBAs), which govern such matters as wages, hours, and working conditions between the players and the league, mandate that state workers' compensation statutes exist as the exclusive remedy to the injured athlete.²⁵ The injured athlete must also consider the CBA entered into by the player's associated union and its importance in imposing methods with which players can seek to recover damages beyond workers' compensation statutes.²⁶ In many cases, courts find the abovementioned impediments enough to bar civil liability of team physicians. Lastly, affirmative defenses such as assumption of the risk and contributory negligence pose a threat to an injured athlete's possible recovery as the athlete most likely made the ultimate decision to set foot onto the playing field, or to reenter play following a possible concussion.²⁷

A. Collective Bargaining Agreements

Much aligned with the policy considerations behind workers' compensation statutes, the CBA serves a very important purpose of representing, in a realistic and functional manner, unionized employees. Federal statutes mandate the right of athletes as employees to form labor unions and "to bargain collectively through representatives of their own

23. *Id.*

24. Furrow, *supra* note 10, at 175-76.

25. See discussion *infra* Part II.B.

26. See discussion *infra* Part II.A & III.

27. See discussion *infra* Part II.C.

choosing, and to engage in other concerted activities.”²⁸ Collective bargaining, generally, is exactly as it sounds; employees and employers come together, either collectively or through representatives, to decide how future problems of the employment relationship will be handled.²⁹

Issues predetermined by the CBA include, but are in no way exclusive to, wages, hours worked, benefits, retirement, circumstances surrounding termination, and injury compensation.³⁰ In fact, employers are required to provide representatives of employees all information and “data relevant to a particular existing controversy.”³¹ Accordingly, collective bargaining is utilized in an effort to prevent controversy over issues that are “germane to the industrial relations environment, and [that] exist with or without unionization.”³²

Consequently, each professional league CBA and associated standard player contract is an indelible aspect to an analysis of a team physician’s legal duty to the players.³³ The CBA establishes not only the extent with which medical care must be provided to injured athletes, but also how much of team-provided or paid medical care will exist and what rehabilitation options will be available to the athlete.³⁴

In general, disputes arising out of the terms and provisions of the CBA must be decided through arbitration rather than litigation.³⁵ Furthermore, because federal labor law governs the collective bargaining process, the CBA mandatory arbitration provisions often act to preempt civil actions brought in state court when the dispute at hand involves a matter governed by the CBA.³⁶ On the other hand, state civil actions arising independent of the CBA provisions or governance, and that do not require interpretation of its terms, may be allowed.³⁷

28. 29 U.S.C. § 157 (2006).

29. See BENJAMIN J. TAYLOR & FRED WITNEY, LABOR RELATIONS LAW 3 (3rd ed. 1971).

30. *Id.*

31. 51 C.J.S. *Labor Relations* § 217 (2008).

32. TAYLOR & WITNEY, *supra* note 29, at 3.

33. See, e.g., NAT’L FOOTBALL LEAGUE COLLECTIVE BARGAINING AGREEMENT, art. XLIV §§ 1-3, XLVIII-C, LIV (2006) [hereinafter NFL CBA]; See also Matthew J. Mitten, *Emerging Legal Issues in Sports Medicine: A Synthesis, Summary, and Analysis*, 76 ST. JOHN’S L. REV. 5, 42 (2002).

34. Mitten, *supra* note 33.

35. *Id.*

36. See *Smith v. Houston Oilers, Inc.*, 87 F.3d 717 (5th Cir. 1996). In *Smith*, the Fifth Circuit held that interpretation and construction of the league CBA was governed by federal labor law. *Id.* at 720-21. The court reasoned that if the dispute involves a labor dispute that was subject to arbitration under the CBA, then the state tort claims were preempted by federal labor laws, which require the exhaustion of all arbitration remedies provided in the CBA before permitting a civil suit. *Id.* at 721.

37. See *Hendy v. Losse*, 925 F.2d 1470 (9th Cir. 1991). In *Hendy*, the Ninth Circuit held that

In light of the foregoing, athletes are faced with an uphill battle in trying to recover damages in excess of that which is agreed upon within the CBA, at least with reference to a dispute between the player and team or its employees.

B. Workers' Compensation and Blanket Tort Immunity Through the Dual Employment Role of Team Physicians

Workers' compensation laws are designed to afford employees – in this instance, athletes – with greater protection against the sanctions resulting from employment-related injuries.³⁸ The protection provided by workers' compensation laws assures that “[i]njured workers no longer ha[ve] to establish negligence attributable to their employer in order to obtain legal redress. They merely ha[ve] to demonstrate that their conditions arose out of and during the course of their employment.”³⁹ However, as a consequence of the greater protection afforded by workers' compensation statutes, states have uniformly eliminated a private right of action against employers when workers are injured on the job and that injury is covered by workers' compensation.⁴⁰ In this sense, when workers are injured in the workplace, workers' compensation statutes act as the sole remedy for the injured, proving to be a virtual immunity to civil liability against employers.⁴¹

Additionally, many states have codified this immunity. For instance, New York limits an injured employee's right to compensation or benefits to the exclusive remedies provided under the states' workers' compensation laws if that employee was “injured or killed by the negligence or wrong of another in

state tort claims alleging that the Chargers negligently hired and retained its team physician, as well as intentionally and negligently withheld medical information from the plaintiff were not subject to the CBA mandated arbitration, *Id.*, because these claims “arose independently of the CBA and did not require construction of its terms for their resolution.” Mitten, *supra* note 33, at 44.

38. See MARK A. ROTHSTEIN ET AL., EMPLOYMENT LAW 406 (1994).

39. *Id.*

40. ARTHUR LARSON & LEX K. LARSON, LARSON'S WORKERS' COMPENSATION LAW § 113.01 (2007).

41. John Redlingshafer, *Tonight's Matchup – Workers' Compensation v. Medical Malpractice: What Should Lower Paid, Inexperienced Athletes Receive When a Team Doctor Allegedly Aids in Ending Their Careers?* 2 DEPAUL J. SPORTS L. CONTEMP. PROBS. 100, 117 (2004). Notably, however, not all states have identical workers' compensation laws, and indeed, depending on the jurisdiction, some workers' compensation schemes are more protective, “while others exempt professional athletes altogether.” *Id.*; see FLA. STAT. ch. 440.02(17)(c)(3) (2002) (exempting professional athletes from workers' compensation). This distinction, however, is beyond the scope of this Comment because it does not seek to analyze the scope or applicability of workers' compensation schemes, but rather to cast doubt upon the legal doctrine that allows team physicians to escape liability under the protection of those schemes if and when they do apply. For an analysis of the various case law and state workers' compensation schemes, as well as their applicability to professional athletes, see Redlingshafer, *supra* note 41.

the same employ, the employer's insurer or any collective bargaining agent of the employer's employees or any employee, of such insurer or such collective bargaining agent (while acting within the scope of his or her employment)."⁴²

Illustrating the power of this statutory immunity, Greg Lotysz, a young NFL offensive tackle for the New York Jets, sued the team's orthopedic surgeons for medical malpractice after two infections resulting from knee surgery ended his NFL career.⁴³ The Supreme Court of New York, Appellate Division, affirmed the trial court's dismissal of Lotysz's suit, holding that even though he was injured while performing his duties as a New York Jet, fellow New York Jet employees treated him for his injuries, and as such, New York workers' compensation laws barred the suit.⁴⁴

Emerging from this virtual and often statutory immunity is the so-called "dual capacity" or "co-employee" doctrine.⁴⁵ It acts as a means by which workers injured on the job can exercise a private right of action against an employer, effectively circumventing the virtual tort immunity enjoyed by employers.⁴⁶ The doctrine states that "[a]n employer may become a third person, vulnerable to tort suit by an employee, if – and only if – it possesses a second persona *so completely independent from and unrelated to its status as employer* that by established standards the law recognizes that persona as a separate legal person."⁴⁷

Although the co-employee doctrine carves out a scenario in which an employer may still be liable outside of workers' compensation, the standard it employs creates a very high threshold that workers must meet before they can exercise such a private right of action against an employer or one of its employees.⁴⁸ As such, the co-employee doctrine becomes an almost stand-alone impediment to an injured worker's (or injured athlete's) recovery against an employer, or any "capacity" which that employer fulfills, such as team physician.⁴⁹ In a sense, a single legal person or employer as it were, can have many capacities such as that of a team physician, especially since the term "capacity" has no statutory definition.⁵⁰ A few courts have destroyed employer immunity where "there was not a separate legal person, but merely a

42. NY CLS Work Comp § 29(6).

43. See generally *Lotysz v. Montgomery*, 309 A.D.2d 628 (N.Y. App. Div. 2003).

44. *Id.*

45. LARSON & LARSON, *supra* note 40, at § 113.01.

46. *Id.*

47. *Id.* (emphasis added).

