Conflicting Horizons: Understanding NFL Medical Care and the Tradeoff Between Short-Term and Long-Term Health Outcomes

James W. Tsaparlis*

In recent history, the National Football League (NFL) has had its fair share of spotlight-grabbing controversies; from Deflategate to domestic abuse to concussions—and everything in between. Perhaps the NFL's darkest reality, the NFL's medical care and prescribing practices have somehow eluded the spotlight. Nevertheless, former players recently exposed the grim and shadowy past of the NFL by alleging—in a class action—intentional misrepresentation and concealment in the context of NFL medical care.[1] Though the court recently dismissed plaintiffs' second amended complaint, the complaint in *Evans v. Arizona Cardinals* did highlight a pattern and practice of knowing departure from federal regulations, including the Controlled Substances Act and the Food, Drug, and Cosmetic Act.[2] The *Evans* complaint reads like a story depicting the NFL's instances of illicit medical care as part of an overarching, tacit policy of providing medical care to merely return players to the field, no matter what the long-term health implications for the players might be.[3]

This Article will review the players' actual healthcare setting with a focus on the role of team doctors and trainers, plus prescription drugs. Next, this Article will address the role of personal doctors, second opinion providers, and NFL coaches and ownership. After assessing the NFL players' healthcare ecosystem, this Article will argue that NFL medical care has, as alleged in

* J.D., Suffolk University Law School; M.B.A., Sawyer Business School. All views expressed herein are exclusively those of the author.

1. *See generally* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA (alleging NFL fostered medical environment geared toward returning players to field rather than health).

2. *See id.* at 42-50 (citing specific examples of unlawful NFL conduct and instances where unlawfulness became known). The *Evans* case is distinct from the array of predecessor suits brought against the NFL, in that the plaintiffs are suing all 32 NFL teams, rather than the league as a whole, and have been able to circumvent arbitrating their claims under the NFL-NFL Player's Association Collective Bargaining Agreement. *See* Rick Maese, *NFL Abuse of Painkillers and Other Drugs Described in Court Filings*, WASH. POST (Mar. 9, 2017), https://www.washingtonpost.com/sports/redskins/nfl-abuse-of-painkillers-and-other-drugs-described-in-court-filings/2017/03/09/be1a71d8-035a-11e7-ad5b-d22680e18d10_story.html?utm_term=.5052e6b30b4d (suggesting most cases preempted by labor deal). Resultantly, U.S. District Judge William Aslup found the plaintiffs' claims to constitute an exception to the collective bargaining agreement rule—specifically, the illegality exception—allowing the parties to proceed to discovery. *Id.*

3. *See id.* at 22-36 (alleging "return to play practice or policy").

Evans, historically sacrificed players' long-term health in favor of the short-term end of returning players to the field. In conclusion, this Article will briefly introduce possible remedies geared toward safeguarding the long-term health of NFL players.

I. THE NFL HEALTH CARE ECOSYSTEM

The universe of medical care provided to players includes several key figures, the most prominent of whom are team doctors and trainers, personal doctors, second opinion providers, and coaching staff.[4] Understanding the role that each plays in providing medical care to players sets the stage for understanding how a culture of returning players to the field came to permeate and define NFL medical care altogether. Each of these key figures will be examined in turn before addressing NFL prescribing practices.

A. Team Doctors

Typically, an NFL club hires team doctors to administer care to team members.[5] Thirty out of thirty-two NFL clubs employ doctors as independent contractors, the majority of whom report directly to the team's general manager.[6] In accord with the most recent collective bargaining agreement (CBA), the NFL Players Association (NFLPA) merely validates that the physicians selected by a club are board certified in the field of expertise which they provide.[7] Most team physicians remain in private practice; often, a lucrative endeavor because they are able to associate their private practice with service to professional athletes.[8] Prior to 2004, many doctors and hospitals paid for the privilege of sponsoring an NFL team to provide medical services, though the NFL eliminated this practice in 2004.[9]

Team doctors typically visit with an NFL team on Mondays and Wednesdays to evaluate and follow up on injuries sustained from gameplay.[10]

4. *See* Christopher R. Deubert et al., *Protecting and Promoting the Health of NFL Players: Legal and Ethical Analysis and Recommendations*, 7 Harv. J. Sports & Ent. L. 1, 13-15 (2016) (identifying all key stakeholders in NFL player health). A review of all key stakeholders would additionally include neutral doctors, the NFL and its clubs, the NFLPA, club employees, family members, and other player advisors (contract or financial).

