

Fall 2012

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Recommended Citation

Mitch Koczerginski, *Who Is at Fault When a Concussed Athlete Returns to Action?*, 47 Val. U. L. Rev. 63 (2012).

Available at: <https://scholar.valpo.edu/vulr/vol47/iss1/2>

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WHO IS AT FAULT WHEN A CONCUSSED ATHLETE RETURNS TO ACTION?

Mitch Kocerginski*

I. INTRODUCTION

It is evident that the long-term effects of concussions are destructive.¹ An inadequately treated concussion can have many terrible effects, including depression, dementia, and even death.² In recent years, professional sports have seen a sudden change in the treatment of concussions.³ To many athletes and fans, this new treatment seemed

* J.D. Candidate, University of Ottawa Faculty of Law (2014); J.D. Michigan State University College of Law (2012). I would like to express my gratitude to Professor Brian C. Kalt of Michigan State University College of Law for his wisdom and guidance, without which this project would not have been possible. I would also like to thank the Valparaiso University Law Review editorial board for devoting their hard work and time in editing this Article.

¹ Christopher Wanjek, *Why NFL Players Suffer Dementia, Depression*, LIVESCIENCE (June 5, 2007, 7:29 AM), <http://www.livescience.com/4499-nfl-players-suffer-dementia-depression.html>. Traumatic Brain Injuries (“TBI”) are a growing concern in sports:

Concussions and other mild brain injuries have long been a leading cause of [TBI] and death throughout the world. . . . Although typically resulting only in short-term disruption of brain function, concussions are the source of approximately 75% of TBIs every year, and can lead to more serious long-term effects if not properly treated. The most common causes of concussions are falls, motor vehicle crashes, being struck by or against objects, and assaults. However, the percentage of concussions due to sports injuries is increasing.

Elisabeth Koloup, Comment, *Get Your Head in the Game: Legislation Addressing Concussions in Youth Sports and its Development in Maryland*, 42 U. BALT. L.F. 207-08 (2012) (footnotes omitted).

² *Id.* Although most concussions are not fatal, the long-term effects of one or multiple concussions can have serious repercussions:

Sustaining an isolated concussion will not generally cause death. However, suffering repeated concussions raises the danger of second-impact syndrome . . . , a potentially fatal condition that occurs when a player returns to competition before the symptoms of a first concussion resolve. After sustaining a concussion, brain cells that are not irreversibly destroyed remain alive but in an extremely vulnerable state. A second blow to the head, no matter how trivial, while the brain is still recovering from the first concussion, may lead to a fatal herniation of the brain.

Alexander N. Hecht, *Legal and Ethical Aspects of Sports-Related Concussions: The Merrill Hoge Story*, 12 SETON HALL J. SPORT L. 17, 24 (2002).

³ See *Concussions: New Rules for Treating NHL Players*, NHL.COM (Mar. 14, 2011, 3:21 PM), <http://www.nhl.com/ice/news.htm?id=556004> (providing that professional sports leagues, such as the NHL, are “adopting a more rigorous protocol for examining players with possible concussions”).

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strange, given the fact that concussions are nothing new.⁴ There is a culture clash between the old view of a concussion and the current one, in that the latter appreciates concussions as a serious condition, whereas the former often dismisses them as a trivial occurrence.⁵ In fact, the macho culture of contact sports often referred to the injury as simply “getting your bell rung” and encouraged athletes to return to play immediately or risk being labeled as soft.⁶

⁴ See, e.g., Steve Bulpett, *Mickael Pietrus Injured in Loss*, B. HERALD, Mar. 24, 2012, http://news.bostonherald.com/sports/basketball/celtics/view/20220324hollins_gets_straight_talk_from_rivers/srvc=home&position=recent (“[Pietrus] was taken to the hospital with what was termed a ‘closed head injury.’”); see also Mike Florio, *Aikman Opens up About Why He Doesn’t Talk About Concussions*, NBC SPORTS (Jan. 9, 2011, 9:23 AM), <http://profootballtalk.nbcsports.com/2011/01/09/aikman-opens-up-about-why-he-doesnt-talk-about-concussions/> (describing Troy Aikman’s experience with concussions and football). Aikman said:

I had one my rookie year, . . . I was knocked out cold for 10 minutes. I had blood coming from my ear. The second was I got knocked out in the ‘93 season NFC championship game against San Francisco. I got knocked out in the third quarter. I spent the night in the hospital. They asked me questions. I didn’t know what planet I was on. I still to this day have no recollection of ever having played in that game. So whenever I see footage of that game, it’s like somebody else is out there doing it.

Id. Even NASCAR drivers are susceptible to potential concussions. *Dale Earnhardt Jr. Has Concussion*, ESPN (Oct. 15, 2012), <http://m.espn.go.com/rpm/nascar/story?storyId=8489668&wjb=>. Dale Earnhardt in describing his experience after a crash said:

I remember everything about that accident, everything after that accident, . . . [b]ut I knew I didn’t feel . . . you know your body and how your mind works. I knew something was just not quite right. I decided to push through and work through it. I had concussions before and knew exactly kind of what I was dealing with. I felt pretty good after a week or two, definitely 80 to 90 percent after the Chase started. By the time I got to Talladega I felt 100 percent, really good.

Id.

⁵ LINDA CARROLL & DAVID ROSNER, *THE CONCUSSION CRISIS: ANATOMY OF A SILENT EPIDEMIC* 10–11 (2011); see also Erika A. Diehl, Note, *What’s All the Headache?: Reform Needed to Cope with the Effects of Concussions in Football*, 23 J.L. & HEALTH 83, 90 (2010) (stating that oftentimes athletes do not know the serious implications of a concussion and explaining that the “He-man” mentality makes players reluctant to report a potential concussion). One author cites the “gladiator” mentality as one reason why athletes refuse to take themselves out of the game when suffering from a concussion. Ryan McLaughlin, Note, *Warning! Children’s Brains in Danger: Legislative Approaches to Creating Uniform Return-To-Play Standards for Concussions in Youth Athletics*, 22 IND. INT’L & COMP. L. REV. 131, 141 (2012). This mentality grows out of a culture that praises athletes for playing through the pain. *Id.* This mindset is prevalent in football and hockey. *Id.* at 141–42. One author concludes that “players alone cannot be relied upon to report and manage their concussions” because of this mentality. *Id.* at 142 (internal citation omitted).

⁶ CARROLL & ROSNER, *supra* note 5, at 10; see also McLaughlin, *supra* note 5, at 141 (“Studies show that many athletes suffering from head injuries often refuse to take themselves out of games for fear of appearing weak to their teammates.”).

Recently, several National Football League (“NFL”) alumni have initiated suits, alleging, among other things, that the NFL fraudulently misrepresented the seriousness of concussions.⁷ Some retired athletes have even exclaimed that, had they known about the risks associated with concussions, they would not have continued to participate in the sport.⁸ While reports of this litigation have littered the news, professional sports leagues have taken notice of the dangers of concussions.⁹ Consequently, several professional leagues have heightened their return to play requirements for athletes who may have suffered a concussion.¹⁰ This Article examines whether the new guidelines effectively minimize the impact of concussions at the professional level and contends that they do not. Specifically, the new guidelines still permit a significant risk, namely that concussed athletes will return to play too soon, because unfettered discretion is placed in the hands of team-physicians and “motivated athletes.”¹¹ Moreover, this Article posits that the new return to play guidelines insulate team-

⁷ See Trial Pleading, *Barnes v. NFL*, No. BC468483, 2011 WL 3791910 ¶ 56 (Cal. App. Dep’t Super. Ct. Aug. 26, 2011) (alleging that the NFL has known for a long time “that multiple blows to the head can lead to long-term brain injury, including memory loss, dementia, depression and CTE and its related symptoms”).

⁸ Ben McGrath, *Does Football Have a Future?*, THE NEW YORKER, Jan. 31, 2011, http://www.newyorker.com/reporting/2011/01/31/110131fa_fact_mcgrath.

⁹ See *Concussions: New Rules for Treating NHL Players*, *supra* note 3 (noting that at a recent general managers (“GMs”) meeting for the NHL, GMs were provided with the results of a two year study on concussions, finding that forty-four percent of concussions were a result of a legal hit). Twenty-six percent resulted from accidental hits, and twenty-five percent stemmed from an illegal hit or a fight. *Id.* Hall of Fame coach, John Madden, wanted to educate youth about the seriousness of concussions in his new video game, Madden NFL 12. Alan Schwarz, *Madden Puts Concussions in New Light in His Game*, N.Y. TIMES, Apr. 2, 2011, http://www.nytimes.com/2011/04/03/sports/football/03madden.html?_r=0. To accomplish this goal, the designers of the game ensured that any player who sustained a concussion would be benched for the remainder of the game with no exceptions. *Id.* In addition, the announcers on the game explain that “the player was removed because of the seriousness of head injuries.” *Id.*

¹⁰ See *Concussions: New Rules for Treating NHL Players*, *supra* note 3 (discussing the new concussion policies instituted by the NHL); see also Bryan Lipsky, Note, *Dealing with the NFL’s Concussion Problems of Yesterday, Today, and Tomorrow*, 18 FORDHAM INTELL. PROP. MEDIA & ENT. L.J. 959, 959–60 (2008) (“Even though the NFL is currently succeeding at heights never before seen for an American sports league, the NFL and its current players (including the union) have not adequately dealt with the issue of the horrible health and financial situation of so many of its former players who helped make the NFL as successful as it is today.”) (footnotes omitted).

¹¹ James H. Davis, *“Fixing” the Standard of Care: Motivated Athletes and Medical Malpractice*, 12 AM. J. TRIAL ADVOC. 215, 216–17 (1988) (explaining the motivation of athletes to downplay or conceal their injuries.).

physicians from liability for inadequately treating concussions, causing questions of liability to become too complex to unravel.¹²

Concussion liability in professional sports depends on the relevant parties' awareness of specific facts.¹³ Specifically, physician liability for inadequately treated concussions can sometimes depend on a determination of whether a team-physician has sufficient awareness of an athlete's symptoms in order to properly diagnose a concussion or clear that athlete to return to play.¹⁴ This Article argues that return to play guidelines that allow athletes to return to action prior to being symptom-free constitute a breach of a duty owed to athletes by team medical staff.

Part II defines a concussion and explains why it is so dangerous.¹⁵ Part III then summarizes how many professional sports leagues have responded to the new data about concussions and describes some of the new return to play guidelines that have been adopted.¹⁶ Part IV examines problems with the new return to play guidelines and specifically discusses the difficulty with distinguishing between a team-physician's abuse of discretion and a motivated athlete's concealment of symptoms.¹⁷ Part IV also discusses the difficulty in bringing a medical malpractice suit against a team-physician.¹⁸ Finally, Part V proposes possible solutions that aim to (1) remove the suspect subjectivity from the process of diagnosing a concussion and (2) secure more accountability from team-physicians.¹⁹

¹² While this Article is applicable to professional sports leagues generally, it will mostly rely on actions and policies of the National Football League ("NFL") and National Hockey League ("NHL").

¹³ See Susan Davies, Charles J. Russo & Allan G. Osborne Jr., Commentary, *Concussions and Student Sports: A Silent Epidemic*, 282 EDUC. LAW REP. 759, 760 (2012) ("Concussions have been called a "silent epidemic" because symptoms can be subtle and covert."); *infra* Part IV.B (explaining what is necessary in order to find a team-physician liable in professional sports).

¹⁴ See *infra* Part IV.A (noting that athletes sometimes try to conceal their injuries so that the treating physician will let them continue playing, making it difficult for physicians to diagnose properly).

¹⁵ See *infra* Part II (defining and discussing the three grades of concussions).

¹⁶ See *infra* Part III (examining the manner in which the NFL and NHL have adapted to new information about concussions).