48. *Id.*

49. *Id.*

50. *Id.*

separate relationship or theory of liability,” but this remains the minority approach.⁵¹

Indeed, because there is no bright-line test to determine the applicability of the co-employee doctrine, any court deciding such a matter must make a discretionary decision in determining the structure of the employer and what capacity it, or one of its agents, was acting in at the time of injury.⁵² Considering just how many roles an employee, and by extension, an employer, can engage in throughout “the course of a day’s work as landowner . . . products manufacturer . . . repairman . . . doctor [or] safety inspector – it is plain enough that [conflicting case law] could go a long way toward demolishing the exclusive remedy principle [of workers’ compensation].”⁵³ For this reason, to keep with the statutory intent of workers’ compensation laws, courts often bar civil liability by applying the co-employee doctrine to various capacities of the employer.⁵⁴

Accordingly, the co-employee doctrine will most likely derail an athlete’s potential malpractice suit against a team physician, especially since league CBAs mandate that applicable workers’ compensation statutes apply to professional athletes injured while playing in their respective sports.⁵⁵ Indeed,

51. *Id.*; see also *Bryant v. Fox*, 515 N.E.2d 775 (Ill. App. Ct. 1987) (holding that suit against a team orthopedic surgeon was not barred by the exclusive remedy provision of the workers’ compensation laws); *Redlingshafer*, *supra* note 41, at 121-23 (discussing the different applications of exclusive remedy provisions among states, as well as the scope of coverage of workers’ compensation laws to athletes).

52. *Id.* Of course, it is prudent to point out that not all States agree on the scope and applicability of workers’ compensation schemes to athletes. *Redlingshafer*, *supra* note 41, at 119-21. On several occasions, courts have denied workers’ compensation awards to athletes based upon statutory interpretation. See *Palmer v. Kansas City Chiefs Football Club, Inc.*, 621 S.W.2d 350 (Mo. 1981); *Rowe v. Balt. Colts*, 454 A.2d 872, (Md. Ct. Spec. App. 1983). However, when workers’ compensation is deemed applicable, the co-employee doctrine attaches, and thus, so does immunity for team physicians.

53. *LARSON & LARSON*, *supra* note 40, at § 113.01.

54. See *Lotysz v. Montgomery*, 309 A.D.2d 628 (N.Y. App. Div. 2003); *Hendy v. Losse*, 819 P.2d 1, 1 (Cal. 1991); *Stringer v. Minn. Vikings Football Club, LLC*, 705 N.W.2d 746, 754 (Minn. 2005).

55. See *Lotysz*, 309 A.D.2d at 628; *Hendy*, 819 P.2d at 1; *Stringer*, 705 N.W.2d at 734.; See NFL CBA, art. LIV § 1 (2006); MLB BASIC AGREEMENT, art. IX, § E (2007); MLB BASIC AGREEMENT Schedule A, Regulation 2 (2007); NAT’L BASKETBALL ASS’N COLLECTIVE BARGAINING AGREEMENT, art. IV, § 5(c) (2005) [hereinafter NBA CBA]; NAT’L HOCKEY LEAGUE COLLECTIVE BARGAINING AGREEMENT, art. 31, §31.5(a) (2005) [hereinafter NHL CBA]. This limitation is quite the hindrance to any civil remedies against a team physician because “a player whose injury is aggravated by negligent medical treatment or by a team officials’ failure to use reasonable care to protect his health is barred from recovering tort damages against the team or its employees.” *Mitten*, *supra* note 33, at 45 (emphasis added). An exception to the bar against civil action in tort exists if the employer or team acts intentionally in injuring the athlete; however, an athlete must choose between workers’ compensation and an intentional tort claim, as utilizing workers’ compensation will bar, on

such provisions limiting recovery to applicable workers' compensation statutes exist within the CBAs of all four major American sports: football, baseball, basketball, and hockey.⁵⁶

The NFL CBA states:

In any state where workers' compensation coverage is not compulsory or where a Club is excluded from a state's workers' compensation coverage, a Club will either voluntarily obtain coverage under the compensation laws of that state or otherwise guarantee equivalent benefits to its Players. In the event that a Player qualifies for benefits under this section, such benefits will be the equivalent to those benefits paid under the compensation law of the State in which the Club is located.⁵⁷

The MLB CBA states:

If a Player's Contract is terminated by a Club by reason of the Player's failure to render his services due to a disability resulting directly from injury sustained in the course and within the scope of his employment under the Contract . . . the Player shall be entitled to receive from the Club the unpaid balance of the full salary for the year in which the injury was sustained, less all workers' compensation payments received by the Player as compensation for loss of income for the specific period for which the Club is compensating him in full.⁵⁸ All workmen's compensation payments received by the Player as compensation for loss of income for a specific period during which the Club is paying him in full, shall be

res judicata grounds, the tort claim. *Id.* at 46. Nonetheless, the exception for intentional conduct is not the focus of this Comment as it seeks to slide the liability scale from one extreme, that being an intentional standard, to a more relaxed negligence standard, one that would apply in any other medical malpractice case.

56. See NFL CBA, art. LIV § 1 (2006); MLB BASIC AGREEMENT, art. IX, § E (2007); MLB BASIC AGREEMENT Schedule A, Regulation 2 (2007); NBA COLLECTIVE BARGAINING AGREEMENT, art. IV, § 5(c) (2005); NHL CBA, art. 31, §31.5(a) (2005).

57. NFL COLLECTIVE BARGAINING AGREEMENT, art. LIV § 1 (2006). Notably, the language employed by the NFL CBA attempts to mirror workers' compensation coverage for athletes in states and jurisdictions where teams cannot elect coverage for the athletes, such as Florida. Redlingshafer, *supra* note 41, at 113.

58. MLB BASIC AGREEMENT, art. IX, § E (2007).

paid over by the Player to the Club.⁵⁹

The NBA CBA states that the “NBA shall provide the following additional benefits to NBA players: . . . [w]orkers’ compensation benefits in accordance with applicable statutes.”⁶⁰

The NHL CBA states:

In any state in which workers’ compensation coverage is not compulsory or required for professional athletes under state law, a Club will either voluntarily obtain coverage under the compensation laws of that state or otherwise guarantee equivalent benefits to its Players. In the event that a Player qualifies for benefits under this Article, such benefits will be equivalent to those benefits paid to injured employees under the compensation law of the state in which his Club is located regardless of any statutory exclusion from coverage for professional athletes.⁶¹

Thus, because each league mandates applicable workers’ compensation benefits to their players, the players are left without a civil remedy against the team if they are injured in the workplace.⁶² Moreover, because team physicians exist as an extension of the team, the co-employee doctrine controls, barring civil actions against team physicians by players.⁶³ This limitation exists as a point of contention because athletes may feel unprotected due to an inability to recover civil remedies.