5. *See* Marvin Washington, *The Dual Role of NFL Team Doctors*, 46 HASTINGS CENTER REPORT at 38 (2016) (indicating NFL teams solely able to "hire or fire a physician").

6. *See* Deubert, *supra note 4*, at 74

7. *See* Washington, *supra* note 5, at 38 (acknowledging quality of care despite physicians beholden to team ownership).

8. *See* Deubert, *supra* note 4, at 101 (suggesting team doctors remain primarily engaged in running private practices; *see also* Rick Maese, *supra* note 2 (noting lucrative nature of physicians' association with NFL teams).

9. *See id.* at 74-75 (emphasizing questionable nature of sponsorships and public pressure led to their ultimate demise in 2004).

10. *See* Deubert, *supra* note 4, at 102.

On Fridays, physicians typically hold "office hours," and on game days physicians make themselves available from two hours before game time through the game's conclusion.[11] On game days, the team doctor ultimately decides which players will be eligible to play notwithstanding injury, after evaluating their functioning during pre-game warm-ups.[12] Given their otherwise limited team involvement, team doctors substantially depend on the trainers "to monitor and handle the player's care during the week," given that they are always with the team.[13]

By default, team doctors are put in the awkward position of satisfying the business ends of those who pay them—team ownership—while trying, without compromise, to do what is in the best medical interest of patient-players.[14] A 2016 Associated Press survey of 100 players revealed that 39% of players believed team doctors and coaches did not have the best interests of players in mind with respect to injuries and player health.[15] Asking rhetorically, "Do the doctors put the clubs' priorities, which is winning, above the players' health and long-term well-being?" one critic says, "[t]he answer, from someone who played for over a decade in the NFL and who has had five surgeries related to NFL injuries, is that the team's needs come first."[16] This former player is not alone in his thinking. Other current players have echoed these sentiments, noting "More than anything [team doctors] want a player on the field . . . I feel like the team doctor only has the best interest of the team in mind and not necessarily the player."[17] The problem perceived by players appears to be more the result of doctors' dual obligations in this larger organizational structure, than a belief that the player's receive poor or unethical medical care.[18]

11. *See id.* (internal citation omitted) (adding that gameday availability constant whether played at home or away).

12. *See id.* at 103 (positing mid-game obligation of physicians to respond to injuries).

13. *See id.* at 102 (indicating physicians also conduct end of the year physical examinations).

14. *See* Washington, *supra* note 5, at 38 (implying doctors forced to do the impossible in serving two masters). Indeed, physicians have a duty to care for the patient; in the words of the American Medical Association Code of Medical Ethics: "The relationship between a patient and a physician is based on trust, which gives rise to physicians' ethical responsibility to place patients' welfare above the physician's own self-interest or obligations to others, to use sound medical judgment on patients' behalf, and to advocate for their patients' welfare." *See American Medical Association Code of Medical Ethics*, AM. MED. ASS'N 1.1.1 (2016), https://www.ama-assn.org/delivering-care/ama-code-medical-ethics.

15. *See id.* (stating 47% believed the opposite to be true, while 14% withheld an answer or were unsure). When the field of those polled is narrowed to players with more than four years of NFL experience, however, a substantial 65% believed that team doctors and coaches did not have the best interests of the player in mind. *Id.*

16. *See id.* (advocating for medical staff independent from ownership to safeguard player health).

17. *See* Deubert, *supra* note 4, at 105 (portraying current and former players' predominate distrust for team doctors).

18. *See* Arthur L. Caplan et al., *Players' Doctors: The Roles Should Be Very Clear*, 46 HASTINGS CENTER REPORT at 25 (2016) (arguing "how [doctors] are selected, evaluated, and terminated and to whom they report" fuels quandary); *see also* Deubert, *supra* note 4, at 11 (highlighting inherent conflict of interest for team doctors).