¹⁷ See *infra* Part IV (noting the competing interests of the athlete, physician, fans, and team management).

¹⁸ See *infra* Part IV (explaining the reasons that courts are reluctant to find team-physicians liable for negligent treatment of athletes).

¹⁹ See *infra* Part V (introducing new technology that would remove the subjective component in diagnosing concussions).

II. WHAT IS A CONCUSSION AND WHY IS IT SO DANGEROUS?

There are various definitions for the term concussion. Webster's dictionary defines a concussion as a "stunning, damaging, or shattering effect" from a hard blow to the head, or "a jarring injury of the brain resulting in disturbance of cerebral function."²⁰ A concussion can also be defined as a "mild traumatic brain injury where 'the brain impacts the interior of the skull' due to a 'blow to the head, fall, or violent head movement.'"²¹ While the definitions of a concussion vary slightly, experts in the field generally hold that a concussion leads to the loss of brain function.²²

To assist doctors in understanding the severity of a concussion, concussions are usually divided into three grades.²³ The first grade of a

²⁰ WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 472 (2002). The Mayo Clinic staff define and discuss the effects of a concussion:

A concussion is a traumatic brain injury that alters the way your brain functions. Effects are usually temporary, but can include problems with headache, concentration, memory, judgment, balance, and coordination

Although concussions usually are caused by a blow to the head, they can also occur when the head and upper body are violently shaken. These injuries can cause a loss of consciousness, but most concussions do not. Because of this, some people have concussions but don't realize it.

Concussion: Definition, MAYO CLINIC (Feb. 22, 2011), <http://www.mayoclinic.com/health/concussion/DS00320>. Another medical dictionary defines a concussion as "a hard blow or collision [or] a condition resulting from the stunning, damaging, or shattering effects of a hard blow; *especially*: a jarring injury of the brain resulting in disturbance of cerebral function and sometimes marked by permanent damage." *Medical Dictionary: Concussion*, MEDLINE PLUS: MERRIAM-WEBSTER (2012), <http://www.merriam-webster.com/medlineplus/concussion> (emphasis in original).

²¹ Kristina M. Gerardi, *Tackles that Rattle the Brain*, 18 SPORTS LAW. J. 181, 183-84 (2011) (quoting Steve Holder, *Understanding Post-Concussion Syndrome*, HEAD & BRAIN INJURIES (June 25, 2008), <http://www.headbraininjuries.com/post-concussion-syndrome>).

²² *Concussions*, INJURYINFORMATION.COM, <http://www.injuryinformation.com/injuries/concussions.php> (last updated Sept. 22, 2009) (explaining that the long-term effects of a concussion depend on its severity or "grade").

²³ Gerardi, *supra* note 21, at 184; *see* Diehl, *supra* note 5, at 89 (stating that there are more than forty-one methods that have been devised to gauge the severity of a concussion, making it difficult to determine which approach is best). "It is estimated that 3.8 million sports and recreation related concussions occur each year in the US. Conservative estimates indicate that more than 300,000 sportrelated [sic] concussions occur each year in the United States, but that figure only represents head injuries resulting in hospital admissions." *Id.* at 88. *See also* Lesley Lueke, Commentary, *High School Athletes and Concussions*, 32 J. LEGAL MED. 483, 487 (2011) ("The severity of a concussion is measured by the symptoms displayed, and, depending on the symptoms and their durations, the concussion can be designated as Grade 1, Grade 2, or Grade 3.").

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concussion does not result in a loss of consciousness, and common symptoms include “dizziness, nausea, motion sickness, blurry vision, vomiting and impaired balance.”²⁴ Grade 1 symptoms generally last between fifteen and thirty minutes and in rare cases can linger for days after impact.²⁵ Unfortunately, there are no specific treatments for a Grade 1 concussion, because symptoms often disappear quickly on their own accord.²⁶ However, as with all concussions, it is widely recognized that one should refrain from all physically and mentally strenuous activity until the symptoms have fully dissipated.²⁷ While Grade 1 concussions are subtle, they can be very dangerous since they are difficult to recognize and, consequently, often go undiagnosed.²⁸ The danger in allowing mild concussions to pass undiagnosed is that once someone has suffered a concussion, the athlete becomes more susceptible to subsequent concussions and, worse, the effects of each concussion are cumulative.²⁹ For instance, one study on the design of football helmets found that “what [initially] appeared to be the mildest injuries on the field often required the longest recovery periods.”³⁰

A Grade 2 concussion is more severe than a Grade 1 concussion by virtue of the fact that the symptoms last longer.³¹ Grade 3 concussions

²⁴ *Concussions*, *supra* note 22. The Center for Disease Control and Prevention (“CDC”) identifies four types or groups of concussions symptoms:

The first group, thinking/remembering includes difficulty thinking clearly, concentrating, remembering new information and feeling slowed down. The second set, described as physical, includes headaches, fuzzy or blurred vision, nausea or vomiting early on, dizziness, sensitivity to noise or light, balance problems, and feeling tired. The third set, emotional/mood symptoms address irritability, sadness, emotional, nervousness, and/or anxiety. Finally, the slowing down symptoms cover sleeping more or less than usual and/or having trouble falling asleep.

Davies et al., *supra* note 13, at 761.

²⁵ *Concussions*, *supra* note 22.

²⁶ *Id.*

²⁷ *Id.*

²⁸ Gerardi, *supra* note 21, at 185. Researchers conducted a study of athletes at the University of Akron and found that “thirty percent of the athletes surveyed continued to play in spite of symptoms.” Diehl, *supra* note 5, at 91. In addition, the study found that “fifty-six percent [of the athletes surveyed] had no knowledge of the consequences of a head injury,” which helps explain why many athletes do not feel the need to report such injuries. *Id.*

²⁹ See CARROLL & ROSNER, *supra* note 5, at 6-7; Lueke, *supra* note 23, at 490 (stating that an individual who suffers from one concussion is more likely to sustain a subsequent concussion).

³⁰ *Newer Football Helmet Design May Reduce Incidence of Concussion in High School Players*, DEP’T OF NEUROLOGICAL SURGERY (Jan. 9, 2006), http://www.neurosurgery.pitt.edu/news/2006/football_helmets.html.

³¹ See Gerardi, *supra* note 21, at 185 (distinguishing a Grade 2 concussion from a Grade 1

are the most severe and typically result in a loss of consciousness, “whether for seconds or for minutes.”³² Moreover, symptoms of Grade 3 concussions can last for weeks and in some cases much longer.³³ Similarly, Grade 2 and 3 concussions require medical attention.³⁴

While only Grade 2 and 3 concussions expressly require medical attention, one’s brain, regardless of the grade of the concussion suffered, is extremely vulnerable for a period of time following the initial concussion-causing impact.³⁵ Consequently, if someone returns to a physically or mentally strenuous activity before being symptom free, the athlete is vulnerable to suffering a second concussion quite easily.³⁶ This vulnerability is referred to as “second-impact syndrome.”³⁷ One author

concussion by virtue of its longer duration); *see also Concussions, supra* note 22 (“While symptoms of a Grade 1 concussion last up to 15 minutes, a Grade 2 can linger for as much as 24 hours, with additional traits lingering for days after.”).

³² Gerardi, *supra* note 21, at 185.

³³ *Concussions, supra* note 22.

³⁴ *Id.* While all concussions are dangerous, including Grade 1 concussions, only Grade 2 and 3 concussions require immediate medical attention. *Id.* This is partly due to the fact that Grade 1 concussions are often unnoticed. *Id.*

³⁵ Gerardi, *supra* note 21, at 185 (quoting Jacob Silverman, *Is There a Link Between Concussions and Dementia?*, DISCOVERY HEALTH, <http://health.howstuffworks.com/concussions-and-dementia.htm>).

³⁶ *See* Gerardi, *supra* note 21, at 186–87 (providing an introduction of the vulnerable state of an individual’s brain after suffering a concussion); Koloup, *supra* note 1, at 214 (“Concussions sustained in sporting events can be especially dangerous, as returning to play before full recovery can result in permanent brain damage and death.”) (footnote omitted).

³⁷ *See* Gerardi, *supra* note 21, at 186 (“Second Impact Syndrome is a term used to define what happens when a person experiences a mild concussion, and then suffers from another concussion shortly thereafter.”) (footnote omitted); *see also* McLaughlin, *supra* note 5, at 136 (“‘Second Impact Syndrome’ is a condition that occurs when individuals, predominately children and teenagers, who have not fully recovered from an initial concussion suffer another impact. This can cause the brain to swell dangerously, resulting in loss of blood flow and often death.”). Legislators in Colorado, recognizing the dangers of concussions in youth athletics, passed the Jake Snakenberg Youth Concussion Act after a high school student tragically died while playing high school football. *Id.* at 136 n.59. The Act states in pertinent part:

(1)(a) Each public and private middle school, junior high school, and high school shall require each coach of a youth athletic activity that involves interscholastic play to complete an annual concussion recognition education course.

(b) Each private club or public recreation facility and each athletic league that sponsors youth athletic activities shall require each volunteer coach for a youth athletic activity and each coach with whom the club, facility, or league directly contracts, formally engages, or employs who coaches a youth athletic activity to complete an annual concussion recognition education course.

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describes second-impact syndrome, explaining that “[a]fter a concussion, [t]he brain remains in a vulnerable state for a period of time . . . during which a person has not yet returned to full functioning and is more susceptible to a recurrent injury, almost as though the threshold for injury [has] been lowered.”³⁸ Another author explains that

second-impact syndrome could occur any time an athlete suffered a jolt to the head too close on the heels of an earlier concussion. If the brain didn’t have enough time to recover from the initial concussion, a second one could have a much more devastating impact—even when the second [concussion] resulted from nothing more than a light tap.³⁹

Therefore, given the potential seriousness of second-impact syndrome, it is necessary that a person be completely asymptomatic before returning to any physical contact sport.⁴⁰

While second-impact syndrome can have fatal consequences, a more common danger exists—the development of long-term concussion symptoms.⁴¹ The development of long-term concussion symptoms

(2)(a) The concussion recognition education course required by subsection (1) of this section shall include the following:

(I) Information on how to recognize the signs and symptoms of a concussion;

(II) The necessity of obtaining proper medical attention for a person suspected of having a concussion; and

(III) Information on the nature and risk of concussions, including the danger of continuing to play after sustaining a concussion and the proper method of allowing a youth athlete who has sustained a concussion to return to athletic activity.

COL. REV. STAT. § 25-43-103 (2011). New Jersey, Rhode Island, and Washington have passed similar laws. N.J. STAT. ANN. § 18A:40-41.2 (West 2010); R.I. GEN. LAWS ANN. § 16-91-3 (West 2010); WASH. REV. CODE ANN. § 28A.600.190 (West 2011). In recent years, however, some experts have called the syndrome into question: “Studies have increasingly found a lack of conclusive evidence of the syndrome, and it is more likely that a single impact of any severity may result in this rare complication, especially in the developing brain.” Diehl, *supra* note 5, at 92.

³⁸ Gerardi, *supra* note 21, at 186 (quoting David Gillis, *Concussion in Football: When Is It Safe to Return to the Game?*, NEUROLOGY TODAY, Feb. 2004, at 62, 62, available at http://journals.lww.com/neurotodayonline/Fulltext/2004/02000/Concussion_in_Footbal_When_Is_It_Safe_To_Return.18.aspx) (footnote omitted).

³⁹ CARROLL & ROSNER, *supra* note 5, at 14.

⁴⁰ See Gerardi, *supra* note 21, at 187.