After all, team physicians are the first line of defense available to athletes in preventing further aggravation of an existing injury and limiting premature reentry to play. Essentially, team physicians act as “gate-keepers” to the playing field.⁶⁴ This is especially true with respect to concussions. A team

59. MLB BASIC AGREEMENT Schedule A, Regulation 2 (2007).

60. NBA COLLECTIVE BARGAINING AGREEMENT, art. IV, § 5(c) (2005).

61. NHL CBA, art. 31, §31.5(a) (2005). Similar to the NFL, the NHL CBA attempts to mirror workers’ compensation coverage for athletes in states and jurisdictions where teams cannot elect coverage for the athletes, such as Florida. See Redlingshafer, *supra* note 41, at 113.

62. See *Lotysz v. Montgomery*, 309 A.D.2d 628 (N.Y. App. Div. 2003); *Hendy v. Losse*, 819 P.2d 1 (Cal. 1991); *Stringer v. Minn. Vikings Football Club, LLC*, 705 N.W.2d 746, 763 (Minn. 2005); see also *Palmer v. Kansas City Chiefs Football Club, Inc.*, 621 S.W.2d 350 (Mo. 1981); *Rowe v. Balt. Colts*, 454 A.2d 872, (Md. Ct. Spec. App. 1983).

63. *Id.*

64. See Matthew J. Mitten, *Team Physicians as Co-employees: A Prescription that Deprives Professional Athletes of an Adequate Remedy for Sports Medicine Malpractice*, 50 ST. LOUIS L.J.

physician is many times the only barrier between an athlete with a head injury and a potentially life-threatening situation. Yet, courts still give team physicians a pass by allowing blanket civil immunity through their co-employee status.⁶⁵ This exemption and statutory justification is a stark divergence from the civil liability of team physicians prior to 1991.

Before 1991, team physicians were independent contractors, using their status as physicians to professional athletes to build lucrative private practices.⁶⁶ However, as an independent contractor, a team physician was still personally liable for medical malpractice.⁶⁷ In order to skirt this liability, and at the insistence of medical malpractice insurance providers, teams began designating the team physician as an employee, effectively subjecting the physician to the co-employee rule.⁶⁸ Consequently, under this new structure, the team physician is no longer a separate legal person as necessary to assert personal liability beyond the protections offered by state workers' compensation laws.⁶⁹ This imputed immunity to malpractice claims does nothing more than provide team physicians with a "disincentive to adequately protect professional athletes' health and to serve effectively as a 'gatekeeper.'"⁷⁰

To be sure, with inherent conflicts of interest, economic and self-imposed pressures, and fiduciary concerns in placing the health and safety of the players above all else, the courts have done a disservice to professional athletes by strictly construing the meaning of the co-employee doctrine as it applies to this limited situation.⁷¹ Nonetheless, as it stands, without proposed legislation, an alteration to each league's CBA, or a staunch change in case law, team physicians will continue to enjoy immunity to medical malpractice liability.⁷²

211, 212 (2005).

65. *See id.* at 213-14.

66. *Id.* at 215.

67. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* at 214.

71. *See* discussion *infra* Parts V.A-C (discussing the major problems with applying the co-employee doctrine to team physicians in professional sports and possible solutions to penetrating or subverting its application with reference to team physicians).

72. *See* discussion *infra* Part V.C (proposing new CBA provisions and new legislation to address team physician liability).

C. Assumption of the Risk

Assumption of the risk is an oft-used defense to sport related injuries, particularly when taking into account the inherent dangers befalling an athlete as he takes his place on the field of play.⁷³ The defense of assumption of the risk is usually asserted to act as a complete bar to any potential recovery for the plaintiff, even if the defendant was negligent.⁷⁴ Essentially, the defense asserts that the plaintiff knew what he was getting himself into and that, although the defendant may be negligent, it is offset by the plaintiff's understanding of the risks involved, ultimately relieving the defendant of any duty owed to the plaintiff.⁷⁵ In order to successfully apply the defense of assumption of the risk, the defendant "must not only prove that the plaintiff had knowledge of the danger involved, but that he or she also had an appreciation for the magnitude of the danger."⁷⁶ Moreover, the defense must also prove that the plaintiff voluntarily engaged in the activity in the face of and despite the known risks involved.⁷⁷

However, this general test becomes virtually inapplicable to victims of head trauma or concussions. Part of the problem is that occasionally athletes need protection from even themselves. Often, an athlete's ego may lead him back onto the field prematurely following an injury. Moreover, in the instance of a head injury, the athlete may not possess the requisite cognitive ability to appreciate the magnitude of the risks of premature reentry.⁷⁸ For instance, "[a]n athlete's attempt to return to play prematurely may not be the result of simple enthusiasm for the sport or disregard for medical advice; it may actually be due to an inability to remember medical instructions because of post-traumatic amnesia" caused by a concussion.⁷⁹ Accordingly, if a player cannot be entrusted to make a medical decision about his ability to play, and subsequent post-traumatic amnesia has dislodged the player's ability to make a cognitive decision, then proving and asserting an affirmative defense of assumption of the risk or contributory negligence should be blocked by the very nature of the initial injury.

73. See Keya Denner, *Taking One for the Team: The Role of Assumption of the Risk in Sports Torts Cases*, 14 SETON HALL J. OF SPORTS & ENT. L. 209, 210 (2004).

74. *Id.*

75. See generally Rita Hanscom, *Assumption of Risk Defense in Sports or Recreation Injury Cases*, 30 AM. JUR. PROOF OF FACTS 161 (2002).

76. Denner, *supra* note 73, at 210-11.

77. *Id.* at 211.

78. See Kimberly G. Harmon, *Assessment and Management of Concussion in Sports*, AM. FAM. PHYSICIAN, Sept. 1, 1999, available at <http://www.aafp.org/afp/990901ap/887.html>.

79. *Id.*

III. TRENDS IN CASE LAW POSSIBLY LEADING TO TEAM PHYSICIAN LIABILITY

Recently, two cases shed a ray of hope on penetrating workers' compensation statutes as well as CBA restrictions. Each case showed a trend toward realizing a separate duty owed by the team physician to the player, not just the team.⁸⁰ In *Hendy v. Losse*, the California Supreme Court dismissed the civil claims of a professional football player, holding that the state's workers' compensation laws bar civil suits between co-employees for injuries caused within the scope of employment.⁸¹ However, in deciding against *Hendy*, the Supreme Court opined that if a team physician provides medical care other than that which is considered a part of the employee's employment, then blanket civil immunity would be inapplicable to the physician co-employee.⁸² This language shows a slight divergence from the perceived absolute bar to civil liability enjoyed by team physicians. Even still, the proposition of successfully sidestepping the co-employee doctrine is not promising because most team physicians are retained for the purpose of making decisions about whether players are fit to play. Therefore, it would be very difficult to prove that in negligently allowing a victim of severe head trauma to re-enter play prematurely, the team physician was acting outside the scope of which he was hired.

More pointedly, the dissenting opinion in *Stringer v. Minnesota Vikings Football Club, LLC* mirrors a growing trend that team physicians should re-evaluate their perceived liability.⁸³ The dissent expressed policy concerns that providing a blanket liability under workers' compensation laws could lead to team physicians not exercising the requisite due care when evaluating players.⁸⁴ The dissent also questioned the majority's reasoning behind cloaking the team physician's negligence within the realm of the team's duty to provide a safe work place for the players.⁸⁵

The dissent reckoned that by protecting the team physicians from liability only places, perhaps unjustifiably, another layer of protection over the team physician and any tort liability that might be imposed.⁸⁶ The dissenting opinion was much aligned with the court of appeals, which held that the

80. See *Hendy v. Losse*, 819 P.2d 1, 11 (Cal. 1991); *Stringer v. Minn. Vikings Football Club, LLC*, 705 N.W.2d 746, 763 (Minn. 2005).