B. Athletic Trainers

Unlike team doctors who tend to be independent contractors, NFL clubs directly employ athletic trainers full-time employees.[19] Typically, NFL trainers report to the team doctor and implement training and rehabilitation at the behest of the team doctor, who unlike the team trainer, tends to be absent from the team.[20] In short, team trainers are always with the team and thus more actively manage day-to-day player care in accord with the direction provided by a team doctor.[21] Trainers are "the first and most consistent source of medical care" for the players.[22]

Under state law, athletic trainers are broadly responsible for preventing, recognizing, and remedying injuries sustained by players.[23] More precisely, trainers can be expected to deal in protective equipment, conditioning, nutrition; and in conjunction with the team doctor, physical exams, injury response, follow-up care, and all other matters related to the player's well-being.[24] Under the Professional Football Athletic Trainers Society Code of Ethics, in addition to providing "the best possible health care for the players," trainers act as liaison between the "player, physician, coaching staff, management, and media."[25] Naturally, the same structural conflicts inherent in the team doctor's position apply with equal force to NFL trainers.

One former player under Super-Bowl-winning coach Tom Coughlin spoke out against the health care environment he witnessed firsthand under Coughlin, saying that the trainer "would never intervene on a player's behalf. He was browbeaten. Coughlin controlled him. That's who has no spine. He's a puppet."[26] Similar sentiments are reiterated by current players elsewhere. For instance, one current player indicated that the first take of trainers is always "underrepresentation of the actual injury" in order to "downplay the situation to convince me you don't need to take any time off whatsoever . . . take off as little time as possible and get back on the job immediately."[27] Most tellingly,

19. *See* Deubert, *supra* note, at 137 (calling NFL trainers the players' "first line of healthcare").

20. *See id.* at 138.

21. *See id.* at 140 (positing team trainer must, as "matter of law and ethics," practice under doctor's instruction).

22. *Id.* at 139 (discussing trainer's role in monitoring player health and progression to report to absentee team doctor).

23. *See id.* (noting some state laws enumerate, in broad terms, trainers' duties); *see also* N.C. Gen. Stat. Ann. § 90-523 (indicating trainer "carries out the practice of care, prevention, and rehabilitation of injuries"); N.Y. Educ. Law § 8352 (McKinney) (defining practice of athletic training to include "managing athletic injuries").

24. *Id.* (*citing* Illinois Athletic Trainer's Practice Act, 225 Ill. Comp. Stat. Ann. 5/3 (2017)).

25. *See* Deubert, *supra* note 4, at 143 (providing portions of non-public ethics code for trainers' professional association).

26. *See* Washington, *supra* note 5, at 38 (describing an interview with former Jacksonville player John Jurkovic).

27. *See* Deubert, *supra* note 4, at 147 (reciting player responses to prompts about distrust for team trainers).

and corroborative of the *Evans* allegations, one current player remarks: "The training staff is meant to rehabilitate you to play on Sunday. It is not meant to rehabilitate you for . . . every-day activities later in life. The thought of '[y]our playing could [cause] further damage isn't the concern—it's '[c]an you play?'"[28] As Deubert, et al., point out, the competing duties and responsibilities of doctors and trainers under the current organizational structure of NFL teams adversely affect the care, or at a minimum the perception of care, provided to players.

C. Personal Doctors

Personal doctors play a woefully minimal role in counteracting the long-term health implications of team-sponsored medical care vis-à-vis team doctors and trainers. In the first place, some players who make it to the NFL make it already dependent on team-provided care, without having had a personal doctor of their own.[29] Put simply, some players are strangers to traditional, personal health care and management. Most players surveyed in the Deubert paper reported an utter under-utilization of personal doctors, with some notable quotes from current players reading, "I only use doctors that are in the system," "I wouldn't think the majority of guys have a personal physician," and "I had never gone to the doctor."[30] This lack of personal care from professionals who are charged with the sole duty and responsibility of caring for the whole patient-player leads some to advocate for a rule mandating that players obtain personal doctors.[31]