⁴¹ *Id.* at 184-90.

seems to stem from the insufficient treatment of short-term concussion symptoms.⁴² While the short-term symptoms of concussions can last for minutes, days, or even weeks, the long-term symptoms can be permanent.⁴³ Such symptoms include “persistent to low-grade headaches, poor attention and concentration, memory dysfunction, sleep disturbance, and anxiety and/or a depressed mood, among others.”⁴⁴ Even more alarming is the link between concussions and the development of chronic traumatic encephalopathy (“CTE”) and dementia.⁴⁵ The lingering effects of concussions are often described as “post-concussion syndrome.”⁴⁶ However, some physicians reserve this term to describe concussion symptoms that persist past the three-month period.⁴⁷ Additionally, if symptoms persist beyond one year, they are believed to be permanent.⁴⁸

⁴² See *id.* One of the difficulties in treating even short-term concussions is that medical technology is often inconclusive: “[T]raditional structural neuroimaging techniques, such as CTs, MRIs, and EEGs, are not helpful in the diagnosis of a concussion, as concussions are metabolic injuries.” Diehl, *supra* note 5, at 91.

⁴³ Gerardi, *supra* note 21, at 184, 186 (“If symptoms last for over three months, recovery usually occurs completely within one year; unfortunately, ‘[i]f the symptoms continue beyond one year, they are often permanent.’”) (footnote omitted).

⁴⁴ *Id.* at 184.

⁴⁵ *Id.* at 187–90. CTE is a “progressive neurodegenerative disease caused by repetitive trauma to the brain which eventually leads to dementia.” *Id.* at 189 (quoting Christopher Nowinski, *10 Point Plan To Save Football*, SPORTS LEGACY INST. (Oct. 28, 2009), <http://www.athleticbusiness.com/pdf/10pointplan.pdf>). CTE is marked by a buildup of a toxic protein called *tau* that initially impairs the normal functioning of the brain and eventually kills brain cells. *Id.* at 189–90. “CTE is a disease that ‘should not naturally exist in a single human being.’” *Id.* at 190 (quoting Nowinski, *supra*). One author explains, “Early on, CTE sufferers may display clinical symptoms such as memory impairment, emotional instability, erratic behavior, depression and problems with impulse control. However, CTE eventually progresses to full-blown dementia. . . . CTE . . . is the only fully preventable cause of dementia.” *Id.* (quoting Gina DiGravio, *20 More NFL Stars to Donate Brains to Research*, B.U. SCH. MED. (Feb. 1, 2010), <http://www.bumc.bu.edu/busm-news/2010/02/01/20-more-nfl-stars-to-donatebrains-to-research/>). “Dementia is an impairment of thinking and memory that interferes with a person’s ability to do things which he or she previously was able to do.” David Roeltgen, *The Difference Between Dementia and Alzheimer’s Disease*, HEALTH CENT. (Apr. 16, 2007), <http://www.healthcentral.com/alzheimers/c/118/8646/dementia-disease>. This disease consists of a group of symptoms that disturb a person’s daily functioning by hindering his or her intellectual and social abilities. *Id.* Symptoms of dementia include “memory loss, difficulty communicating, inability to learn or to remember new information, difficulty with planning and organizing, difficulty with coordination and motor functions, personality changes, inability to reason, inappropriate behavior, paranoia, agitation, and hallucinations.” *Dementia: Symptoms*, MAYO CLINIC (April 16, 2011), <http://www.mayoclinic.com/health/dementia/DS01131/DSECTION=symptoms>.

⁴⁶ Gerardi, *supra* note 21, at 185.

⁴⁷ *Id.*

⁴⁸ *Id.* at 186. Speaking to the long-term effects of concussions, veteran sports agent Leigh

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III. RESPONSE TO NEW DATA BY PROFESSIONAL SPORTS LEAGUES

In response to this new information, league administrators have faced external pressure to create superior guidelines for the prevention and treatment of concussions. For instance, in 2011, Air Canada threatened to revoke their National Hockey League (“NHL”) sponsorship unless the league tightened its rules dealing with concussions.⁴⁹ Additionally, the NFL was the subject of intense scrutiny by Congress after it declined to accept contemporary studies linking concussions to dangerous long-term effects.⁵⁰ While both the NHL and NFL have made positive changes to their concussion management policies, the policies remain deficient. Moreover, the NFL’s policy still lags behind the NHL’s in terms of effectiveness.

One change in policy implemented by the NHL to combat the recent concussion epidemic included the revision of its concussion management protocols.⁵¹ First, a doctor, rather than a trainer, must make immediate return to play decisions.⁵² Second, immediate examinations to detect whether an athlete had suffered a concussion

Steinberg made the following statement: “What are the stakes? It’s one thing to pick up your child and have aches and pains. It’s another thing to bend down and not be able to identify that child.” Dave Scheiber, *Concussions on Their Minds*, TAMPA BAY TIMES, Aug. 5, 2007, http://www.sptimes.com/2007/08/05/Sports/Concussions_on_their_.shtml.

⁴⁹ *Concussions: New Rules for Treating NHL Players*, *supra* note 3. The concussion problem in the NHL is due both to intentional hits to the head as well as accidental collisions:

In the 2010–2011 NHL season alone, there was “a threefold increase in games lost due to concussions suffered through accidental collisions,” a startling trend that has garnered the attention of NHL Commissioner Gary Bettman. Late in the 2009–2010 season, the league addressed the problem of injurious hits on players by adding “Rule 48,” which bans lateral blindside hits to the head. Reports further suggest that the league is considering additional guidelines to address growing concerns regarding concussions.

McLaughlin, *supra* note 5, at 144.

⁵⁰ Gerardi, *supra* note 21, at 211 (“In 2009, after the NFL released a study that showed evidence that former NFL players suffered from long-term mental trauma, Congress stepped in.”) (footnote omitted).

⁵¹ See Gary Bettman, *Transcript: Commissioner Bettman Post-GM Meeting*, NHL.COM (Mar. 14, 2011), <http://www.nhl.com/ice/news.htm?id=556021> (announcing the new protocols for the NHL after meeting with the various teams’ GMs); *New NHL Concussion Guidelines: Let’s Get the Doctor Involved!*, PUCK, THAT HURTS! (Mar. 14, 2011), <http://puckthathurts.wordpress.com/2011/03/14/new-nhl-concussion-guidelines-lets-get-the-doctor-involved/> [hereinafter *New NHL Concussion Guidelines*]; see also McLaughlin, *supra* note 5, at 135 (explaining that identifying concussion symptoms is the first step in determining whether an athlete has suffered a concussion). “Because all concussions cannot be prevented, the solution must, and perhaps more importantly should, be focused on the assessment and management of concussions once they occur.” *Id.*

⁵² Bettman, *supra* note 51.

must occur in a quiet room, free from distractions, as opposed to on the bench, where such examinations would sometimes occur.⁵³ The initial examination represents a strong improvement in the NHL's concussion management policy, as it increases the likelihood of concussion detection. Where the old policy allowed a motivated athlete to insist he is okay and return on the next shift, the new policy requires a physician evaluation if an athlete exhibits any of the following symptoms: loss of consciousness, motor coordination or balance problems, slowness to get up following a hit to the head, blank or vacant look, disorientation, clutching the head after a hit, or a visible facial injury in combination with any of the above.⁵⁴ Evidently, the threshold requiring an evaluation is purposefully low.

By lowering the threshold of symptoms requiring an evaluation, the new policy disables motivated athletes from continuing to play after having potentially suffered a concussion until approved by a physician. Moreover, the new policy attempts to remove subjectivity from the detection process by legislating that physicians use the Sports Concussion Assessment Tool ("SCAT 2"), which is a standardized assessment tool developed at the Third International Conference on Concussions in Sports.⁵⁵ The SCAT 2 evaluation method is also utilized by other sports organizations, including the International Ice Hockey Federation ("IIHF") and Fédération Internationale de Football Association ("FIFA").⁵⁶

The SCAT 2 is a neuropsychological test that assists in "determining if someone's brain is working properly by testing their ability to answer questions and perform simple memory and physical tasks."⁵⁷ The SCAT 2 requires a physician to do a symptom evaluation, a cognitive and physical evaluation, a balance evaluation, and a coordination evaluation.⁵⁸ These tests are similar to roadside sobriety tests that police officers administer.⁵⁹ Finally, if an athlete is suspected of having

⁵³ *Id.*; see *New NHL Concussion Guidelines*, *supra* note 51 ("The NHL [was] already using the SCAT 2 . . . but the bench [was] absolutely the wrong place to do it . . .").

⁵⁴ Bettman, *supra* note 51; *New NHL Concussion Guidelines*, *supra* note 51.

⁵⁵ Bettman, *supra* note 51; see *New NHL Concussion Guidelines*, *supra* note 51 (providing that the SCAT 2 is a standardized assessment tool developed at the Third International Conference on Concussion in Sports); see also *SCAT2: Sport Concussion Assessment Tool 2*, CCES, [http://www.cces.ca/files/pdfs/SCAT2\[1\].pdf](http://www.cces.ca/files/pdfs/SCAT2[1].pdf) (providing a link to the actual form used to perform the SCAT 2 evaluation) (last visited Oct. 20, 2012).

⁵⁶ Jeffrey Greenfield, *Sports Related Head Trauma*, WEILL CORNELL MED. COLL., <http://cornellneurosurgery.com/pedneuro/pdf/Talk08-GreenfieldConcussion.pdf> (last visited Oct. 20, 2012).

⁵⁷ *New NHL Concussion Guidelines*, *supra* note 51.

⁵⁸ Bettman, *supra* note 51.

⁵⁹ *New NHL Concussion Guidelines*, *supra* note 51.

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suffered a concussion, the SCAT 2 provides that the athlete should not return to play the same day.⁶⁰ Moreover, it recommends a six-step return to play process that can last days, weeks, months, or indefinitely.⁶¹ If concussion symptoms return at any stage, the athlete must recede to the previous step where he was symptom free.⁶²

However, while the threshold to require an evaluation and progression under the SCAT 2 is low, some critics believe it is not low enough.⁶³ Such critics believe that there is still too much opportunity for athletes and team-physicians to mask concussion symptoms, prematurely allowing an athlete to return to play.⁶⁴ Additionally, it is often difficult to determine whether the threshold for requiring an examination has been met.⁶⁵ Such risks become even more likely with the recent changes to the NFL's concussion management policy, which relies more on physician discretion and athlete candor than the NHL's policy.

Initially, the NFL resisted the new data linking the mistreatment of concussions to long-term brain disease.⁶⁶ For instance, one of the studies the NFL relied upon "found that players who experienced three or more

⁶⁰ Bettman, *supra* note 51.

⁶¹ SCAT2: *Sport Concussion Assessment Tool 2*, *supra* note 55. First, players that are suspected of having suffered a concussion should simply rest until symptom-free. *Id.* Second, once symptom-free, players can progress to light aerobic exercise. *Id.* If the player remains symptom-free, then he can progress to step three, sport-specific exercise; and then step four, non-contact drills; step five, full contact drills; and finally step six, a return to competition. *Id.*

⁶² *Id.* For instance, if a symptom-free athlete who progresses from light aerobic exercise (step four) to sport-specific exercise (step five) begins to experience a recurrence of symptoms, then under this model the athlete must return to light aerobic exercise (step four) until the symptoms disappear again. *Id.*

⁶³ *Id.*

⁶⁴ *New NHL Concussion Guidelines*, *supra* note 51. Skeptics believe team-physicians still have too much discretion under SCAT 2:

The SCAT 2 and the NHL Protocol for Concussion Evaluation and Management leave plenty of room for the team physician to decide if the player is ready to get back in action . . . [which is] fodder for another huge debate—whether team doctors are looking out for the athlete's best interests, the team's interest in getting their player back on the ice, or the athlete's insistence that he's fine

Id.