81. *Hendy*, 819 P.2d at 3.

82. *Id.* at 12.

83. *Stringer*, 705 N.W.2d at 763-68 (Hanson, J., dissenting).

84. *Id.* at 763-64.

85. *Id.* at 765-66.

86. *Id.* at 767.

employer must provide a safe workplace for employees, but beyond that, team physicians have a separate personal duty of care that extends outside the owner's responsibility to supply a safe workplace.⁸⁷

Obviously, the *Stringer* dissent is the minority opinion of the court, and thus, provides no tangible ammunition for an injured athlete seeking recourse against a team physician. Although the dissent attempts to strip away the co-employee status of the team physician, the courts continue to make determinations similar to those of the *Stringer* majority, applying the co-employee doctrine and limiting these injured athletes' remedies to that offered by workers' compensation laws.

What the courts – in both the aforementioned cases and in other cases that have immunized team physicians through the co-employee doctrine – have failed to account for is the severity of concussions and their telltale symptoms that should trigger immediate diagnosis by any diligent and competent team physician. Indeed, the severity of injury related to concussions can vary from simple dizziness to the less common, but tragic, fatality. Concussions occur far too often in professional sports. Only after understanding and appreciating the importance of proper diagnosis with regards to concussions, can courts begin to step away from previous doctrine and break the mold to offer greater remedies to injured athletes.

IV. CONCUSSIONS IN SPORTS: SYMPTOMS, CONSEQUENCES, AND WHY CONCUSSIONS ARE DIFFERENT

Head injuries in sports, as one can imagine, are rather common, with the most common type of head injury being a concussion.⁸⁸ "Concussion" is a term often tossed around amongst athletes and in locker rooms, yet many athletes and non-medical professionals lack a greater understanding of just how devastating a concussion and more specifically, recurring concussions can be. Considering that a concussion in its most simplistic form is a "transient disturbance of neurologic function caused by trauma[.]" athletes and physicians must understand the possible hazards resulting from such an injury.⁸⁹ In other words, when a concussion is suffered, the brain is literally knocked temporarily senseless. Considering the valuable and irreplaceable function of the human brain, this is an alarming concept.

It is of grave importance that players are afforded the ability to hold team

87. *Stringer v. Minn. Vikings Football Club, LLC*, 686 N.W.2d 545, 550-51 (Minn. Ct. App. 2004), *aff'd* 705 N.W.2d 746 (Minn. 2005).

88. Harmon, *supra* note 78.

89. *Id.*

physicians liable for malpractice when players are negligently misdiagnosed or when players are negligently allowed to return to play following a concussion, not only because of the possible detrimental outcomes of such an event, but also due to the sheer frequency with which concussions occur. In fact, traumatic brain injury is the leading cause of death among sports-related injuries, and as such must be afforded due consideration.⁹⁰ Consider that the NFL estimates that more than 160 concussions occur in the league each year.⁹¹ Moreover, studies show that of the 1.5 million or more players that will suit up in high school football games this year, forty-seven percent will suffer a concussion, with thirty-five percent suffering more than one concussion.⁹² These statistical phenomena implicate the paramount nature of proper diagnosis even further because once an athlete sustains a concussion, the player becomes four to six times more likely to sustain a second concussion.⁹³ These statistics, coupled with grave consequences of suffering one or multiple concussions, such as permanent neurologic impairment, postconcussion syndrome, and even death due to second-impact syndrome, are enough to warrant separate analysis when evaluating team physician liability.⁹⁴

A. Symptoms of and Guidelines for Treating Concussions in Sports

At times, diagnosing a concussion properly can be quite challenging due to a variety of symptoms that may or may not be present at the time of examination.⁹⁵ “Symptoms of concussion include dizziness, headache, difficulty in concentrating, disturbances of vision or equilibrium, post-

90. What is Neurosurgery, *Sports-Related Head Injury*, NEUROSURGERYTODAY.ORG, July 2006, http://www.neurosurgerytoday.org/what/patient_e/sports.asp.

91. *Id.*

92. Quiana Burns, *Ready for Some Football & and [sic] Concussions?*, ABC NEWS, Aug. 31, 2006, <http://abcnews.go.com/Health/story?id=2379230&page=1>; see also Alan Schwartz, *Silence on Concussions Raises Risks of Injury*, NY TIMES, Sept. 15, 2007, available at http://www.nytimes.com/2007/09/15/sports/football/15concussions.html?pagewanted=1&_r=1.

93. *Id.*; David R. Wierciszewski, *Conditions: Sports Concussion*, DISABOOM, <http://www.disaboom.com/Health/sportsconcussion/treatment.aspx> (last visited Nov. 14, 2008).

94. Robert Cantu, M.D., *Second Impact Syndrome Risk Requires Caution in Return-to-Play Decision*, MOMSTEAM.COM, <http://www.momsteam.com/health-safety/concussion-safety/return-to-play/second-impact-syndrome-risk-requires-caution-in-retur> (last visited Feb. 15, 2009); Lindsay Barton, *Second Impact Syndrome: A Rare But Usually Fatal Condition*, MOMSTEAM, <http://www.momsteam.com/health-safety/concussion-safety/general/second-impact-syndrome-signs-and-symptoms> (last visited Feb. 15, 2009).

95. John W. Powell, *Cerebral Concussion: Causes, Effects, and Risks in Sports*, 36 J. OF ATHLETIC TRAINING 307, 308, 2001, available at <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=155423>.

traumatic amnesia (loss of memory for events occurring after the injury) and loss of consciousness.”⁹⁶ The loss of consciousness may be short-term, long-term, or nonexistent.⁹⁷ In addition, the “signs and symptoms present at the time of injury may disappear very quickly, or they may linger for long periods.”⁹⁸

In fact, at times, team physicians can be overwhelmed by the plethora of different guidelines to which they must adhere in determining when a symptomatic athlete can return to play.⁹⁹ “At least sixteen different guidelines for [evaluating concussions] . . . reflect[] the lack of consensus, which results from the absence of evidence-based data.”¹⁰⁰ The guidelines utilize primarily the same variables to determine the severity of concussions and when to return to play.¹⁰¹ The variables include “the length and duration of concussion symptoms, as well as the length and duration of post-traumatic amnesia or loss of consciousness.”¹⁰² Notably, under all guidelines, if an injured player is symptomatic for greater than fifteen minutes, and it is only his first concussion, a consensus exists that the athlete should not return to play until asymptomatic for at least one week.¹⁰³

All of these factors and inconclusive research result in somewhat of a muddled standard as to when an athlete should return to play and how significant certain symptoms may be. However, that notwithstanding, there are measurable guidelines that create a standard of examination and resulting diagnoses that a team physician should adhere to in order to protect an athlete, sometimes from himself. After all, often the injured athlete is disoriented, confused, and incoherent.¹⁰⁴ Accordingly, an injured athlete with symptoms of head trauma, specifically a concussion, may not be the best source of

96. Harmon, *supra* note 78.

97. Powell, *supra* note 95, at 308.

98. *Id.*

99. Harmon, *supra* note 78.

100. *Id.* Harmon compares the most widely used guidelines in Table 1 of the article. *Id.* The table applies the guidelines in its attempt to categorize the severity of concussion based on length of concussion symptoms, the associated “rating” or “grade” of concussion with those symptoms, and when an athlete can return to play, depending on which concussion the athlete has just experienced (first, second, or third). *Id.*

101. *Id.*

102. *Id.* Harmon lists in Table 2 all symptoms of a concussion and at what stage they are realized. *Id.* Headache, dizziness, confusion, tinnitus, nausea, vomiting, and vision changes are early symptoms; whereas, memory disturbances, poor concentration, irritability, sleep disturbances, personality changes, and fatigue occur later in the symptomatic stages. *Id.*

103. *Id.*; Table 1, *supra* note 100.