D. Second Opinion Providers

Second opinion providers tend to be doctors either confirming or contrasting the medical opinion given by an NFL club doctor.[32] The roles of second opinion providers are widely contested and appear to vary somewhat based on the specific NFL team.[33] Some players report encouragement to seek out their CBA-guaranteed right to a second opinion, while other players report feeling discouraged.[34] At one extreme, former Colts player Tyler Varga recounted

28. *See id.*

29. *See* Caplan, *supra* note 18, at 25 (discussing professional basketball player's inability to access personal healthcare due to impoverishment).

30. *See* Deubert, *supra* note 4, at 165 (providing players' perspectives on non-use of personal doctors).

31. *See* Caplan, *supra* note 18, at 26 (dismissing ability of team medical staff to truly care for patient-players while beholden to other stakeholders).

32. *See* Deubert, *supra* note 4, at 154 (considering personal doctor to, in some instances, be second opinion providers).

33. *See id.* (noting importance of second opinion derivers from general or specific distrust of team doctors).

34. *Compare* Washington, *supra* note 5, at 39 (showing Indianapolis Colts retaliated against player for seeking second opinion), *with* Laurent Duvernay-Tardif, *Health Care for NFL Players: Upholding Physician*

being prescribed amantadine to treat a concussion from which he felt effects for four months.[35] When Varga obtained a second opinion which cautioned against the drug's use because of psychotic side effects and addictiveness, he notified the team doctor he would not take the drug.[36] Within 45 minutes, the Colts placed Varga on injured reserve—"a punitive response because he got a second opinion and decided not to take the amantadine."[37] Nevertheless, it appears that a small portion of second-opinion seekers actually receive diverging instruction from the second opinion provider; somewhere between roughly 10% and 30% actually receive differing treatment instruction or injury diagnoses.[38]

E. Coaching Staff & Ownership

NFL Coaches exercise a tremendous amount of authority and control over their players.[39] As the arbitrator reviewing the New Orleans Saints' so-called Bountygate scandal, former NFL Commissioner Paul Tagliabue elaborated:

> In such circumstances, players may not have much choice but to 'go along,' to comply with coaching demands or directions that they may question or resent. They may know—or believe—that from the coaches' perspective, 'it's my way or the highway.' Coaching legends such as George Halas and Vince Lombardi are not glorified or remembered because they offered players 'freedom of choice.'[40]

Given the tremendous pressure to win, coaches are naturally inclined to make decisions geared toward their team's immediate success—especially in a league increasingly apt to dismiss under-performing coaches.[41] In this vein, players and their agents actively voice their view that coaches place strong implicit and explicit pressure on their player's to get them on the field and performing.[42] One current player accurately summarized the perspectives of the rest in saying, "I think that [player health] is much less of a priority to them than winning and/or producing the best players on the field and getting the best production out of them."[43] It is important to note that the coach may not just

Standards and Enhancing the Doctor-Patient Relationship, HASTINGS CENTER REPORT 46 (2016) (intimating Kansas City Chiefs' medical team accepts and encourages second opinions).

35. *See* Washington, *supra* note 5, at 39.

36. *Id.*

37. *Id.* (lamenting team physician's unwillingness to work with Varga to find an agreeable treatment option).

38. *See* Deubert, *supra* note 4, at 157 (stating these rates may be slightly lower than those in the general population).

39. *See id.* at 221 (arguing players inclined to heed their coach's word to secure their position on roster).

40. *In the Matter of New Orleans Saints Pay-for-Performance/"Bounty,"* at 16-17 (Tagliabue, Arb. Dec. 11, 2012).

41. *See* Deubert, *supra* note 4, at 221 (arguing coaches must win to keep their jobs).

42. *See id.* (capturing player and player agent responses to prompt about coaches' influence in medical context).