⁶⁵ *Id.*

⁶⁶ Gerardi, *supra* note 21, at 204–05 ("[A]s of 2007, the NFL continued to stand 'behind an ongoing series of studies from its mild traumatic brain injury committee that followed active players from 1996 through 2001.' This Committee has repeatedly denied any claims that there was such a link.") (footnotes omitted); *see also* Koloup, *supra* note 1, at 214 (explaining that concussions were not discussed in the context of professional sports until the 1980s and that the media paid more attention to the effect of concussions on athletes in the 1990s).

concussions did not demonstrate evidence of neurocognitive decline.”⁶⁷ However, in 2009, congressional pressure analogizing the NFL’s denial of the link between concussions and long-term brain disease to tobacco companies that denied the link between cigarette smoking and lung cancer demanded that changes be implemented.⁶⁸ Only after congressional pressure did NFL Commissioner Roger Goodell oversee changes to the NFL’s concussion management policy.⁶⁹ The changes in policy implemented in response to the congressional hearing included modifications to game play rules and stricter return to play measures.⁷⁰

The development of the helmet over the past sixty years saw the replacement of soft, leather-padded helmets with hard-shelled helmets.⁷¹ Corresponding with this trend, it has become common over the past several seasons for some athletes to use their hard-shelled helmets as a weapon to initiate contact.⁷² The fast paced nature of the game caused

⁶⁷ Gerardi, *supra* note 21, at 205 (quoting Alan Schwarz, *N.F.L. Data Reinforces Dementia Links*, N.Y. TIMES, Oct. 24, 2009, at D1, available at http://www.nytimes.com/2009/10/24/sports/football/24dementia.html?_r=1).

⁶⁸ Joseph M. Hanna & Daniel Kain, *NFL’s Shaky Concussion Policy Exposes the League to Potential Liability Headaches*, 21 N.Y. ST. B.A. ENT., ARTS & SPORTS L.J., Fall/Winter 2012, at 33-34 (“Representative Linda Sanchez (D-CA) analogized the NFL’s denial of a causal link between NFL concussions and cognitive decline to the tobacco industry’s denial of the link between cigarette consumption and ill health effects.”) (footnote omitted).

⁶⁹ Gerardi, *supra* note 21, at 219, 223. Even under this model, there is still a tremendous amount of dependence on athlete candor to disclose their injuries or symptoms to training staff. Given this dependence, it is likely that concussions may continue to be undiagnosed.

⁷⁰ *Id.* at 222-23.

⁷¹ *Id.* at 218; see also Diehl, *supra* note 5, at 103 (noting that football helmet manufacturers have been held liable under a strict liability theory, but suggesting that new standards make it unlikely that a plaintiff will prevail under this theory today).

⁷² Gerardi, *supra* note 21, at 218 (“Now, some player’s [sic] actually use their hard-shelled helmet as a weapon to initiate contact, thereby causing their own injuries.”). Some plaintiffs have attempted to sue helmet manufacturers, alleging that the manufacturer established an express or implied warranty under the Universal Commercial Code provision (“UCC”), which states in pertinent part:

(1) Express warranties by the seller are created as follows:

(a) Any affirmation of fact or promise made by the seller to the buyer which relates to the goods and becomes part of the basis of the bargain creates an express warranty that the goods shall conform to the affirmation for promise.

(b) Any description of the goods which is made part of the basis of the bargain creates an express warranty that the goods shall conform to the description.

(c) Any sample or model which is made part of the basis of the bargain creates an express warranty that the whole of the goods shall conform to the sample or model.

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such conduct to result in hard helmet-to-helmet collisions, increasing the likelihood of a concussion for both athletes.⁷³ To decrease the likelihood of helmet-to-helmet collisions, the league now enforces sanctions against athletes for illegal helmet-to-helmet hits.⁷⁴ For instance, in 2010, Pittsburgh Steeler's linebacker James Harrison was fined four times for a total of \$125,000 for illegal helmet-to-helmet hits.⁷⁵ However, given the large salaries that NFL athletes earn each year, critics have questioned whether such fines actually deter illegal helmet-to-helmet contact.⁷⁶

Like the NHL, the NFL has adopted stricter return to play guidelines in an effort to decrease the likelihood of a concussed athlete prematurely returning to competition.⁷⁷ In May of 2007, the NFL announced a set of standards to help manage concussions.⁷⁸ These standards included the following guidelines:

- (1) Medical decisions must always override competitive considerations; (2) Standardized neuropsychological

(2) It is not necessary to the creation of an express warranty that the seller use formal words such as "warranty" or "guarantee" or that he have a specific intention to make a warranty, but an affirmation merely of the value of the goods or a statement purporting to be merely the seller's opinion or commendation of the goods does not create a warranty.

U.C.C. § 2-313 (1977). In *Bell Sports, Inc. v. Yarusso*, the plaintiff was severely injured while riding an off-road vehicle. 759 A.2d 582, 593 (Del. 2000). The plaintiff was wearing a helmet that was advertised as being specifically for off-road use. *Id.* The court found the manufacturer liable because "express warranties can arise from similar textual representations found in owners' manuals even where not specifically labeled as such." *Id.*

⁷³ Gerardi, *supra* note 21, at 218; see also Koloup, *supra* note 1, at 214 n.52 (citing a study showing that an athlete who participates in a contact sport has a "19% chance of receiving a concussion for every year he or she participates in that contact sport")

⁷⁴ Gerardi, *supra* note 21, at 218 ("The NFL has recently begun enforcing illegal helmet-to-helmet hits . . .") (internal quotation marks omitted). NFL Commissioner Roger Goodell believes that fines have already increased the safety of the game: "After viewing game tapes from the second half of the 2008 season, Goodell commented that the tackling techniques that lead to injury had decreased following the imposition of fines." Diehl, *supra* note 5, at 112.

⁷⁵ Monte Burke, *James Harrison: Is the NFL's Most Fined Player Also Its Best?*, FORBES (Dec. 1, 2010, 3:10 PM), <http://www.forbes.com/sites/monteburke/2010/12/01/james-harrison-is-the-nfls-most-fined-player-also-its-best/>.

⁷⁶ Jim Litke, *Harrison's Response to Suspension, 'LOL!'*, BOSTON.COM (Dec. 14, 2011), http://articles.boston.com/2011-12-14/sports/30516766_1_james-harrison-browns-fines/2. In response to Harrison's fine for an illegal helmet-to-helmet hit against Mohammed Massaquoi, Massaquoi's agent voiced his frustration, exclaiming: "Harrison has made \$20 million over the past three years, and they only fined him \$75,000? . . . To me, that's not going to be a deterrent." *Id.*

⁷⁷ Gerardi, *supra* note 21, at 222-23.

⁷⁸ *Id.* at 222.

baseline testing will be required for all NFL players; (3) Return-to-play decisions should continue to be made by team medical personnel using their expertise and professional judgment; (4) The NFL rule requiring every player to wear a chin strap that is completely and properly buckled to the helmet will be strictly enforced; and (5) The NFL will establish a whistle blower system so that anyone may anonymously report any incident in which a doctor is pressured to return a player to play from a concussion or that a player with a concussion is pressured to play.⁷⁹

Additionally, the NFL adopted the position that an athlete should not return to the game on the same day if he lost consciousness, a position that it did not previously outwardly endorse.⁸⁰ While such changes are indicative of a positive trend towards a safer game, lingering problems remain.

IV. PROBLEMS WITH THE CURRENT SOLUTIONS

A successful plaintiff in a medical malpractice action must prove that (1) the physician owed a duty to the plaintiff, (2) the physician breached the duty, (3) the physician was the cause of the plaintiff's injury, and (4) the plaintiff suffered damages.⁸¹ While the policy modifications made by both the NHL and NFL described in the previous section indicate progress in the effort to reduce concussions, they do so at a cost to the assessment of medical malpractice liability in the event that an athlete is negligently approved to return to play after suffering from a concussion. While the policies are a step forward from the ones they replaced, which did not require a physician examination after a severe hit, both leagues' return to play guidelines leave a tremendous amount of discretion with team-physicians to decide whether an athlete may have suffered a concussion that requires an examination.⁸²

⁷⁹ *Id.* at 222–23 (quoting Stephanie Cajigal, *Fourth Case of Chronic Traumatic Encephalopathy Reported in Former NFL Player*, NEUROLOGY TODAY, July 17, 2007, at 6, 6, available at http://journals.lww.com/neurotodayonline/Fulltext/2007/07170/Fourth_Case_of_Chronic_Traumatic_Encephalopathy.4.aspx) (internal quotation marks and footnotes omitted).

⁸⁰ *Id.* at 223.

⁸¹ Michael Landis, *The Team Physician: An Analysis of the Causes of Action, Conflicts, Defenses and Improvements*, 1 DEPAUL J. SPORTS L. & CONTEMP. PROBS. 139, 140 (2003).

⁸² *New NHL Concussion Guidelines*, *supra* note 51.

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A. *The Tension Between a Physician's Negligent Treatment of Concussions and a Motivated Athlete's Concealment of Symptoms*

Whether a physician has abused such discretion is difficult to determine because of the possibility that a motivated athlete is masking his or her symptoms. Consequently, an athlete-plaintiff will find it unduly difficult to establish the causation element of a medical malpractice action. As a result of the new return to play policies placing the decision-making power with a team hired physician, there are additional obstacles that could prevent athletes from bringing medical malpractice actions against team-medical staff. Further, the nature of the relationship that a team-physician has with the team can compromise an athlete-plaintiff's ability to prove the duty and breach elements of a medical malpractice action. This Article demonstrates that the nature of the relationship between the team-physician and the team can sometimes completely prohibit actions from being brought against the physician.

1. Tendency of Motivated Athletes to Conceal Injuries

There can be no denying that athletes and non-athletes are two completely different types of patients. As one author explains, "[w]hen a non-athlete visits a doctor, he seeks to be 'cured' by the least drastic course of treatment possible. . . . [However,] [t]he motivated athlete may want to be 'fixed' more than to be cured."⁸³ For instance, when a non-athlete breaks a finger, it can be reasonably expected that he will refrain from activity likely to aggravate the broken finger until it has completely healed. However, it is not out of the ordinary for an athlete to tape the broken finger and resume activity as quickly as possible.⁸⁴ For example, in 2004, Boston Bruin Joe Thornton played an entire best-of-seven playoff series with a broken rib.⁸⁵ Competition, the need to look good to coaches and management, and public pressure each contribute to the motivations of an athlete to discount his own long-term health for short-term athletic participation.⁸⁶

The competitive aspect of professional sports motivates athletes to conceal or seriously downplay the severity of their injuries.⁸⁷ Such

⁸³ Davis, *supra* note 11, at 216.

⁸⁴ *Id.* at 217.

⁸⁵ Russell Gunner, *Playing the Injury Game*, CLUB PHYSIO PLUS, <http://clubphysioplus.com/injurygame.html> (last visited Oct. 12, 2012).

⁸⁶ Davis, *supra* note 11, at 217-21.

⁸⁷ *Id.* at 217; see Daniel J. Kain, Note, "It's Just a Concussion:" *The National Football League's Denial of a Causal Link Between Multiple Concussions and Later-Life Cognitive Decline*, 40 RUTGERS L.J. 697, 711 (2009) ("A sad consequence of the NFL's player contract scheme is the tendency of players to withhold concussion symptoms from their trainers and team

competitive motivations include the fear of being replaced and financial sacrifice.⁸⁸ A major factor that may compromise an athlete's candor to medical staff is the small window of opportunity to showcase one's talent on the professional stage.⁸⁹ Even a minor injury can have devastating effects on an athlete's professional opportunities.⁹⁰ Injuries can also have disastrous effects on the salaries that athletes can negotiate.⁹¹ For instance, the record-breaking five-year \$96,000,000 contract that the Denver Broncos signed Peyton Manning to during the 2012 off-season pays him \$18,000,000 in the first year, but does not offer him injury protection.⁹² This means that if Manning is unable to pass a physical, the Broncos do not have to fulfill their obligation for the remaining years of the contract.⁹³ Consequently, athletes have a major incentive to "tough it out" through injuries in order to achieve the maximum financial benefits under their contracts.