104. *Id.*

information in determining a diagnosis.¹⁰⁵

B. Consequences of Concussions and Why Concussions Are Different than Any Other On-field Injury

Although a concussion is dangerous in and of itself, receiving a concussion is generally not a life-threatening or overtly serious medical issue.¹⁰⁶ Where the danger lies, and the reason it is so gravely important to hold team physicians accountable in this regard, is in the act of negligently and prematurely returning an injured athlete to the playing field.¹⁰⁷ This is because, in relation to head traumas, the most dangerous and severe injuries relate to recurring concussions, embodied by a constant swelling and trauma to the brain.

Perhaps the most tragic example is second-impact syndrome, which “occurs in players who return to competition before the symptoms of a first concussion have completely resolved. A second blow to the head, *even a minor one*, can result in a loss of . . . the brain’s blood supply; [this] . . . is usually fatal.”¹⁰⁸ Other second-impact syndrome symptoms can “include physical paralysis, mental disabilities and/or epilepsy.”¹⁰⁹ This is extremely alarming since the exact type of negligence a team physician exhibits when prematurely sending a player back onto the playing field, a negligence that might get that player killed, is virtually per se protected from civil liability by the co-employee doctrine.

Consider that between 1992 and 1995, seventeen cases of second-impact syndrome were reported by the Center for Disease Control; meaning, that in just three years, seventeen athletes suffered from a bleeding in the brain due to a second, or subsequent, head trauma.¹¹⁰ The seventeen victims were participating in various sports, including boxing, football, snow skiing, and ice hockey.¹¹¹ Additionally, over the past five to ten years, there has been a substantial increase in instances of second-impact syndrome.¹¹² One reason

105. *Id.*

106. *Id.*

107. *Id.*

108. *Id.* (emphasis added).

109. Nelson Langer Nelson PLLC, *SIS Incidents, Athletes at Risk: Second Impact Syndrome in Sports*, NLNLAW.COM, http://www.nlnlaw.com/html/articles/schultz_sis.html (last visited Feb. 16, 2009).

110. *Id.*; R.C. Cantu, *Second-Impact Syndrome*, 17 CLINICS IN SPORTS MED. 37, 37 (1998), available at <http://www.indconsult.com/das/article/body/127214779-2/org=journal&source=&sp=10112907&O/N/114613/1.html>.

111. Nelson Langer Nelson PLLC, *supra* note 109.

112. Cantu, *supra* note 110, at 37.

for the emergence of second-impact syndrome cases is the fact that it has only begun to gain widespread medical acceptance within the past five years, and thus, many cases of second-impact syndrome were likely misdiagnosed or unreported.¹¹³

Another reason that second-impact syndrome cases have increased is that by its very definition and nature, second-impact syndrome occurs when an athlete suffers a head trauma – often a mild concussion or bruised brain – and then suffers a second head trauma before the symptoms from the first have cleared.¹¹⁴ In other words, unlike first concussions, which are an invariable component of many sports, second-impact syndrome is preventable if team physicians properly diagnose, treat, and, if necessary, withhold from play, an athlete that sustains a head trauma.¹¹⁵

What may be most alarming is that throughout the medical community, “there is a lack of awareness that a brain injury can lead to serious injury or death. The answer is recognition that there is no such thing as a minor concussion. You can ice a knee injury, but you can’t ice a brain injury.”¹¹⁶ Critical to this analysis is the overbearing consideration that by protecting team physicians from civil liability, they will necessarily feel less pressure to preclude a player from reentering play after a head trauma, which can and will ultimately lead to more fatalities and catastrophic injuries due to second-impact syndrome.¹¹⁷ Indeed, proper team physician diagnosis and treatment of head trauma is paramount because “[u]ntil the first concussion symptoms are cleared sufficiently, the brain loses its ability to regulate blood flow and massive injury can result from a second blow.”¹¹⁸ This Comment does not suggest that each case of second-impact syndrome is a result of negligence on the part of a team physician; rather, this Comment suggests that if it were, then the team physician ought to be liable for this conduct.

Beyond second-impact syndrome, “there is evidence that repeated concussions can result in cumulative neurologic damage, even when the injuries are separated by months or years.”¹¹⁹ A common and severe example of neurologic damage is punch-drunk syndrome, also known as dementia pugilistica.¹²⁰ As the name suggests, punch-drunk syndrome often occurs in

113. Nelson Langer Nelson PLLC, *supra* note 109.

114. *Id.*

115. *Id.*

116. *Id.*

117. See Cantu, *supra* note 110, at 43.

118. Nelson Langer Nelson PLLC, *supra* note 109.

119. Cantu, *supra* note 110.

120. Fallon, *supra* note 6.

boxers, but is not exclusive to them.¹²¹ An athlete with punch-drunk syndrome suffers weakness in lower extremities, “unsteadiness of gait, slowness of muscular movements, hand tremors, hesitancy of speech, and mental dullness.”¹²² Moreover, athletes who suffer from punch-drunk syndrome often experience personality changes, including rage reaction and morbid jealousy.¹²³

Several other neurological consequences can result from continuous blows to the head. Muhammad Ali, who has been diagnosed with and suffers from Parkinson’s disease, is a famous example of the tragic but realistic effects of multiple concussions received while playing a contact sport.¹²⁴ However, his affliction is by no means exclusive to him and remains a danger to those who participate in sports that submit its athletes to regular head trauma.

A related fear of prematurely returning an athlete to play and further exposing him to head injury is postconcussion syndrome.¹²⁵ Athletes afflicted by postconcussion syndrome experience various symptoms, which can continue for months after the initial impact, including fatigue, equilibrium disturbances, headaches, or difficulty in concentrating.¹²⁶ Again, team physicians rushed to return a player to action, risking further injury, should be aware that “[i]t is not unusual for symptoms to return with exertion and, in these cases, athletes should still be restricted from play.”¹²⁷ Furthermore, because of the post-traumatic amnesia experienced following many concussions, and the subsequent lack of cognitive decision-making ability of injured players, team physicians should be held to an even higher standard when allowing a player to re-enter play post-concussion, rather than a lower standard that allows a physician to escape what could amount to gross negligence or even recklessness.

Although the majority of possible reactions to subsequent concussions are quite tragic and often career- or even life-ending, some of the most devastating repercussions of multiple blows to the head involve far less obvious consequences. When former NFL defensive linebacker Andre Waters killed himself at the age of forty-four, forensic pathologist Dr. Bennet Omalu of the

121. *Id.*

122. Punch-Drunk Syndrome, <http://medical-dictionary.thefreedictionary.com/punch-drunk+syndrome> (last visited Feb. 16, 2009).

123. *Id.*

124. Fallon, *supra* note 6.

125. Harmon, *supra* note 78.

126. *Id.*

127. *Id.*

University of Pittsburgh examined his brain and discovered that “the condition of Waters’ brain tissue was what would be expected in an 85-year-old man.”¹²⁸ Dr. Omalu further identified characteristics in Waters’s brain that mirrored the early stages of Alzheimer’s disease, which Dr. Omalu attributed to repeated concussions.¹²⁹ Dr. Omalu made a final prediction that had Waters not killed himself, his brain would have completely deteriorated, leaving him incapacitated within ten to fifteen years.¹³⁰

In an effort to refute allegations that no scientific evidence exists linking concussions to depression, the Center for the Study of Retired Athletes conducted an analysis of 2500 former NFL players. The study revealed that “cognitive impairment, Alzheimer’s-like symptoms and depression rose in direct proportion to the number of concussions a player had sustained.”¹³¹ In fact, researchers at the University of Pennsylvania School of Medicine have found direct evidence that mild repetitive head injuries can lead to Alzheimer’s disease.¹³²

In light of the foregoing, it is obvious that head traumas of any degree, ranging from mild concussions to recurring and life-threatening head injuries, warrant special care, diagnosis, and treatment. As pointed out by numerous examples, these concussions do not simply affect an athlete’s status on the field. Recurring head traumas give rise to debilitating and degenerative diseases, as well as premature mortality. Accordingly, as more medical research is brought to light, there must be a change in one of three areas – the common law, the CBA, or the legislature – to protect the very livelihood of the same athletes for which we so willingly cheer.