43. *Id.*

pressure the player, but also may influence the medical staff as they determine a player's fitness to compete on any given Sunday.[44]

F. The Role of Prescription Drugs

In a 2011 study on opioid prevalence among former NFL players, 52% of the 644 retired NFL players interviewed, reported using opioids during the course of their NFL careers, with 71% of that cohort reporting misuse (use not just as prescribed).[45] Moreover, 15% of those who misused during their careers reported continued misuse afterward.[46] In 2011, the prevalence of ongoing opioid use stood at a whopping 7%, which alone may not seem like much, but actually constituted over three times the rate of opioid use in the general population.[47] Ninety-three percent of the players interviewed indicated persistent pain; with 81% considering their pain to be "moderate to severe."[48] This level of pain represented triple the amount experienced by the general population.[49] Pain, and ergo drugs, play a major role in the NFL health care ecosystem, but the role of drugs persist long after NFL careers end. Just how has this prevalence of prescription drug use arisen and what role does it play in the NFL?

Cue the *Evans* complaint. A document obtained through discovery in the *Evans* litigation sheds insight into the NFL's perspective on prescription drugs. Dr. Thomas McLellan, an associate of the NFL's longtime medical advisor on prescription drugs, Dr. Lawrence Brown, prepared a document entitled, "The Role of League-Wide Incentives in Promoting the Opioid Abuse Problem: The Need for League-Wide Collaboration to Solve the Problem (the Document).[50] The Document first addresses "Pain and the Ability to Play Competitive Football," indicating (1) pain is ubiquitous and unavoidable for NFL players, (2) pain inhibits players from playing at their best, (3) a player's failure to play

44. *See id.* (documenting coaches' emphasis on winning and corrosive effect on players).

45. Linda B. Cottler et al., *Injury, Pain, and Prescription Opioid Use Among Former National Football League (NFL) Players*, 116 DRUG AND ALCOHOL DEPENDENCE 188-94, 188 (July 2011), http://ac.els-cdn.com/S0376871611000020/1-s2.0-S0376871611000020-main.pdf?_tid=59a8f16c-3b21-11e7-89d8-00000aacb35e&acdnat=1495040188_074963158f0f573fb01d68ba9bbf4c2e. The opioid epidemic across the United States is well-documented as "one of the nation's most significant public health problems because it can lead to physical and mental impairment and even death." *Id.* at 189 (describing misuse as use of an opioid other than as prescribed). The NFL is far from immune to this public health crisis. *See* Eugene Monroe, *Getting off the T Train*, THE PLAYERS' TRIBUNE (May 23, 2016), HTTPS://WWW.THEPLAYERSTRIBUNE.COM/2016-5-23-EUGENE-MONROE-RAVENS-MARIJUANA-OPIOIDS-TORADOL-NFL/.

46. *See* Cottler, supra note 45, at 193 (adding only 5% of players who used as prescribed, afterward reported misuse).

47. *Id.*(suggesting contributory role of undiagnosed concussions and significant NFL pain in opioid prevalence).

48. *Id.* at 193.

49. *See id.*

50. Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 1 (alleging conspiracy to conceal information required to be disclosed to players illustrated by Document).

at his best means "loss of status and income" for the player, and (4) NFL teams whose players do not play at their best face "loss of status and revenue."[51] Given the nature of NFL injuries and their downstream effects, more rest, expanded rosters, or shorter/fewer games may seem inevitable—but such responses would reduce NFL profit margins.[52]

Thus the Document turns to "Pain relieving medications and Competitive Football."[53] The Document states that opioids and other pain medications are efficacious "*in the short term*" when it comes to the prototypical musculo-skeletal pain experience by most NFL players.[54] Then, the document suggests that "[f]or these reasons," use and misuse of pain medications are common.[55] Tying together these points, McLellan concludes: "It is in the players', the teams', and the league's reputational and financial interests to use [pain killers] for pain relief."[56]

The Document appears to summarize and convey the NFL's understanding of prescription drug use from the top, but it does not draw into focus the player's perspective. Hall-of-Famer Warren Sapp described a long line before game time to receive Toradol injections, saying "They're like Tic Tacs. You walked in, you got it and you played the game."[57] Toradol is a powerful, non-addictive, non-steroidal anti-inflammatory drug (NSAID) presenting an increased risk of kidney failure and bleeding—especially in contact sports.[58] The drug deadens sensation, mitigates pain perception, and thereby inhibits a player's ability to sense injury.[59] Nevertheless, another player, Fred Smoot suggested that, despite a fractured sternum (which forced him to sleep upright for four months because he could not lie down), he returned to the NFL for one last season, playing every game, "thanks to a syringe full of [a] drug called Toradol."[60]

51. *See id.*

52. *See id.*at 2 (emphasizing need of keeping best players on the field to bolster game attendance and viewer ratings).