While it is evident that pressures exist among professional athletes who sustain injuries that affect their mechanical abilities, they likewise exist when athletes realize they are suffering from cognitive injuries like concussions.⁹⁴ For example, former NHL defenseman Jamie Heward,

management for fear of losing their jobs.").

⁸⁸ Davis, *supra* note 11, at 217-18. NFL athletes are enrolled in a retirement plan that provides "retirement, disability, and other benefits for all retired NFL players who have met certain vesting requirements." Michael L. Meyer, Note, *If Nobody Picks up the Ball, is it Really a Fumble, or is it a Forfeit? The NFL Players Association Request for Legislative Changes to the Labor-Management Relations Act of 1947*, 43 VAL. U. L. REV. 1375, 1393 (2009). In order for a player's plan to vest, he must log three "seasons" of time in the NFL. *Id.* at 1393 n.90. A season, for purposes of a retirement plan, includes at least three games in order for a player's plan to vest. *Id.* Therefore, if a rookie suffers from a concussion during his first three years, he has a tremendous incentive to try to conceal the injury so that he can "log" the requisite time for his retirement plan. *Id.*

⁸⁹ Davis, *supra* note 11, at 217. For instance, "Joe Frazier was America's heavyweight boxer in the 1964 Olympics only because Buster Mathis had broken his thumb during the Olympic trials." *Id.* at 218 (emphasis added).

⁹⁰ *Id.* at 217-18.

⁹¹ *Id.* at 218.

⁹² See Alfie Crow, *Peyton Manning Contract Details: Broncos Will Pay \$18 Million in 2012*, SBNATION (Mar. 20, 2012, 12:24 PM), <http://www.sbnation.com/2012-nfl-free-agency/2012/3/20/2887461/peyton-manning-contract-denver-broncos> ("Manning's deal is essentially a one-year deal for \$18 million guaranteed, but if he's fully healthy in March of 2013, it will jump to a total of \$58 million guaranteed for the first three years.")

⁹³ *Id.*

⁹⁴ See Andrew D. Hohenstein, Comment, *Team Physicians: Adhering to the Hippocratic Oath or Just Plain Hypocrites?*, 19 MARQ. SPORTS L. REV. 579, 593 (2009) (explaining that athletes suffering from concussions or other kinds of head trauma may need protection from 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." *Id.* (footnote omitted).

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who was forced into retirement because of concussion complications, conceded that he had concealed concussion symptoms from team trainers out of fear that revealing such symptoms would compromise his career.⁹⁵ At a conference to raise awareness of this issue, Heward reflected on his professional career, stating that

[w]hen I got hit the first reaction was “I’m not going to get paid. If I don’t get back on the ice, I’m not going to get paid. Somebody’s going to take my job and I need to get back on the ice.” So at times, hockey players, we’re our worst enemy.⁹⁶

Heward is not alone in this train of thought; it is the dominant thought process of many professional athletes.⁹⁷ Heward noted that athletes will blatantly lie to trainers in order to avoid being removed from the lineup.⁹⁸ This allegation is corroborated by a December 2009 Associated Press report, which documented that twenty percent of one hundred and sixty NFL athletes surveyed admitted to hiding or downplaying the effects of concussions.⁹⁹ Indeed, after an anonymous NFL athlete was questioned about the cause of a recent concussion, he was quoted in the *New Yorker* as saying, “I’m always concussed, they just caught me this week.”¹⁰⁰

Athletes are often motivated to play through injuries by the desire to remain in the good graces of coaches and management.¹⁰¹ When Vancouver Canuck Mike Robitaille sat out for multiple games due to an injury, his coach, Phillip Maloney, commented, “[o]f course, we were short a defenceman with (Mike) Robitaille out (sore shoulder). I don’t know exactly how bad it is but I tell you he’d better start playing. If he doesn’t, I’m going to have to consider suspending him.”¹⁰² Furthermore, injured athletes are often encouraged by management to appear in

⁹⁵ *Hockey Coaches, Trainers Discuss Safety, Pressure to Play During Concussion Seminar*, HOCKEY NEWS (Dec. 12, 2009, 3:20 PM), <http://www.thehockeynews.com/articles/30019-Hockey-coaches-trainers-talk-safety-pressure-to-play-at-concussion-seminar.html>.

⁹⁶ *Id.*

⁹⁷ *Id.* (explaining that hockey is not the only sport experiencing these issues).

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ McGrath, *supra* note 8, at 12.

¹⁰¹ Davis, *supra* note 11, at 219. See generally Brianna J. Schroeder, Note, *Power Imbalances in College Athletics and an Exploited Standard: Is Title IX Dead?*, 43 VAL. U. L. REV. 1483, 1513–20 (2009) (discussing several of the control features in collegiate sports and the influences that push players to continue playing).

¹⁰² *Robitaille v. Vancouver Hockey Club Ltd.* (1981), 124 D.L.R. 3d 228, 230 (Can. B.C. C.A.).

games despite their injuries, because, after all, paying fans are there to see them.¹⁰³ In the 1999–2000 NHL season, Eric Lindros suffered a total of four concussions.¹⁰⁴ In response, General Manager Bob Clarke questioned the severity of Lindros' concussions and criticized the Lindros family—who had voiced their opinions in favor of Lindros' health—for “meddling.”¹⁰⁵ Lindros eventually lost his captaincy following the ensuing drama.¹⁰⁶

The Robitaille and Lindros anecdotes illustrate that athletes are often motivated to conceal injuries in order to stay in the good graces of coaches and management. Robitaille and Lindros resisted such pressure, but they were both veteran players who were already established in the NHL.¹⁰⁷ Conversely, the majority of athletes in professional contact sports, like the NHL and NFL, find themselves in stages of their careers where respect is still being earned. Indeed, a study of high school athletes found that forty-seven percent had suffered a concussion in a single season, while another study revealed that trainers were only aware of concussions in four percent of high school players.¹⁰⁸ When the athletes were asked why they did not report their concussions to trainers and coaches, common answers were that they “didn't want to leave the game, didn't want to let teammates down, didn't want to appear weak or injury-prone to the coach, [and] didn't want to risk losing playing time or a starting position”¹⁰⁹ Therefore, athletes who are in a position where they must prove themselves to coaches are often highly motivated to conceal injuries in order to stay in the game.

Lastly, public pressure causes athletes to mask their injuries in favor of maintaining a positive reputation in the media spotlight.¹¹⁰ The

¹⁰³ Davis, *supra* note 11, at 220.

¹⁰⁴ *Lindros Hangs up Skates After 13 NHL Seasons*, USA TODAY, Nov. 8, 2007, http://www.usatoday.com/sports/hockey/nhl/2007-11-08-lindros-retirement_N.htm.

¹⁰⁵ *Id.*

¹⁰⁶ *Id.*

¹⁰⁷ Mike Robitaille was in the NHL for more than six seasons before filing his complaint against the Vancouver Canucks' medical staff. *Mike Robitaille: Stats*, NHL.COM, <http://www.nhl.com/ice/player.htm?id=8448373> (last visited Apr. 5, 2012). Likewise, Eric Lindros was in the NHL for seven seasons before complaining about the Philadelphia Flyers' medical staff. *Eric Lindros: Stats*, NHL.COM, <http://www.nhl.com/ice/player.htm?id=8458515#&navid=nhl-search> (last visited Oct. 12, 2012).

¹⁰⁸ CARROLL & ROSNER, *supra* note 5, at 48.

¹⁰⁹ *Id.*

¹¹⁰ See Davis, *supra* note 11, at 221 (“The public's attitudes concerning sports may well represent an affirmation of the athletes' duty to sacrifice their physical health.”); see also Ross Tucker, *Truth About Players Playing Injured*, SPORTSILLUSTRATED.COM (Dec. 2, 2009, 2:54 PM), http://sportsillustrated.cnn.com/2009/writers/ross_tucker/12/02/concussions/index.html (asserting that players also feel pressure to play through an injury because they feel a sense of responsibility to their teammates). “[There] is a sense of responsibility to

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'macho' attitude that permeates the sports industry is not sympathetic to athletes who are constantly out on injured reserve.¹¹¹ In the contemporary sports arena, it is recognized that "[t]he wrath of the fan is often directed at a star player who expresses a concern about his health while praise is given to the marginal player who volunteers to play hurt."¹¹² These pressures contribute to the motivated athlete's tendency to downplay or conceal the severity of his injury. This tendency has the potential to create tremendous causation problems for prospective allegations of medical malpractice against team-physicians.

If an athlete causes his own injury by concealing an earlier injury from team medical staff, then he ought to be unsuccessful in a medical malpractice action against the team-physician. This makes sense given that a physician cannot breach a duty if he has no reason to know that an athlete-patient is hurt.¹¹³ However, it cannot be assumed that all athletes conceal their injuries, because to do so would essentially prevent an athlete from negating causation of his own injuries and, consequently, from bringing a successful medical malpractice action against a team-physician who has engaged in medical malpractice. While the tendency of motivated athletes to conceal their injuries cannot be ignored, it has to be acknowledged that in the event that the team-physician is at fault, it would be difficult for an athlete to prove that he was not the cause of his own injury. As if the causation problem is not complicated enough by the athlete's concussion concealment, the following section explains how team-physicians face their own pressures to allow athletes to prematurely return to play.

2. Questionable Loyalty of Team Physicians

As Michael Landis explains, the loyalty that a team-physician has to an athlete-patient is often compromised by the physician's desire for fame, success, and various conflicts of interest that lend themselves to the position.¹¹⁴ The possibility that such factors might persuade a team-

play through pain because of the understanding that your teammates would do the same." *Id.*

¹¹¹ See Davis, *supra* note 11, at 218 ("The athlete is rewarded for his actual performance by not being carried on 'injured reserve' or being labeled 'injury prone.'").

¹¹² *Id.* at 221 (footnote omitted).

¹¹³ There are exceptions to this rule, for example, in instances when a physician should have known about an injury despite an attempted concealment by an athlete. It is important to note that the issue is not black and white and that there are instances where the athlete and physician are both legally responsible for an injury.

¹¹⁴ Landis, *supra* note 81, at 147. One author has suggested that there are four duties that accompany the sports medicine physician, which include the duty to:

Protect athletes from injury, re-injury, or permanent disability, placing

physician to favor the team over the athlete complicates the task of assigning negligence when an athlete prematurely returns to play.

First, the method by which a physician creates a relationship with a team suggests a dynamic favorable to management.¹¹⁵ Ordinarily, a physician is either retained with an employer-employee status or as an independent contractor.¹¹⁶ However, it is becoming increasingly common for teams to select physicians using a bidding method, where physicians will actually pay to become the team-physician.¹¹⁷ Whatever the method of selection, physicians typically use their status with the team as a form of advertising.¹¹⁸ Furthermore, physicians commonly become involved in the industry to satisfy an affection for sports, often receiving benefits in the form of free tickets and opportunities to meet athletes.¹¹⁹ The desire for the fame and success associated with the position can interfere with a physician's loyalty to their athlete-patients. For instance, a physician might feel pressured to treat an athlete according to the interests of management in order to preserve his position as the team-physician.

The position of team physician carries with it numerous potential conflicts of interest given the physician's ethical obligation in treating patients.¹²⁰ Such conflicts of interest may occur between the team-

their welfare over that of the team or other competing interests;

Offer candid and full disclosure as to the nature and extent of injuries and the consequences of returning to play;

Practice good medicine, as defined by practice guidelines and consensus statements; and

Enable players to avoid unnecessary risk, 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.

Barry R. Furrow, *The Problem of the Sports Doctor: Serving Two (Or is it Three or Four?) Masters*, 50 ST. LOUIS U. L.J. 165, 172 (2005).

¹¹⁵ Landis, *supra* note 81, at 147.