128. Farrey, *supra* note 6.

129. *Id.*

130. *See id.* In response to Waters’ suicide the NFL issued a statement dedicating “substantial resources to independent medical research of current and retired players, strict enforcement of enhanced player safety rules, development and testing of better equipment, and comprehensive medical management of this injury.” *Id.* (quoting NFL press release).

131. *Id.* (citing Alan Schwarz, *Study of Ex-N.F.L. Players Ties Concussion to Depression Risk*, N.Y. TIMES, May 31, 2007). Conversely, although a link between concussions and depression is regarded as quite probable, there are experts who believe that there is still not enough empirical scientific evidence to categorically link the two. *See* Farrey, *supra* note 6 (quoting Leszek Christowski, a county medical examiner). This link between concussions and depression is not to be confused with the proven link between concussions and Alzheimer’s. Press Release, *supra* note 6.

132. Press Release, *supra* note 6.

V. LEGAL ANALYSIS OF TEAM PHYSICIAN LIABILITY WITH REGARDS TO
CONCUSSIONS AND POSSIBLE SOLUTIONS TO THE SHORTCOMINGS OF
CURRENT DOCTRINE

To understand the legal implications currently governing a team physician's conduct, as well as any possible civil liability that he or she may incur because of negligent medical care of an athlete, it is necessary to evaluate the team physician's role within the organization. That said, what might be even more important is the various legal doctrines governing team physicians that can be evaluated in an effort to spur transformation in this area of law. For instance, team physicians have a fiduciary duty to their players, as patients, and should be held accountable as such. Furthermore, obvious economic pressures and conflicts of interest exist within the team physician, team, and player dynamic. Lastly, given the catastrophic nature of recurring concussions and the team physician's unique role as gatekeeper to the field of play, both the leagues and legislators must work to reconcile what currently exists, quite literally, as a problem without a sufficient remedy.

*A. Team Physician Accountability (or Lack Thereof) and Ignoring the
Fiduciary Obligation to the Athletes.*

Team physicians experience extreme pressure from many different sources, including players, management, owners, and the physician's personal bias toward speedy recovery and team success.¹³³ Frequently, a team physician may find himself in a quandary in which he feels an obligation to not only perform adequate medical care on his patient athletes, but also to help the team's interests, which may include reinstituting an injured player before all remnants of risk to further injury are removed.¹³⁴ Often, the team physician is one of the biggest fans of the particular team with which he works, but, of course, being a fan does not naturally equate to committing malpractice.¹³⁵ However, as a practical matter, when the team physician is both an enormous fan of a certain team, and he or she greatly desires to see that team succeed, it is no surprise that his "decisions are greatly influenced by the need of the team and the desire of the patient to play."¹³⁶ "Let him play and we'll keep a close watch on him" is a mentality that should be avoided and sanctioned rather than accepted through practice and doctrine.¹³⁷

133. Furrow, *supra* note 10, at 171; Redlingshafer, *supra* note 41, at 114-16.

134. Furrow, *supra* note 10, at 168.

135. *Id.* at 166.

136. *Id.* (quoting former NFL player Bernie Parrish).

137. *Id.* (quoting former NFL player Bernie Parrish).

Even still, no matter the want or need of a team physician as an individual or in a personal capacity, he is first and foremost a fiduciary to his patients—here, his athletes.¹³⁸ “A fiduciary obligation in medicine means that the physician focuses exclusively on the patient’s health; the patient assumes the doctor’s single-minded devotion to him; and the doctor-patient relationship is expected to be free of conflict.”¹³⁹ This fiduciary obligation is nothing short of a “sacred trust”¹⁴⁰ and “an intense obligation to ignore social and other concerns that interfere with the care of the specific patient,”¹⁴¹ which includes any pressures applied by a team physician’s employer; specifically, a professional sports organization. Ultimately, this framework is designed to “equalize the relationship and empower the patient.”¹⁴²

The problem that lies herein, and with respect to workers’ compensation statutes available as a defense to team physicians, is that by shielding physicians from civil liability, there is no accountability for malpractice. Essentially, the fiduciary obligation to the patient is ignored, and if not ignored, then most definitely not assured, because there is no “check” on the team physician’s medical practice while under the same employ as the athletes whom the physician is treating.

This lack of accountability is crucial in analyzing a fundamental flaw within professional sports; namely, professional athletes are without a protection afforded to the vast majority of society, which is the ability to be made whole in the event that a physician commits malpractice.¹⁴³ In sum, the current doctrine that allows a grossly negligent team physician to contribute to the catastrophic or even fatal injury of an athlete, with that athlete or his estate having no separate form of recourse other than limited workers’ compensation statutes, seems like it should be a departure from reality, not the norm.

B. Economic Pressures and Conflicts of Interest as Applied to Team Physicians Should Be Enough to Induce Liability

Upon first gloss, one can easily surmise that team physicians have the best intentions when approaching their medical duties, completely devoid of outside influence and able to focus on the best interests of the players under their care. Nonetheless, it may be imprudent to make such an assumption. It

138. *Id.* at 167.

139. *Id.*

140. *Id.* (quoting HANS JONAS, PHILOSOPHICAL ESSAYS: FROM ANCIENT CREED TO TECHNOLOGICAL MAN 124 (1974)).

141. *Id.*

142. *Id.* at 168.

143. *See id.*

is no small leap to see that several economic, team-related, and personal conflicts of interest exist within the current structure of the team physician-player relationship, and as such, should concern athletes, legislators, and the players union alike. For instance, "[t]he team physician has the potentially conflicting responsibilities of providing medical care to the players and protecting their health while also facilitating the club's ability to win games by having its best players on the field."¹⁴⁴ This foundational conflict of interest alone is abhorrent when observed in light of a physician's duty to protect and preserve the patient-athlete's health and safety. On one side of the conflict, the physician is worried about the health of the patient, while on the other, the physician is worried about his employer's ability to win a game, albeit a quite lucrative game.

Far too frequently, team physicians feel extreme pressure from the team officials and management, as well as the fans, and even the injured players themselves.¹⁴⁵ The motivations of each are often over-simplified: fans want to win; management wants the team to be successful, both in terms of winning and in terms of revenue generation; and players want to be on the field so that their team can win, and often, so the player can meet certain monetary incentives within the player's contract.¹⁴⁶

To be sure, physicians are highly incentivized to keep players on the field in an effort to please management and owners so as to maintain job security.¹⁴⁷ However, in doing so, these team physicians also pad their own pockets. Often, team physicians are not highly paid by the teams with which they work, but team physicians can recoup these low wages "because ordinary clients flock to a doctor whom multi-million-dollar athletes trust with their careers."¹⁴⁸ Greed is not a novel concept, nor is it overly concerning since it is a fundamental and natural consequence to business and sports. Furthermore, this Comment does not purport that team physicians should be walled off from these responsibilities and interests, but only that they should be held accountable for their actions when practicing medicine.

Consider this common occurrence. In 2007, Jon Kitna, an NFL quarterback, was sacked in the second quarter of a regular season football game.¹⁴⁹ Severely shaken up, he came off the field for a medical evaluation;

144. Mitten, *supra* note 64, at 212.

145. *Id.* at 213; Redlingshafer, *supra* note 41, at 114-16.

146. *See* Redlingshafer, *supra* note 41, at 115-16.

147. *Id.* at 115.

148. *Id.* at 115-16 (quoting Justin P. Caldarone, *Professional Team Doctors: Money, Prestige, and Ethical Dilemmas*, 9 SPORTS LAW. J. 131, 145 (2002)).