53. *Id.* (emphasis added).

54. *See id.*

55. *Id.* (advocating for collaborative enterprise to resolve dilemma).

56. Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 2-3.

57. *See* Sally Jenkins & Rick Maese, *Pain and Pain Management in NFL Spawn a Culture of Prescription Drug Use and Abuse*, WASH. POST (Apr. 13, 2013), https://www.washingtonpost.com/sports/redskins/pain-and-pain-management-in-nfl-spawn-a-culture-of-prescription-drug-use-and-abuse/2013/04/13/3b36f4de-a1e9-11e2-bd52-614156372695_story.html?utm_term=.ee2877c0d8ce.

58. *See* J.M. Tokash *et al.*, *Ketorolac Use in the National Football League: Prevalence, Efficacy, and Adverse Effects*, PHYS. SPORTSMED 30(9): 19-24 (2002). Toradol's intended, FDA-approved use lies in treating pain and reducing imnflammation post-operatively; not in using the drug prophylactically. *See* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 57-60.

59. *See* Jenkins, *supra* note 57.

60. *See id.* (noting Smoot's perception that "[p]ainkillers are like popping aspirin").

So players use the drugs, and the drugs work to keep them on the field, but just how pervasive is prescription drug use? Internal NFL documents indicate that, for example, in the 2012 season the 32 NFL teams (with 53-man active rosters) on average dispensed 5,777 NSAIDs and 2,213 doses of controlled substances.[61] Commenting on these figures, the director of the Division of Medical Ethics at New York University's Medical Center remarked, "It makes you think, are the physicians looking out for the health of their players, or are they just trying to keep them on the field?"[62]

The allegations in the *Evans* complaint, if they turn out to be true, seem to answer this question. Representative of the claims and factual assertions in the *Evans* complaint, the Buffalo Bills' longtime trainer Bud Carpenter, testified to witnessing doctors administer prescription injections without disclosing their contents or side effects.[63] Many players report receiving prescription drugs from trainers, without examination and disclosure, and in the absence of a licensed physician.[64] Whatever the truth of these allegations, the incontrovertible evidence of prescription drug prevalence in the NFL and the way that drugs are used—to keep players on the field—present major long-term health risks for NFL players.

II. THE SHORT-TERM, LONG-TERM TRADEOFFS & IMPLICATIONS

Whether by design or not, the NFL healthcare ecosystem functions first and foremost to return players to the field. As Deubert, et al., argue, the primary health care providers for players—team doctors and trainers—provide their services from positions marred by serious conflicts of interest.[65] Notwithstanding these conflicts and players' apparent understanding of their existence, players remain largely unable to counteract the detriment these conflicts present. First, for many players, team-provided medical care supplants independent, primary care from a young age. As a result, the health care that players do receive tends to be in the context of performing a team sport, and in turn, geared towards returning players to the sport. Likewise, second opinions in the NFL arise in the context of performance, and if one ponders the topic and when it appears in the news, it is often where a player has received bad news such as diagnosis of a season-ending injury and seeks a

61. *See* Maese, *supra* note 2 (noting numbers average out to six-to-seven pills or injections per player per week during NFL season).

62. *Id.* (positing figures neither contain exact dosages and types nor distribution across players on given team).

63. *See id.* (reiterating numerous documents showing concealment of illegal conduct by doctors and trainers).

64. *See* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 34-35 (presenting Minnesota Vikings team email suggesting underutilization of Toradol yields competitive advantage).