¹¹⁶ *Id.*

¹¹⁷ See Kain, *supra* note 87, at 708 ("An emerging practice in sports medicine involves medical providers auctioning off the right to be an NFL team's official medical provider, hospital, or physician-group.") (internal quotation marks and footnotes omitted). For instance, Major League Soccer, the Orlando Magic, the Jacksonville Jaguars, and the Carolina Panthers all use this selection method. Landis, *supra* note 81, at 147.

¹¹⁸ See Kain, *supra* note 87, at 708 (asserting that a physician may provide a team with medical care for free or at a reduced cost in return for the good publicity that accompanies the prestige of serving as a professional team's "official healthcare provider").

¹¹⁹ Landis, *supra* note 81, at 147.

¹²⁰ See *id.* at 148 (explaining that once a physician accepts a position with a team,

physician and management, the team-physician and the athlete, the team-physician and third parties, and the team-physician and the athlete's family.¹²¹ The conflict between a team-physician and management is the most intuitive. The management acts as the physician's employer, provides the physician's paycheck, and has the ability to select another physician.¹²² Moreover, the management has an interest in having all of its star athletes on the field in order to maximize revenues.¹²³ Consequently, the physician is stuck between the conflicting interests of its management-employer and the obligations owed to the athlete-patient.¹²⁴ This becomes even more difficult for the physician when dealing with a motivated athlete that prefers to be "fixed" rather than "cured."¹²⁵ Team-physicians are not only caught between the interests of management and the duty owed to an athlete, but also between a duty owed to an athlete and the athlete's desire to play through an injury.¹²⁶ While the interests of management and the motivated athlete in playing injured might be consistent, they conflict with the physician's ethical duties.

The team-physician can also experience a conflict of interest with third parties.¹²⁷ For instance, when a team-physician makes a statement to the press, there are huge consequences in the media for the athlete's agent and family.¹²⁸ Whatever the physician says can directly or indirectly affect the value of the athlete's next contract or the decision of

numerous conflicts of interest arise and plague the development of that trust); Kain, *supra* note 87, at 708 (contending that the NFL, like any successful business, creates an atmosphere where numerous conflicts arise because of the money-making nature of the enterprise). "In order for teams to maximize profit through winning games, it stands to reason that coaches and management place incredible pressure on trainers to return their most talented athletes to the playing field as soon as possible." *Id.* at 708-09 (footnote omitted).

¹²¹ Landis, *supra* note 81, at 148-51.

¹²² *Id.* at 148.

¹²³ *Id.* at 149. Some might argue that it is contrary to both the short-term and long-term goals of management to play injured athletes. After all, it is intuitive that injured athletes do not perform as effectively as when they are healthy. However, depending on the injury, an athlete's actual physical ability to perform might not be compromised by the injury. For instance, if a quarterback is suffering from a sore shoulder, the athlete could seek a "fix" that could numb the shoulder in order for him to perform relatively comfortably during a game. This is especially true of cognitive injuries, such as a concussion, where a player's physical ability to perform is not necessarily diminished.

¹²⁴ *Id.* at 150.

¹²⁵ Davis, *supra* note 11, at 216.

¹²⁶ Landis, *supra* note 81, at 150 ("The mottos 'no pain, no gain' and 'winning is everything' are attitudes extending past the competition and the locker room.") (footnote omitted).

¹²⁷ *Id.* at 150-51.

¹²⁸ *Id.* at 150.

whether his current team exercises an option under the current contract.¹²⁹ Also, the physician often develops a relationship with the athlete's family and may be sympathetic to the fact that the athlete is their sole source of income.¹³⁰ With so much pressure to permit athletes to return to play, it is not so farfetched to believe that a team-physician may abuse his or her discretion and allow an athlete to return prematurely or downplay the severity of an athlete's injury. In fact, many athletes have accused their team physicians of breaching the loyalty they feel that they ought to have from their physician.¹³¹ For example, Eric Lindros accused the Philadelphia Flyers' medical staff of downplaying the seriousness of his head injuries in order to push him to compete.¹³²

A physician's discretion in permitting an athlete to return to play after a concussion is particularly dangerous given the invisible nature of the injury.¹³³ "For most people who sustain a concussion, there is no way to document the damage, no way to explain the bizarre and wide-ranging symptoms they experience each day, [and] no way to prove beyond any doubt that there's actually an injury."¹³⁴ Under the current policies, if an athlete prematurely returns to play before recovering from a concussion, it is difficult to know whether it is the result of a physician's abuse of discretion, a motivated athlete's concealment of symptoms, or both. Consequently, it is difficult to determine whether the physician or athlete is a proximate cause of the injuries that result from a premature return to action without solely relying on the testimony about what was or was not conveyed to the physician during an examination. In order to avoid reliance on the testimony of

¹²⁹ *Id.* at 151; Crow, *supra* note 92 (illustrating how an NFL contract can be contingent on the ongoing health of the athlete).

¹³⁰ Landis, *supra* note 811, at 151. While one might assume that the best economic decision for an athlete is to be health cautious in order to extend ones career as long as possible, it is evident that short-term health can have astronomical effects on the financial opportunities afforded to athletes. *See supra* note 96 (illustrating the opportunity costs that professional athletes face when considering their health versus the economic gains). Thus, a physician may feel pressure to conceal an athlete's injury at a particular point in time.

¹³¹ *See, e.g.,* Landis, *supra* note 81, at 150 (providing an example from the NHL of one such athlete).

¹³² *Id.*

¹³³ *See* Schroeder, *supra* note 101, at 1517-20 (stating that athletic trainers and physicians have a substantial amount of power over an injured athlete, because they have the power to tell the individual whether he or she can play again). Even if there is some objective test to gauge whether an athlete is fit to play, the final word rests with the trainer. *Id.* at 1518 n.168. This power is compounded by the fact that an athlete often cannot afford to spend an extended period of time away from the game. *Id.*

¹³⁴ CARROLL & ROSNER, *supra* note 5, at 142.

physicians and athletes during litigation, there ought to be a level of objectivity infused into return to play policies.

B. The Difficulty in Bringing a Medical Malpractice Action Against a Team-Physician

Courts have applied general medical malpractice principles to actions brought by athletes who allege improper treatment of athletic injuries by trainers or physicians.¹³⁵ Thus, liability of a trainer or physician for medical malpractice will depend on whether the appropriate standard of care has been followed.¹³⁶ However, there are various roadblocks that could prevent an athlete from bringing a medical malpractice action against team trainers or physicians.¹³⁷ For instance, a medical malpractice action depends on the existence of a physician-patient relationship, which can be difficult to establish with respect to team-physicians who are hired by third-party employers.¹³⁸ Moreover, if a workers' compensation statute controls, it has been held that "a coemployee physician is immune from malpractice liability to an injured athlete if the physician was acting within the scope of employment when the injury-causing conduct occurred."¹³⁹ In such cases, an athlete's exclusive remedy may be limited to a workers' compensation action against the team.¹⁴⁰

1. Existence of a Physician-Patient Relationship

The prerequisite of establishing a physician-patient relationship creates a potential roadblock for athletes bringing malpractice claims against examining physicians by virtue of the way some courts have defined the relationship.¹⁴¹ The nature of the physician-patient relationship between a team-physician and an athlete is sometimes hard to define, because the patients are the athletes but sports physicians are employed by a third party.¹⁴² Consequently, whether the requisite

¹³⁵ Matthew J. Mitten, Annotation, *Medical Malpractice Liability of Sports Medicine Care Providers for Injury to, or Death of, Athlete*, 33 A.L.R. 5th 619, § 5, at 637-38 (1995).

¹³⁶ *Id.*

¹³⁷ *Id.* § 8, at 639-40.

¹³⁸ See *infra* Part IV.B.1 (discussing the significance of the existence of a physician-patient relationship).

¹³⁹ Mitten, *supra* note 140, § 8, at 639.

¹⁴⁰ *Id.* at 640 (examining the court's reasoning in *Hendy v. Losse*, 819 P.2d 1, 3 (Cal. 1991)).

¹⁴¹ Craig A. Isaacs, Comment, *Conflicts of Interest for Team Physicians: A Retrospective in Light of Gathers v. Loyola Marymount University*, 2 ALB. L.J. SCI. & TECH. 147, 154 (1992).

¹⁴² *Id.* "The matter is additionally complicated by the athlete's status as either a professional, college, or sanctioned athlete. Each characterization requires that a different

physician-patient relationship exists is influenced by the nature of the care provided to the athlete.¹⁴³

The nature of care given to the athlete is significant to the determination of a physician-patient relationship, because it reveals whether the physician's purpose in seeing an athlete is to benefit the patient or a third party.¹⁴⁴ While it is generally held that a third-party-hired physician forms a physician-patient relationship with athletes that they treat therapeutically, courts are divided as to whether such a relationship is formed when a physician sees a patient strictly for examination purposes and when such an examination is intended only for the benefit of the third-party employer.¹⁴⁵ Courts have held that "when the physician is retained . . . for the purpose of performing a screening examination, as opposed to therapeutic treatment, the physician is not liable if . . . [the physician] 'does not intend to treat or benefit the patient and does not injure [the patient] during the examination.'" ¹⁴⁶ However, while such a division exists, there is general agreement that such a relationship creates a limited duty on the part of the examining physician not to cause injury to the examinee through affirmative treatment or advice on a course of treatment.¹⁴⁷

A pair of cases decided by the Supreme Court of New York illustrate this principle. In *Murphy v. Blum*, the court found that a physician-patient relationship was not formed between an NBA referee and a physician who was retained by the NBA solely to advise the league of whether the referee was physically fit for employment.¹⁴⁸ In *Murphy*, the physician was retained solely as an advisor for the league and not for the examinee.¹⁴⁹ Accordingly, the results of the examination were

criteria apply." *Id.* at 155.

¹⁴³ *Id.* at 154–55.

¹⁴⁴ *Id.* at 155.

¹⁴⁵ *Id.* at 155–56.

¹⁴⁶ *Id.* at 155 (quoting DAVID W. LOISELL & HAROLD WILLIAMS, *MEDICAL MALPRACTICE* ¶ 8.02[5] (1991)); see also *Williams v. Nat'l R.R. Passenger Corp.*, 16 F. Supp. 2d 178, 181 (D. Conn. 1998) (holding that no physician-patient relationship exists between a physician who is merely conducting a drug test and an employee who was compelled by his employer to participate).

¹⁴⁷ *Heller v. Peekskill Cmty. Hosp.*, 603 N.Y.S.2d 548, 549 (N.Y. App. Div. 1993); see also *Dyer v. Trachtman*, 679 N.W.2d 311, 315 (Mich. 2004) ("The limited relationship . . . imposes a duty on the IME [independent medical examination] physician to perform the examination in a manner not to cause physical harm to the examinee."); *Devitre v. Orthopedic Ctr. of St. Louis, LLC.*, 349 S.W.3d 327, 332 (Mo. 2011) ("[A] physician who only provides an independent medical examination but does not treat the examinee 'has a limited physician-patient relationship with the examinee that gives rise to limited duties to exercise professional care.'" (quoting *Dyer*, 679 N.W.2d at 314).

¹⁴⁸ 554 N.Y.S.2d 640, 642 (N.Y. App. Div. 1990).

