LEGAL AND ETHICAL CONFLICTS ARISING FROM THE TEAM PHYSICIAN'S DUAL OBLIGATIONS TO THE ATHLETE AND MANAGEMENT

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Many legal issues may arise when a physician treats an athlete. When a physician is engaged by a school or professional team, and not by the athlete, a distortion of the traditional physician-patient relationship results which may further complicate the legal issues. This article will explore the rights of the athlete and the duty and standard of care of the physician in situations such as preparticipation physical examinations, treatment of injuries, determination of fitness after injury, prescription of pain killers, and privileged communications.

I. Introduction

The nature of sports medicine practice and the composition of its practitioners have changed greatly in the last fifteen years. Injured athletes were traditionally treated almost exclusively by orthopedists. The recent nationwide fascination with physical fitness has led, however, to an exponential increase in the number of physicians specializing in sports medicine.[1] Over 400 sports medicine clinics are in operation in the United States today.[2] Increased demand for treatment of sports related injuries has stimulated the evolution of this subspecialty. At one time, treatment of traumatic injuries by orthopedists was the only type of medical

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1 *See* SPORTS MEDICINE: FITNESS, TRAINING, INJURIES (O. Appenzeller and R. Atkinson eds. 1983) [hereinafter cited as Atkinson] (citing the President's Council on Physical Fitness and the Dept. of Commerce estimations that one hundred million Americans exercise regularly).

2 Scott, *Current Concepts in the Rehabilitation of the Injured Athlete*, 59 MAYO CLIN. PROC. 83, 83 (1984).

care athletes expected.[3] The sports medicine physician today, however, is increasingly required to provide primary care to the athlete.[4] Knowledge of orthopedics is still a prerequisite to the medical management of athletes, but an understanding of general medical principles as they apply to the unique physiology of the trained athlete is also required.[5] Sports medicine now applies medical science to preserve the health of the athlete and to improve his performance.[6] Because the emphasis has shifted from treatment only of injuries, physicians specializing in sports medicine have become a heterogenous group. Internists, cardiologists, family practitioners, pediatricians, nutritionists, and dermatologists have also declared themselves practitioners of sports medicine.[7] There are even gynecologists who specialize in the treatment of female athletes.[8]

The growth of publications dedicated to sports medicine is also a gauge of its increased popularity. Before 1970, there were very few medical treatises and journals addressing sports medicine. In the last fifteen years, however, there has been a steady growth in the number of journals specifically reporting sports related research;[9] and, in the last five years, a number of treatises which unify the data on sports medicine have been published.[10]

The popularity and diversification of sports medicine has led

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3 Murphy, *Forward* to SPORTS MEDICINE (R. Strauss ed. 1984).

4 *Id.*

5 *See* Atkinson, *supra* note 1, at 8. For example, statistics from the U.S. Olympic Team's physicians indicate that greater than eighty-five percent of athletes reporting for aid at Olympic events do so for reasons other than musculoskeletal problems. *Id.*

6 LaCava, *What Is Sports Medicine: Definition and Tasks*, 17 J. SP. MED. & PHYSICAL FITNESS 1 (1977). The author summarized the important dimensions of sports medicine to include (1) sports physiopathology—the study of human adaptation during training, (2) sports-medical evaluation—establishing the athlete's conditioning to the effort required, (3) sports traumatology—study of the treatment and prevention of traumatic injuries. Other areas mentioned were therapeutic sports, sports biotypology, and sports hygiene.

7 *See* Atkinson, *supra* note 1, at 9.

8 For example, Mona Shingold, M.D., who writes for the sports magazine, Runner's World.

9 *See, e.g.*, AM. J. SP. MED., J. SP. MED. & PHYSICAL FITNESS, PHYSICIAN'S SP. MED., MED. SCIENCE & SP., MED. SCIENCE SP. & EXERCISE.

10 *See, e.g.*, SCHNEIDER, SPORTS INJURIES: MECHANISMS, PREVENTION AND TREATMENT (1985); SPORTS MEDICINE (R. Strauss ed. 1984); O'DONOGHUE, TREATMENT OF INJURIES TO ATHLETES (4th ed. 1983).

to some collateral consequences. One important by-product is the medicolegal implications involved in this relatively young field. The last fifteen years have witnessed intense interest in medical malpractice. The case law on this subject, therefore, is extensive, in part because it is an area of law with high public visibility and impact.[11] The substantive law of medical malpractice, though still evolving, is well-developed.[12]

With a few exceptions, liability in medical malpractice cases is based on the underlying theory of negligence.[13] Negligence has been defined as "conduct which falls below the standard established by law for the protection of others against unreasonable risk of harm."[14] The elements which a plaintiff must establish to recover for negligent malpractice are: (1) the existence of the physician's duty to the plaintiff, usually based upon the physician-patient relationship;[15] (2) the applicable standard of care and its breach;[16] (3) a compensable injury;[17] and (4) a causal connection between the deviation from the standard of care and the injury.[18] When a physician is employed by a school or professional team the physician's legal duty and any violation of the standard of care are the elements primarily involved.[19] This article will first