65. *See* Deubert, *supra* note 4, at 10 (arguing inherent conflicts of interest prevail across NFL clubs' medical staff).

more team-favorable outcome. Players, too, then bear some blame—except that their own willingness to play hurt, in part, derives from a get-paid-as-you-play pay structure.[66] The NFL health care ecosystem does little to shift the gameplay-centric focus toward player-oriented care.

Accordingly, the role of prescriptions drugs in this context is suspect. The data suggest that many injured players continue playing week to week only because of dispensed painkillers.[67] These data are corroborated by players who attribute their past ability to play to repeated injections and "cocktails" of different drug therapies.[68] The problem with prescription drugs in this context is that they treat symptoms rather than underlying causes. Where rest may be the most appropriate treatment, it tends to be the most elusive in light of all the factors discussed, but especially the player's and team's reputational and financial interests.[69]

Problematically, though, the use of NSAIDs mask pain and can, thereby, exacerbate injury unwittingly for a player.[70] For example, the off-label use of Toradol to treat players prophylactically pregame, paradoxically, allows a player to get on the field and play through pain while concomitantly increasing the likelihood that the player exacerbates his injury, since his natural pain sensors are dampened.[71] This is a cyclical problem as pointed out by researcher Linda Cottler, who states: "A cycle of injury, pain, and re-injury could lead to subsequent pain pull use during the NFL which in turn could result in later life disability, continued pain and misuse of prescription pain pills."[72] The sheer volume of prescribing in the NFL warrants scrutiny; drugs should be dispensed

66. *See* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 25 (alleging "Clubs have created a coercive economic environment in which all players have non-guaranteed contracts). Additionally, of course, players will often have a winning attitude and may want to return to gameplay even if hurt in order to bolster their team's chances of success.

67. *See* Cottler, *supra* note 45, at 193. "Cocktailing" is generally described as mixing and matching pain-relieving and inflammation-reducing treatments. *See* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 30. It is alleged that even when mixing medications, players historically received little to no disclosure of long-term effects—or even the substance of what players are expected to ingest. *Id.*

68. *See generally* Jenkins, *supra* note 57.

69. *See* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 2-3.

70. *See id.* at 4 (citing NFL e-mails demonstrating awareness of long-term health pitfalls). In addition to noting that player use of opioids increases long-term risk for abuse and addiction, one league e-mail sent by Dr. McLellan acknowledges, "Players in pain who would otherwise not play or play at the same level of competitiveness may be induced by a pain medication and their personal financial/reputational incentives to ply under conditions that could exacerbate their injuries and hinder their recovery." *Id.*

71. *See* Jenkins, *supra* note 57 (including tales from former NFL players regarding prescription use and misuse). For instance, when one former player, Chester Pitts, struggled to even walk post-surgically repairing his knee, Pitts nevertheless played another season thanks to "a cocktail of Toradol injections on Sundays, with anti-inflammatories and narcotic painkillers the other days of the week." *See id.* A 2000 survey of NFL teams revealed that 28 of 30 NFL teams utilized Toradol injections on gamedays while a subsequent 2002 study indicated that those teams averaged roughly 15 pregame injections. *Id.*

72. *See* Cottler, *supra* note 45, at 193.

for good, appropriate indications like pain relief—not for "more questionable indications," like getting an athlete to play through pain.[73] Otherwise, NFL players risk their future health for short-lived NFL glory.

As one study found, during the course of the season, over 65% of NFL players sustain an injury, which often "contribute[s] to a cycle of worsening injuries and long-term consequences."[74] The same study found a "high rate of impairment" in recently retired NFL players, with players "significantly worse off" compared to the general population when it came to performing ordinary activities of daily living.[75] An astounding 93% of NFL retirees report pain lingering from NFL injuries, with 81% of the group categorizing the pain as "moderate to severe."[76] The prevalence and degree of pain persistent among retired NFL players evinces the shortcomings of medical care provided during the course of players' NFL careers. Nevertheless, there are several ways to better safeguard long-term player health.