149. Associated Press, *supra* note 2. This actual game-time concussion and subsequent fourth

the team physician concluded that he likely suffered a concussion and should not play the rest of the game.¹⁵⁰ Fortuitously, Kitna left the game with a comfortable lead.¹⁵¹ Shortly after the injury, Kitna complained of memory loss, severe head pain, and dizziness.¹⁵² After halftime, however, Kitna claimed to be free from all pain and symptoms and began expressing his desire to reenter the field of play.¹⁵³ Even still, the team physician correctly decided that he should remain inactive.¹⁵⁴ Unfortunately, in the fourth quarter, the comfortable lead began to slip away and eventually vanished.¹⁵⁵ Miraculously, the team physician medically cleared Kitna, who returned to the game after being diagnosed with a “mild” concussion, just in time to lead the game-winning drive.¹⁵⁶ After the game, Kitna stated, “I was out of it. I didn’t know anything. I lost coherence. It’s one of those things, you shouldn’t even been able to go back in the game, but it went back to normal and cleared up like it never happened.”¹⁵⁷ He also attributed his miraculous recovery to the “hand of God.”¹⁵⁸

This example illustrates an inherent problem in professional sports, especially football. As observed above, often concussion victims may not be able to comprehend the magnitude of the situation and their own injury as it occurs. Thus, the role of the team physician is paramount to the safety of the athlete.¹⁵⁹ Couple the lack of integrity in a player’s self-examination with the inherent economic and managerial pressure to win in professional sports, and team physicians are left with a conflict of interest that undermines the very nature of the physician-patient relationship. Accordingly, these pressure-packed scenarios create a tumultuous situation for team physicians resulting in the inevitable commission of some degree of medical malpractice. Of course, that assertion is largely speculation since players are not permitted to bring a malpractice action against the team physicians.

Often, the threat of civil recourse can work to neutralize a conflict of interest, offering an incentive to practice medicine with the patient’s best

quarter medical clearance to reenter the game mirrors an all-to-familiar occurrence in the NFL. See *id.*

150. *Id.*

151. *Id.*

152. *Id.*

153. *Id.*

154. *Id.*

155. *Id.*

156. *Id.*

157. *Id.*

158. *Id.*

159. See Harmon, *supra* note 78.

interest in mind in lieu of outside influence. Nevertheless, with team physicians virtually per se protected against a medical malpractice action brought by a player, no such incentive is provided, leaving the conflict of interest to skew a team physicians' analysis away from the athletes' best interests. Consequently, these dangers should act as an overwhelming incentive for courts to hold team physicians to a higher standard and pierce the workers' compensation co-employee immunity.¹⁶⁰

C. Workers' Compensation Statutes and CBAs May Not Be Lock-Tight Shields to Team Physician Liability

As noted above, current CBAs¹⁶¹ and workers' compensation laws generally control, relieving the teams and their physicians of liability for an athlete's injuries beyond what is agreed upon in the CBA and allowed under workers' compensation statutes. However, modern trends suggest that team physicians should re-evaluate their liability.¹⁶² Indeed, as case law and legal scholars begin to question the policy and logic behind allowing team physicians to skirt the issue of civil liability, a growing concern emerges within the field as to the health of the athlete and his or her apparent lack of protection.¹⁶³ Given the proper lobbying, and assuming the continued revelations in medicine regarding concussions, one avenue for change can exist within the players' union, which can fight to implement greater protections against malpractice for its players. The intent of this Comment is to put team physicians on notice that a "prudent approach by all professional team physicians, despite their co-employee status, would be to act as a fiduciary where an athlete's health interest supersedes all other interests,"¹⁶⁴ especially concerning concussions.

The very nature of a concussion is quite different and exclusive from other on-field injuries. As noted above, the inherent dangers to head-trauma lie not in the instance of initial injury, but almost exclusively in subsequent concussions. Another unique aspect of concussions is that concussions put a team physician on notice as to potential and probable future injuries. Unlike

160. See 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, 202 (1999); Justin P. Caldarone, *Professional Team Doctors: Money, Prestige, and Ethical Dilemmas*, 9 SPORTS LAW. J. 131, 145 (2002).

161. See NFL CBA, art. LIV § 1 (2006); MLB BASIC AGREEMENT, art. IX, § E (2007); MLB BASIC AGREEMENT Schedule A, Regulation 2 (2007); NBA COLLECTIVE BARGAINING AGREEMENT, art. IV, § 5(c) (2005); NHL CBA, art. 31, §31.5(a) (2005).

162. Paterick, *supra* note 5.

163. See *id.*

164. *Id.*

other spontaneous injuries that can occur on the field of play, a concussion, although spontaneous, is often evaluated shortly after the initial injury, often during the game, and the team physician renders a decision as to whether the player can reenter play. To be sure, this occurrence is not uncommon with other types of injuries. For example, a player tweaks a knee, is evaluated and allowed to reenter the game, or a player dislocates a shoulder, has it popped back into place, taped up, and is rushed back onto the field. These aforementioned injuries, however, are not analogous in consequence to concussions as rarely can a blown knee result in brain damage, Parkinson's disease, Alzheimer's disease, severe depression, or even death.

Perhaps an analogy is possible though. Consider a professional football player who makes a tackle helmet first and falls to the ground. Upon evaluation, he feels a "funny" sensation, his vision is blurred, and he is having trouble feeling his hands or feet. Nonetheless, the athlete is able to walk and is cleared by the team physician to go back into play, at which time the athlete engages in routine physical contact, falls to the ground, and dies. Perhaps at first blush this hypothetical sounds a bit farfetched. However, consider the following examples of fatalities due to second-impact syndrome:

[In 1998,] [h]igh school football star Ferlito Alejandro died of a brain hemorrhage after making a tackle in his team's season-opening game. "Ferlito was in on a tackle, walked to the sidelines and told his coach he needed a substitute . . . He went to the bench, pulled off his helmet and shoulder pads, then collapsed." It is suspected Alejandro died of second impact syndrome.

[Again, in 1998,] [j]ust before half-time, high school football player Aaron Brunner dashed off the field to the locker room, where coaches say he "threw up and passed out." [He] suffered a subdural hematoma caused by bleeding between his skull and brain. Athletic director Joel Heider said there was no apparent play responsible for the injury . . . It is suspected that [second-impact syndrome] was behind Brunner's unexplained injury.

[Finally, in 1996,] Rey Hernandez, a 29-year-old professional Mexican fighter, fell to the canvas in the seventh round of a fight. The unconscious Hernandez was carried from the ring on a stretcher and died 30 hours later. The punch that killed

him was not particularly violent—it could hardly be distinguished from the thousands that preceded it. Hernandez was in perfect condition, and had passed a state-required physical the day of the fight. His pre-fight licensing application claimed the fighter had a record of 20 wins and 12 losses, with no knockouts and no injuries. It was later discovered that Hernandez had lost more than half his last 24 fights, including three in a row by knockout.¹⁶⁵

In light of these tragic examples, it is difficult to comprehend legislation, or a CBA, that would severely limit an athlete's recovery if an analogous situation were completely preventable by a team physician. To be sure, not every instance of tragedy on a sporting field is the product of medical malpractice, but it is nevertheless stunning to think that regardless of culpability the team physician is completely safe from personal liability and protected under the co-employee doctrine.