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11 *See* AM. MED. ASSOC., SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE, PROFESSIONAL LIABILITY IN THE '80'S (1984) finding that:

> increasing numbers and costs of professional liability claims pose serious problems for physicians and the public. . . . After a temporary respite, numbers of claims are rising dramatically, forcing up professional liability insurance rates. Now, a 'new crisis in affordability' may be developing. This crisis threatens to drive up health care costs and reduce availability of some medical services.

Id. at 3.

12 There are numerous texts and treatises on the subject. For example: W. CURRAN & E. SHAPIRO, LAW, MEDICINE, AND FORENSIC SCIENCE (3d ed. 1982); W. WADLINGTON, J. WALTZ, & R. DWORKIN, CASES AND MATERIALS ON LAW AND MEDICINE (1980) [hereinafter cited as WADLINGTON]; HOLDER, MEDICAL MALPRACTICE (2d ed. 1978); J. KING, THE LAW OF MEDICAL MALPRACTICE IN A NUT SHELL (1977) [hereinafter cited as KING]; and D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE (1960) (updated annually with supplements).

13 *See* J. WEISTART & C. LOWELL, THE LAW OF SPORTS 985 (1979) [hereinafter cited as WEISTART].

14 RESTATEMENT (SECOND) OF TORTS § 282 (1964) [hereinafter cited as RESTATEMENT].

15 *See* Pohl v. Witcher, 477 So.2d 1015 (Fla. Dist. Ct. App. 1985).

16 *Id.*

17 *Id.*

18 *Id.*

19 *See* King, *Duty and Standard of Care for Team Physicians*, 18 HOUS. L. R. 657

explore the nature of the team physician's duty to the athlete and then attempt to define the standards of care in situations where the physician's dual allegiance may present a problem. The issues of causation and damages are also complex when athletes are involved, but a discussion of those issues is beyond the scope of this article.[20]

II. Duty and Standard of Care

Prosser defined duty as "an obligation, to which the law will give recognition and effect, to conform to a particular standard of conduct toward another."[21] As applied to medical malpractice, duty consists of two separable components. The first, the physician's duty to act, is usually predicated by the existence of a physician-patient relationship.[22] The second, the standard of care, is based upon society's expectation that physicians act reasonably under the circumstances. It defines the scope of actions expected from a physician upon undertaking to treat a patient.[23]

Ordinarily, a physician-patient relationship is not hard to find. It is broadly based on a professional medical relationship, which can originate in a number of ways, giving rise to rights and obligations independent of any agreement between the parties.[24] Virtually any overt act is sufficient to create a physician-patient relationship.[25] Even where it is difficult to find the traditional physician-patient relationship, courts have found the duty to ex-

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(1981) [hereinafter cited as *Team Physicians*]. King specifically addressed these issues, relying heavily on extrapolation from general malpractice law to explore its application to team physicians. *Id.* at 659.

[20] *Id.* at 660. Preexisting injury, multiple trauma, assumption of risk, and speculative nature of loss based upon anticipated earnings complicate the discussion of causation and damages when discussing athletes and malpractice. *Id.*

[21] W. PROSSER, HANDBOOK OF THE LAW OF TORTS 324 (4th ed. 1971) [hereinafter cited as PROSSER].

[22] *See* WADLINGTON, *supra* note 12, at 104.

[23] *Id.*

[24] There are two theories concerning the creation of the doctor-patient relationship. The "contract theory" finds the relationship to exist when an express or implied contract can be found which will impose an obligation upon the doctor. This narrow approach has been almost universally rejected in favor of the "undertaking theory" which basically holds that a physician, by undertaking care of a patient, creates a professional relationship with a corresponding duty of care to the patient. *See* KING, *supra* note 12, at 11; RESTATEMENT, *supra* note 14, § 323.

[25] *See, e.g.*, O'Neill v. Montifiori Hospital, 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960) where a physician's phone conversation with a previously unknown person

ist in instances where the doctor's actions were intended to affect the patient.[26]

When a physician works for a school or professional team, however, the matter becomes more complicated. It is clear that when the principal purpose of the physician's services is actual care and treatment, a physician-patient relationship will be found.[27] It is less clear that such a relationship will be found when the physician is hired for non-therapeutic purposes, such as preparticipation physical exams.[28] The traditional view is that no duty exists in circumstances where the examination is non-therapeutic.[29] However, many states hold that physicians may owe a duty of care to the patient to discover dangerous conditions during physical examinations paid for by third parties, and to report them to the examinee.[30] This duty is not necessarily coextensive with one that the physician owes to a private patient.[31]

Another problem which arises in this context is the extent to which the physician may limit the scope of his relationship to a patient. The physician-patient relationship is consensual in nature;[32] as a general rule, a physician may limit the scope of his professional involvement at the beginning of the relationship.[33] He must inform the patient of such limitations in advance unless such limitations are reasonably expected based upon common

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concerning the latter's condition was a sufficient undertaking from which a physician-patient relationship was found.