III. POSSIBLE SOLUTIONS

A. The Deubert Solution

Though the Deubert study deals less with the quality of care that players receive, and more with the structural conflicts of interest prevailing in NFL medical practice, the authors propose a remarkably satisfying solution. Deubert, et al., advocate for providing players with split medical staff; one medical team employed by and advancing the interests of the NFL club's coaching and ownership, and the other medical team acting as doctors purely interested in the patient-player.[77] While pragmatic, it remains to be seen whether such a setup will be introduced in the next CBA. This solution also introduces an added ethical concern for which Deubert and his colleagues do not account; namely, player health could be relegated to a bargaining chip in the give-and-take of CBA negotiations.

B. Promoting Primary Care

NFL players may additionally be able to circumvent the shortcomings of existing care and the inherently conflicted structure in which it is delivered by

73. Eric C. Strain, *Drug Use and Sport—A Commentary on: Injury, Pain and Prescription Opioid Use Among Former National Football League Players by Cottler et al.*, 116 DRUG AND ALCOHOL DEPENDENCE 8-11, 9 (July 2011), http://ac.els-cdn.com/S0376871611000032/1-s2.0-S0376871611000032-main.pdf?_tid=ab81f424-3b22-11e7-ab57-00000aab0f27&acdnat=1495040755_c148ec251b73cd0072a57828b9057e4c.

74. *See* Benjamin G. Domb et al., *Whole-Person Impairment in Younger Retired NFL Players: The Orthopaedic Toll of a Professional Football Career*, ORTHOPAEDIC J. OF SPORTS MED. 1 (2016) (noting absence of studies on orthopaedic toll of NFL injuries on retired players).

75. *Id.* at 4 (emphasizing debilitating effects most prominent in cervical spine, shoulders, and knees).

76. Cottler, *supra* note 45, at 194 (internal citations omitted).

77. *See* Deubert, *supra* note 4, at 10.

making personal, primary care physicians a priority.[78] Unlike the Deubert suggestion, emphasizing personal doctors need not be a CBA bargaining chip. Instead, player agents, in cohort with the NFLPA, can facilitate player-doctor relationships as part of their services to players. In this way, should the existing NFL health care ecosystem remain in place, players would nonetheless have some sort of check on the care that they receive. At least this solution has the potential for players to receive information not affected by conflicts of interest, though the player has to be willing to value long-term functionality over short-term financial gain and on-the-field glory.

C. Providing Federal Oversight

An additional avenue for players to improve their long-term health outcomes lies in lobbying the federal government to pass legislation which would re-shape, or at the very least, scrutinize NFL provider care. The Drug Enforcement Agency has already wagged a finger at the NFL for endemic failure in complying with federal narcotics laws.[79] The NFL clubs' unauthorized dispensation of controlled substances, malfeasant prescription recordkeeping and storage, and travel with drugs across state lines bespeaks a cavalier attitude toward dispensing prescription drugs and truly protecting players.[80] The DEA let NFL medical personnel off the hook once; now it is time that clubs and their medical personnel are held accountable to do what the profession of medicine requires: promote the health and well-being of patients. Additionally, federal action bypasses the ethical quandary of negotiating something as fundamental as player health. To conclude, NFL medical personnel should provide medical care "in a manner that is consistent with the standard of the medical community . . . not the NFL medical community."[81]

78. *See* Caplan, *supra* note 18, at 26 (advocating for league-mandated personal primary health care physicians).

79. *See* Rick Maese, *The DEA Warned NFL Doctors About Drug Laws in 2011. It Didn't Go Well.*, WASH. POST (Apr. 20, 2017), https://www.washingtonpost.com/sports/redskins/the-dea-warned-nfl-doctors-about-drug-laws-in-2011-it-didnt-go-well/2017/04/20/38d8a37a-1fc3-11e7-be2a-3a1fb24d4671story.html?utm_term=.2435f74f0222.

80. *See id.* (documenting 2012 DEA presentation to NFL medical personnel where DEA received pushback despite noncompliance with federal guidelines).

81. *See* Plaintiff's Second Amended Complaint, Evans v. Ariz. Cardinals Football Club, L.L.C., No. 3:16-cv-01030-WHA at 36 (quoting email from Steelers doctor to Steelers trainer and noting NFL prescribing practices departure from ordinary norms).