¹⁴⁹ *Id.*

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communicated to the league with a copy forwarded to the examinee's private physician, but not necessarily to the examinee himself.¹⁵⁰ The court found that because the physical examination was solely for the benefit of a third party, a physician-patient relationship had not been formed.¹⁵¹

However, in *Heller v. Peekskill Community Hospital*, the same court pointed out an exception to this rule, which occurs when the examining doctor causes further injury by either treating the patient or advising the patient as to a course of treatment.¹⁵² In *Heller*, the court reversed a lower court's grant of summary judgment in favor of the defending physician, because the patient could have relied on the physician's advice that he could return to work.¹⁵³ The court specified that "[i]n order for affirmative advice to be actionable, the plaintiff must prove: (1) that the advice given was incorrect, (2) that it was foreseeable that the plaintiff would rely on such advice, and (3) that the plaintiff did in fact rely on the advice to his or her detriment."¹⁵⁴ While these elements establish a physician-patient relationship under New York law, they are indicative of a larger trend to recognize the creation of a physician-patient relationship when a physician offers bad advice and it is foreseeable that a patient may rely on the advice.¹⁵⁵

In the case involving the nature of care between a team-physician and an athlete under the new concussion guidelines, it is not certain whether a court will find that the requisite physician-patient relationship exists. For instance, a court could view the SCAT 2 testing process as analogous to the physical examination in *Murphy*. Like *Murphy*, the SCAT 2 examination could be considered as merely serving an advisory function to the team in order to guide them in strategic coaching decisions and compliance with concussion management protocol. Consequently, physicians might not be found to have established the requisite physician-patient relationship that would create the traditional *duty* owed by a physician to a patient. Moreover, it is not clear that an athlete can rely on an exception by the reasoning noted in *Heller*, because

¹⁵⁰ *Id.* at 641.

¹⁵¹ *Id.* at 642.

¹⁵² *Heller*, 603 N.Y.S.2d at 549-50.

¹⁵³ *Id.* at 550.

¹⁵⁴ *Id.*

¹⁵⁵ See *Greenberg v. Perkins*, 845 P.2d 530, 536 (Colo. 1993) ("[A] physician owes a duty to the person being examined to exercise professional skill so as not to cause harm to that person by negligently performing the examination."); *Devitre v. Orthopedic Ctr. of St. Louis, LLC.*, 349 S.W.3d 327, 329 (Mo. 2011) ("Recipients of an independent medical examination are patients of the physician for the limited purpose of conducting the examination.").

the physician does not necessarily give the athlete or team *advice*, but, rather, is relied on merely to perform the SCAT 2 testing and inform the team about the results.

2. A Physician's Duty of Care to an Athlete

Even if a court finds that a physician-patient relationship exists between a team-physician and an athlete, there are additional obstacles that challenge an athlete's ability to prove duty and breach. Defining the relationship between a physician and a patient is crucial in determining the duty of care that a physician owes to that patient. Generally, the duty of care owed by a physician to his or her patient is that of a reasonably competent physician of a similar class under similar circumstances.¹⁵⁶ This standard is modified in the case of physicians who hold themselves out as specialists, because they ordinarily require a higher standard of care based on the specialty.¹⁵⁷

While courts have not yet treated sports physicians as a specialty, there is a movement advocating for such treatment.¹⁵⁸ As one author explains, "there has been an insurgence of many different types of physicians, including family physicians, orthopedists, general practitioners, osteopaths, internists, general surgeons, pediatricians, and obstetricians and gynecologist acting as a team physician."¹⁵⁹ While some commentators argue that team-physicians should be held to the standard of their *actual* specialty, others argue for recognition of sports medicine as a specialty.¹⁶⁰ Currently, however, courts require that team-physicians follow "good medical practice."¹⁶¹ This means that the conduct of sports physicians will be evaluated by conformity to the conduct of other similarly specialized physicians under similar circumstances.¹⁶² In other words, the duty of care a physician owes an athlete is determined on a case-by-case basis predicated on the specific treatment and care provided.¹⁶³

Generally, the duty an examining physician owes to a patient is simply to perform the examination properly in accordance with good

¹⁵⁶ Isaacs, *supra* note 141, at 156.

¹⁵⁷ *Id.* at 156-57.

¹⁵⁸ Matthew J. Mitten, *Team Physicians and Competitive Athletes: Allocating Legal Responsibility for Athletic Injuries*, 55 U. PITT. L. REV. 129, 144 (1993); Landis, *supra* note 81, at 141.

¹⁵⁹ Landis, *supra* note 81, at 141.

¹⁶⁰ Mitten, *supra* note 158, at 144.

¹⁶¹ *Id.*

¹⁶² *Id.* at 144-45.

¹⁶³ Landis, *supra* note 81, at 141.

medical practice.¹⁶⁴ In *Rosensweig v. State*, the court declined to find a pre-fight examining physician liable for the death of a prizefighter who he had cleared for a boxing match after recently suffering two knockouts in two months.¹⁶⁵ The court pointed to the fact that the physician functioned purely to advise the fight promoter of the patient's ability to perform.¹⁶⁶ Evidence of previous physicians' reports indicating that the decedent boxer had not suffered brain damage as a result of the previous two knockouts suggested that the physician's decision to clear the boxer could be based solely on the results of the current physical examination.¹⁶⁷ Thus, the court found that the duty the physician owed to the boxer was simply to conduct the physical examination in a professional manner in accordance with good medical practice.¹⁶⁸ Given the finding that the examination was conducted properly, the doctor met the duty of care owed to the boxer.¹⁶⁹

In the absence of a generally recognized "sports physician specialty," the standard with which to gauge what constitutes "good medical practice" has the potential to be quite low.¹⁷⁰ For example, a gynecologist that is appointed as a team-physician owes a duty of a reasonably prudent gynecologist of his or her skill level under similar circumstances.¹⁷¹ Consistent with *Rosensweig*, a court is likely to find that good medical practice in performing SCAT 2 or other baseline concussion tests merely requires conducting the test in a professional manner.¹⁷² Therefore, unless a team-physician did not perform the baseline concussion assessment properly, it is likely to be extremely difficult to prove that a team-physician has breached the duty owed to an athlete. This poses a significant issue given the mysterious nature of concussions and the medical community's limited ability to solve the issue.¹⁷³

¹⁶⁴ See *Rosensweig v. State*, 171 N.Y.S.2d 912, 914 (N.Y. App. Div. 1958) (holding that there is no duty to prevent a fighter from participating in a fight when a properly conducted medical examination revealed that the examinee was in good medical condition).

¹⁶⁵ *Id.* at 913-14.

¹⁶⁶ *Id.*

¹⁶⁷ *Id.* at 914.

¹⁶⁸ *Id.*

¹⁶⁹ *Id.*

¹⁷⁰ See Landis, *supra* note 81, at 141 ("Since courts have yet to recognize sports medicine as a separate medical specialty, it appears that a team physician's liability for malpractice will still be decided on a case-by-case basis.") (footnote omitted).

¹⁷¹ See *id.* ("The result is a standard measurement of the physician's conduct by what is commonly done by other physicians in the same specialty.") (footnote omitted).

¹⁷² See 171 N.Y.S.2d at 614 (providing an example of how an examining physician will not be held liable for an athlete's injury or death if the doctor conforms to good medical practice).

¹⁷³ See CARROLL & ROSNER, *supra* note 5, at 142-43 (highlighting the difficulty of

3. Workers' Compensation Statutes

Even if a court finds the requisite physician-patient relationship and a violation of the duty owed by a team-physician to the athlete-patient, an athlete could still be prevented from bringing a cause of action. Because return to play guidelines adopted by professional sports leagues rely on the advice of a trainer or a physician provided by the team, it is possible that applicable workers' compensation statutes prohibiting actions brought against co-employees may prevent athletes from bringing medical malpractice actions against medical service providers.¹⁷⁴

A California court dismissed a football player's medical malpractice action against the team-physician by virtue of a workers' compensation statute prohibiting tort actions against co-employees.¹⁷⁵ In *Hendy v. Losse*, the plaintiff suffered several injuries to his right knee while playing in regular season games and practices for the San Diego Chargers.¹⁷⁶ The defendant team-physician who treated each of the plaintiff's injuries consistently advised the plaintiff to continue playing.¹⁷⁷ The court noted that the defendant either "lacked the knowledge and skill necessary to properly diagnose and treat plaintiff's condition or, although aware of the condition, advised plaintiff to continue to play football, with the result that [the] plaintiff suffered irreparable and permanent injury to his right knee."¹⁷⁸ The plaintiff later consulted a private physician, who "discovered that the cause of his injuries was [the] defendant's failure to properly diagnose and treat his condition."¹⁷⁹ While recognizing that the plaintiff's injuries were the result of the defendant physician's negligent treatment, the court ruled in favor of the defendant by virtue of the applicable workers' compensation statute barring relief from co-employees.¹⁸⁰ The court reasoned that as long as the "defendant was acting within the scope of

recognizing concussions and the limited understanding among the medical community about the effects and reasons for concussions).

¹⁷⁴ See *infra* notes 179–88 and accompanying text (providing examples of athletes who were barred from bringing malpractice claims because of their states' workers' compensation statutes); see also Michelle L. Modery, Comment, *Injury Time-Out: Justifying Workers' Compensation Awards to Retired Athletes with Concussion-Caused Dementia*, 84 TEMP. L. REV. 247, 256 (2011) ("The majority of state statutory workers' compensation provisions do not explicitly mention how to treat professional athletes.").

¹⁷⁵ *Hendy v. Losse*, 819 P.2d 1, 3 (Cal. 1991).

¹⁷⁶ *Id.* at 3–4.

¹⁷⁷ *Id.* at 3.

¹⁷⁸ *Id.* at 3–4 (footnote omitted).

¹⁷⁹ *Id.* at 4.

¹⁸⁰ *Id.* at 11.

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his employment when he diagnosed and/or treated plaintiff," the plaintiff's exclusive remedy is limited to a workers' compensation action brought against the employer.¹⁸¹

Athletes who have medical malpractice causes of action against team-physicians for the mistreatment of concussions can be met with the same fate as the plaintiff in *Hendy* if the applicable workers' compensation statute prohibits such actions. Such an inquiry is dependent upon the nature of the relationship between the team and the physician, as well as the applicable workers' compensation statute.¹⁸² If physicians are aware of the difficulty that an athlete will have in bringing a medical malpractice action, there is a greater potential for moral hazard with regard to medical malpractice. Given the pressures a physician faces to permit injured athletes to return to play and the difficulties that athletes face in bringing a medical malpractice action, physicians may be incentivized to permit a concussed athlete to return to play.¹⁸³

C. *A Note on the Assumption of Risk and Comparative Negligence Doctrines in Sports*

It is natural to question whether an athlete ought to be able to recover damages for injuries suffered as a consequence of his voluntary participation in inherently violent sports such as hockey or football. Traditionally, the assumption of risk doctrine functions as a complete bar to a plaintiff's recovery if it is established that the plaintiff knowingly and voluntarily exposed himself to the risk that resulted in his injury.¹⁸⁴ However, the emergence of the comparative negligence doctrine has changed the way courts treat the assumption of risk doctrine.¹⁸⁵ Under the comparative negligence model, the total recovery is reduced based on the relative culpability of the plaintiff.¹⁸⁶ It is important to note that many states use a modified comparative negligence model, in which case

¹⁸¹ *Id.* at 12.

¹⁸² *See supra* Part IV.B.1 (discussing the implications of the physician-patient relationship); Part IV.B.3 (examining the effect of workers' compensation statutes on a plaintiff's ability to file a malpractice action against a treating physician).

¹⁸³ *See supra* Part III.A (explaining the potential physician motivation to overlook an athlete's injuries); Part III.B (explaining the roadblocks that an athlete faces when bringing a medical malpractice action against a team-physician).

¹⁸⁴ John L. Diamond, *Assumption of Risk After Comparative Negligence: Integrating Contract Theory into Tort Doctrine*, 52 OHIO ST. L.J. 717, 718 (1991) (explaining that assumption of risk historically "constituted a complete defense" to negligence).

¹⁸⁵ *Id.* at 719.