The grave nature of concussions, the devastating consequences, and the frequency with which they occur must force change in this issue. The primary policy justification for the co-employee rule—"namely, [that] employer strict liability for workplace injuries [should be applied] in lieu of vicarious liability for employee torts that injure fellow employees"—could still be achieved while protecting the athletes from potential life-altering injuries.¹⁶⁶ For instance, legislation or a revised CBA that disallowed the use of the co-employee doctrine with reference to team physicians could specifically and expressly exclude the application of vicarious liability of teams in medical malpractice suits sought against team physicians.¹⁶⁷

Ultimately, team physicians should be held accountable to their patient-

165. Nelson Langer Nelson PLLC, *supra* note 109. The rapid deterioration of health for an athlete once second-impact syndrome is triggered is stunning:

At the onset of SIS the athlete is usually stunned, but does not lose consciousness and often completes the play. In the next 15 seconds to several minutes, however, the athlete's brain is severely compromised by a chain reaction. The impact may cause blood vessels to tear, a blood clot forms, and the flow of blood is greatly reduced—causing the brain to swell. This creates pressure on the brain stem, which controls breathing. Shortly thereafter, respiratory failure begins, and the athlete collapses with rapidly dilating pupils and loss of eye movement. The usual time from second impact to brain stem failure is rapid—normally two to five minutes. Death often occurs shortly thereafter.

Id.

166. Mitten, *supra* note 64, at 220.

167. *Id.* at 219.

athletes just as any doctor would be held accountable in treating a patient—to do otherwise breaks from the core policy of the fiduciary nature of the doctor-patient relationship. Nonetheless, as many have argued for the co-employee doctrine to be disallowed in cases such as these, perhaps fruitlessly, it has become clear that the courts are not likely to take action without the help of Congress or the leagues.¹⁶⁸ As such, rather than attempt to do the impossible, which is to completely disallow the application of the co-employee rule to team physicians, legislators and the leagues should take preventative action to prevent further catastrophic injury. This can be accomplished by drafting legislation and revising CBAs that provide a greater incentive to team physicians to make the health and safety of the patient-athletes their one and only concern.

Currently, the league CBAs exist as a barrier to collecting damages beyond those compensable under state workers' compensation laws.¹⁶⁹ As such, in order to protect the athlete from this unjust application of the co-employee doctrine, "the players union should insist on a provision in the league collective bargaining agreement requiring that team physicians be designated as independent contractors rather than club employees."¹⁷⁰ That said, if this is too daunting a task, the players union should at the very least, carve out language that references concussions. "To establish liability, the player would [still] have the burden of proving that the team physician's medical recommendations or treatment deviated from reasonable, customary, or accepted sports medicine care"¹⁷¹ In this scenario, the team would be protected from an unjust application of vicarious liability, the team physicians would be held accountable for their medical evaluations, and the players would be allowed "a tort remedy to recover for the lost or reduced economic value of his career, as well as other damages to compensate for harm such as pain and suffering"¹⁷²—a remedy that currently does not exist outside of workers' compensation.

Another possible alternative to the current CBA language would be to

168. *Id.* at 216. "Courts recognize that it is not necessarily unreasonable for workers' compensation laws to be applied differently to professional athletes than other employees. For example, excluding professional athletes from workers' compensation benefits, or providing them with only reduced benefits, does not deny them equal protection of the law." *Id.* In this respect the courts contradict themselves by eliminating certain aspects of workers' compensation laws to athletes, yet strictly construing others in an unwavering and frankly, unconvincing fashion.

169. See NFL CBA, art. LIV § 1 (2006); MLB BASIC AGREEMENT, art. IX, § E (2007); MLB BASIC AGREEMENT Schedule A, Regulation 2 (2007); NBA CBA, art. IV, § 5(c) (2005); NHL CBA, art. 31, §31.5(a) (2005).

170. Mitten, *supra* note 64, at 219.

171. *Id.*

172. *Id.* at 219.

institute mandatory procedures and standards of care that would be utilized upon a showing of certain head-trauma or concussion related symptoms. For instance, if a player exhibited the symptoms of even the lightest grade concussion, he would be forced to sit out of all contact activity for at least seven days. Obviously, with increased severity of symptoms and injury, the mandatory time-off would increase. This would serve to meet several objections. First, since self-assessment by the player is highly unreliable concerning head trauma, the player's opinion and assessment of his symptoms would no longer matter after the initial symptoms were assessed – that is, the player could not strive to convince a team physician that he was fit to play before he was medically capable of return. Further, standard procedures would create a medical standard of care from which concerned parties could determine when team physicians improperly deviate, possibly causing harm to the athlete, or at minimum placing the athlete in harms way. Additionally, many of the economic pressures placed on both the players and on the team physicians would be alleviated because it would no longer be an option to re-enter play after suffering a concussion. Finally, all parties involved, including the teams, would be greatly incentivized to adhere to the modifications because of the possible adverse legal and league sanctions that would occur upon a breach of procedure.

One final suggestion to the proposed CBA revisions is to mandate annual player, personnel, and coach awareness training as to the symptoms, effects, and grave risks of concussions. Such mandatory training would both educate the parties involved as to the medical aspects of head trauma as well as put these parties on notice as to proper procedures and actions that the parties, including athletes, coaches, and team physicians, should adhere to with regards to head trauma.

All too often, the law exists and is created as an answer to a problem that has already occurred, sufficiently mending fences on the back-end rather than seeking to prevent the problem in the first instance. However, as medical research concerning concussions continues to expand, and the concussed athletes continue to deteriorate, legislators should take note and proactively protect these valued members of our community from this devastation. If the leagues will not take the appropriate action – and the courts continue to adhere to co-employee doctrine precedent – then legislators must take the reigns in this matter. Indeed, it is time to enact appropriate legislation that directly speaks to the applicability of the co-employee doctrine to team physicians.

In our society and culture, the value of a human life is difficult to quantify, but since it necessarily will be quantified when deciding these matters in both a court of law and under the guise of legislation, one would hope it to be worth more than the value of a state workers' compensation package. This issue

should not center on an employer, nor should it focus on the status of "employee." At issue is the treatment of a patient by his physician; to analyze this matter in any other light is to ignore the fact that a team physician is not only a gatekeeper to the playing field, but also a gatekeeper to devastating injury and even death. As such, ignoring this fact by turning a blind eye to the practical result of the co-employee doctrine as applied to team physicians is both a disservice and an unjust response.

CONCLUSION

Even though somewhat analogous precedent exists in relation to team physician liability, the cloak of liability protection afforded a team physician regarding subsequent concussions has yet to be decided by the courts. Whether such a case would evoke a variance in jurisprudence is a matter of opinion. However, unlike several injuries akin to contact sports that have fallen squarely within the liability protection of the co-employee doctrine, concussions and associated injuries, regardless of severity, are usually detectable and preventable by the prudent team physician. Another notable distinction is that concussions by their very nature disorient the athlete and remove the ability to attach fault to the athlete as a decision-maker. In essence, with regards to subsequent concussions in sports, team physicians are often the only reliable line of defense against grave injury to the affected athlete.

Ultimately, team physicians have an overwhelming obligation to provide their patients with adequate and prudent medical attention, and we as a society cannot afford to accept a lesser standard. At issue is a very serious policy concern for the safety of our citizens and athletes. A physician's role and part of the oath he or she swears to uphold is to protect the health of the patient, first and foremost. Any dual employment status or legal liability protectionist measures with reference to malpractice of the team physicians should be disregarded, especially in gross negligence and recklessness cases in which an athlete is subjected to further head trauma after receiving clearance from a team physician.

The same medical standard of care should apply to a team physician as does any other practicing physician lest the doctor is not accountable for his own actions when practicing medicine—a result the courts should not take lightly. This relaxed standard is perilous because it provides no incentive to practice safe medicine and allows doctors to succumb to economic and underlying pressures within an organization with virtually no threat of recourse against such acts. Furthermore, without the application of a stricter standard of care, the resulting inequities are far too great because athletes have

absolutely no protection against subsequent concussions. If the courts were to blindly apply the aforementioned liability protection in a case involving a concussion-related injury, it will effectively remove the only protection an athlete has from ignorantly traversing the field of play while holding the proverbial ticking time bomb.

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