¹⁸⁶ *Id.* at 719-20.

if the plaintiff's negligence exceeds that of the defendants' negligence, then the plaintiff is barred from recovery.¹⁸⁷

Within the jurisdictions that have adopted a comparative negligence standard, there are differing views on how the traditional assumption of risk doctrine should apply.¹⁸⁸ While some courts continue to treat assumption of risk as a complete bar to a plaintiff's recovery, the majority of courts using the comparative negligence model have absorbed the implied assumption of risk doctrine into the comparative negligence framework.¹⁸⁹ Therefore, if the concussion-associated injuries of professional athletes are at least in part the result of a physician's negligence, then the athlete may be able to recover damages despite the traditional recovery-barring assumption of risk doctrine.¹⁹⁰ Moreover, if the concussion-associated injuries of professional athletes are the result of a physician's intentional mistreatment, then athletes may recover full damages given that comparative negligence is not a defense to intentional torts.¹⁹¹ Thus, within the comparative negligence framework, the assumption of risk doctrine should operate solely to determine the plaintiff's level of culpability for his own injuries.

In the case of professional athletics, the question of an athlete's negligent contribution to his own injuries turns on his knowledge of the risk he is assuming by participating in the sport.¹⁹² While the science on concussions has advanced, there has been widespread acknowledgement of the dangers by both professional sports leagues and athletes themselves.¹⁹³ The injury has received ample news coverage, and many athletes have even pledged to donate their post-mortem brains to CTE research with the Sports Legacy Institute associated with Boston

¹⁸⁷ 3 Jacob A. Stein, *Modified or Percentage of Fault System*, in STEIN ON PERSONAL INJURY DAMAGES TREATISE § 14:8 (3d ed. 2012).

¹⁸⁸ Diamond, *supra* note 184, at 721.

¹⁸⁹ See *id.* at 722 ("To the extent that implied assumption of risk is deemed reasonable and consequently does not overlap with contributory negligence, implied assumption of risk ceases to be any defense.").

¹⁹⁰ *Id.* at 740.

¹⁹¹ *Id.*

¹⁹² See, e.g., *Rosensweig v. State*, 171 N.Y.S.2d 912, 914 (N.Y. App. Div. 1958) ("Decedent was engaged in a concededly dangerous activity. From his experience he knew that he would likely be struck by blows to the head. . . . Decedent assumed the risks known to be inherent in the fight.").

¹⁹³ See *Pros to Contribute to Concussion Study*, ESPN.COM: NFL (Sept. 14, 2009), <http://sports.espn.go.com/nfl/news/story?id=4472274> (discussing NFL players who have pledged to donate their brains to science). Arizona Cardinals receiver Sean Morey described why he chose to donate his brain: "One of the most profound actions I can take personally is to donate my brain to help ensure the safety and welfare of active, retired, and future athletes for decades to come." *Id.*

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University.¹⁹⁴ Today's athletes should be aware of the dangers associated with concussions.

However, some athletes still elect to play injured. As one reporter noted about Pittsburgh Penguin's Forward Tyler Kennedy, "Kennedy, who missed a month earlier this season because of a concussion, said that for all the awareness about the dangers of concussions, players still feel pressure to play."¹⁹⁵ When an athlete consciously decides to play prior to fully recovering from a concussion, the athlete is evidently aware of the risk he is taking by doing so. However, the situation changes entirely when an athlete's belief that he has recovered from a concussion is based on the negligent or intentional mistreatment by a team-physician. Whether an athlete has, at least in part, negligently contributed to his own injury by returning to play with a concussion depends upon whether or not the athlete believes that he has suffered a concussion and whether he believes he has completely recovered from it.

V. PROPOSED SOLUTIONS

Proposed solutions that would remedy the problems outlined above include (1) the implementation of technology to minimize physician discretion and reduce the dependence on personal candor of motivated athletes and (2) making policy changes that heighten physician accountability.

A. *Implementation of Technology*

While technology that is able to detect the actual occurrence of a concussion does not exist, technology does exist to detect "impact conditions likely to cause a concussion."¹⁹⁶ Riddell Sports' patented Head Impact Telemetry System ("HITS") functions as an early-warning system for concussions, as well as a way to cumulatively track hits to the head during a game.¹⁹⁷ HITS is marketed by Riddell as a helmet that

¹⁹⁴ *Id.*

¹⁹⁵ Shelly Anderson, *Penguins Notebook: Kennedy Says There's Pressure to Play Hurt*, POST-GAZETTE.COM (Dec. 21, 2011), <http://old.post-gazette.com/pg/11355/1198297-61-0.stm>.

¹⁹⁶ John Mangels, *Technology May Help Detect a Concussion, but the Methods Are Still Evolving*, CLEVELAND.COM (Jan. 15, 2012, 9:00 AM), http://www.cleveland.com/science/index.ssf/2012/01/technology_may_help_detect_a_c.html.

¹⁹⁷ *Id.* Although Riddell patented this technology, it was originally developed by Dr. Stefan Duma from the Virginia Tech-Wake Forest School of Biomedical Engineering and Sciences. Mike Barber, *Va. Tech at the Forefront of Football Helmet Safety*, RICHMOND TIMES-DISPATCH, Sept. 25, 2012, <http://www2.timesdispatch.com/sports/high-school-xtra/2012/sep/25/tdmain01-va-tech-at-the-forefront-of-football-helm-ar-2231433/>. Duma developed a way to test how well a specific helmet protects the individual wearing it. *Id.* Six sensors inside the helmet provide data to team-physicians about the rate of head

contains sensors tucked into the padding of each helmet and detects “[a]ny shock above a pre-set threshold.”¹⁹⁸ The device can be programmed to contact team-physicians whenever a hit exceeds a certain force, thereby notifying them to examine the athlete for signs of a concussion.¹⁹⁹

This technology represents a significant step forward from the current concussion management protocol in the NHL and NFL, where sideline concussion testing is only performed after someone notices an athlete displaying symptoms.²⁰⁰ In fact, proponents of this technology urge that it would benefit athletes at the professional level.²⁰¹ Referring to a brutal helmet-to-helmet tackle that resulted in Cleveland Brown’s quarterback Colt McCoy suffering a concussion, proponents suggest that “[t]he sensors probably would have flagged medical personnel to immediately evaluate . . . McCoy for a concussion.”²⁰² Rather, McCoy, who was permitted to play the remainder of the game, was sacked in the final seconds, and a post-game evaluation revealed that he suffered an “unusually severe, season-ending brain injury.”²⁰³

The unfortunate events that ended Colt McCoy’s season demonstrate that the current concussion detecting policies of the NFL, and similar ones in the NHL, are inadequate. The policies excessively rely on the judgment of trainers and medical staff to notice a significant collision and subsequent symptoms. The HITS technology considerably reduces the chance that an athlete can continue to play immediately after suffering a concussion. While the current system waits for an athlete to demonstrate symptoms of a concussion—potentially while on the field and vulnerable to a second impact—the HITS technology ensures that baseline concussion testing occurs immediately.

Utilization of HITS technology changes the picture of legal liability. An objective threshold by which to examine athletes that is free from human discretion will effectively minimize the concern that an athlete might be attempting to conceal an injury. Such objectivity removes the

acceleration during impact. *Id.* Coaching staff are even notified by pager if one of their players takes a big hit. *Id.*

¹⁹⁸ Mangels, *supra* note 196.

¹⁹⁹ *Id.*

²⁰⁰ *Concussions: New Rules for Treating NHL Players*, *supra* note 3; Gerardi, *supra* note 21, at 223.

²⁰¹ Mangels, *supra* note 196.

²⁰² *Id.* While some might complain that this may deteriorate the game’s pace, implementation of such technology could promote league administrators to alter the focus of the game from speed to athlete safety. Moreover, fans should appreciate such technology, because it would effectively improve the game by preserving the health of the best players in the sport, resulting in more lengthy careers.

²⁰³ *Id.*

concern that it is difficult to distinguish between an athlete's concealment and a physician's abuse of discretion. Additionally, HITS technology would advise an athlete whether he has likely suffered a concussion, thereby informing the comparative negligence assessment of whether an athlete is aware of the risks associated with returning to action. If concussion management is to be taken seriously, then this type of technology should be mandatory in all professional contact sports. While this technology is early in its development and only detects a force likely to have caused a concussion (as opposed to concussions themselves), it ought to be examined by league administrators and perhaps state legislators to eventually be used as a standard for reviewing a physician's judgment in medical malpractice proceedings.

B. Physician Accountability

A significant challenge in evaluating liability for the mistreatment of concussions is that it is difficult to define the duty owed by team-physicians to the athletes that they examine. Given the mysterious nature of concussions, to solve this issue there must be a rigid standard for defining a physician's duty owed to athletes with regard to baseline testing.²⁰⁴ This can be accomplished by recognizing sports physicians as a specialized group of physicians. If this were the case, then there could be a strict protocol for conducting such an evaluation, and, specifically, there would be a substantially lower risk of error. Given the changes in concussion policy by the NHL and NFL and the implementation of baseline testing, it follows that there should be specialized training to those performing such testing. Recognizing sports physicians as a specialty would acknowledge special customs that exist in such a practice area.²⁰⁵ Consequently, the concerns about the existence of a physician-patient relationship and the ensuing duty would be resolved. That is, the physician-patient relationship would be defined by the customs specific to sports physicians who treat a unique class of patients.

Physician loyalty and various conflicts of interest that result can be resolved by allowing player's associations to participate in the physician selection process. If professional sports leagues mandate such a hiring process, then there would not be as much of a concern that a physician

²⁰⁴ CARROLL & ROSNER, *supra* note 5, at 142-43.

²⁰⁵ If a "sports physician" was recognized as a specialization of medicine and HITS technology becomes the standard tool by which to decide if an athlete should be removed from a game or examined, then a custom could be established to dictate that if a player sustains *x* amount of force, then he must be removed for an examination. Adoption of such a policy would essentially fix the physician's duty, thereby clarifying instances of breach.

may feel pressured to abuse his or her discretion in favor of a management-employer.

VI. CONCLUSION

Contemporary research on concussions has illustrated that a relatively common injury in professional sports can be devastating to athletes who suffer from them. New information about the injury has forced professional sports leagues like the NHL and NFL to alter their concussion management protocol in an effort to minimize these disastrous effects.²⁰⁶ This Article has argued that the new policies make strides in the reduction of second-impact concussions, but they do not go far enough. The current return to play guidelines create problems in assessing medical malpractice liability of team-physicians. The proposed solutions, if implemented, would further reduce the possibility of second-impact concussions and clarify questions of liability in the event that an athlete who has suffered from a concussion has returned to action contrary to the concussion management policies.

The objective of these solutions is to clarify the landscape with respect to liability for an athlete's premature return to play after a concussion. Perhaps some athletes, now better informed about the nature of the injury, will be in a better position to make decisions about whether or not to continue playing. For instance, retired Tampa Bay Buccaneer Dave Pear described football as a "slow death."²⁰⁷ Ben McGrath described Pear in a *New Yorker* article on the state of football in the wake of the current concussion epidemic: "[Pear] has a miniscule pension, is uninsurable, and estimates that he has spent six hundred thousand dollars on surgeries and other medical issues . . . related to his football career. 'I'm not trying to end football' he said. 'It's not that I don't like football. . . . I [just] wish I had never played.'"²⁰⁸ However, not all athletes feel the same way. For instance, after Hines Ward was held out of a game due to a concussion, he voiced his objection, stating: "It's my body . . . I feel like if I want to go back out there I should have the right."²⁰⁹ In the event that either type of athlete elects to return to play after suffering a concussion and subsequently endures a second impact concussion, the new proposals would assist in the assessment of liability.

²⁰⁶ See Gerardi, *supra* note 21, at 223; *Concussions: New Rules for Treating NHL Player*, *supra* note 3, ("The NHL is adopting a more rigorous protocol for examining players with possible concussions.").

²⁰⁷ See McGrath, *supra* note 8.

²⁰⁸ *Id.*

²⁰⁹ *Id.*