[26] *See, e.g.*, Rainer v. Grossman, 31 Cal. App. 3d 539, 544, 107 Cal. Rptr. 469, 472 (1973) listing factors which the court should consider in such situations. These factors were presented in a balancing formula which included: the foreseeability of harm; the certainty of the patient's injury; the closeness of the connection between the physician's conduct and the injury suffered; the blameworthiness of the physician's conduct; the policy of preventing future harm; the social utility of the activity as weighed against the risks; the kind of person with whom the physician was dealing; and the relative ability of the parties to adopt practical means of preventing injury.

[27] KING, *supra* note 12, at 17 (citing a third party beneficiary theory and the undertaking theory as giving rise to the physician-patient relationship).

[28] *Id.* at 18-19.

[29] *Id.*

[30] *See, e.g.*, Beadling v. Sirotta, 41 N.J. 555, 197 A.2d 857 (1964).

[31] *Id.* at 561, 197 A.2d at 861.

[32] *See Team Physicians, supra* note 19, at 661.

[33] *See, e.g.*, Nash v. Royster, 189 N.C. 408, 413, 127 S.E. 356, 359 (1925); Birmingham Baptist Hosp. v. Crews, 229 Ala. 389, 399, 157 So. 224, 226 (1934); Vidrine v. Mayes, 127 So.2d 809, 811 (La. App. 1961). *See also* A. HOLDER, MEDICAL MALPRACTICE LAW 34-35 (2d ed. 1978); KING, *supra* note 12, at 20-27.

practices, or on dealings in the past.[34] This has implications in the areas of preparticipation and post-injury physical examinations, especially if the physician is hired on a "one time only" basis to do preseason physicals by a school.[35] King, in *The Duty and Standard of Care for Team Physicians*, analyzed the issue as follows:

> Team physicians may . . . decide not to undertake a broad medical evaluation and management of a patient. But they should nevertheless be responsible not only for conditions within the scope of their undertaking about which they knew or *should reasonably know*, but also with respect to conditions outside that scope when they know or *have reason to know of that condition*.[36]

King cites the example of an athlete who comes to the team physician for treatment of an ankle sprain and during the examination complains of recurrent stomach distress.[37] Absent an emergency, which the physician would be required to address, it is not necessary for the physician to do a full gastrointestinal workup.[38] Rather, his duty would consist of informing the athlete of the need for medical attention and referring the athlete to a suitable physician.[39]

Once the existence of the first aspect of duty, the professional relationship, is established, one must explore the second component, the standard of care. Since negligence law is a fault-based system, there must be a standard of behavior against which an action can be judged. The general negligence formulation requires that one conform to the standard of a reasonable person under the circumstances.[40] When applied to physicians this translates to "that degree of care and skill which is expected of a reasonably competent practitioner in the class to which he belongs, acting in the same or similar circumstances."[41]

In the past, the standard of care was frequently tied to geo-

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[34] *See supra* note 33.

[35] *See generally Team Physicians*, *supra* note 19 (further complications would result if the school contracted with a hospital, and not an individual physician, to provide the preseason examinations).

[36] *Id.* at 683 (emphasis in original).

[37] *Id.*

[38] *Id.*

[39] *Id.*

[40] RESTATEMENT, *supra* note 14, § 283.

[41] Blair v. Eblen, 461 S.W. 2d 370, 373 (Ky. Ct. App. 1970).

graphic regions.[42] The modern trend, however, is to a national or professional standard which reflects the uniform requirements required for accreditation of programs, and the national testing system which establishes norms for physicians at various stages of their training.[43] Continuing education is available through journals, seminars, and, most recently, television.[44] For specialists, a national standard has been found to exist.[45] If a physician represents that he is a specialist, he will be held to the higher standards of that speciality.[46]

The physician is not an insurer of the success of a prescribed treatment.[47] The physician's conduct must fall below acceptable standards in order for negligence to be found.[48] Furthermore, there are often alternative treatments available and responsible physicians can legitimately differ as to the proper course of treatment.[49] A physician will not be found negligent for opting for one of several recognized courses of treatment, even if it is subsequently discovered that he was wrong. This is known as the "respectable minority" rule,[50] which holds that if the proper course of treatment is open to reasonable doubt, liability will not be found for choosing the wrong alternative.[51]

Turning to the sports medicine context, application of the above principles raises some preliminary issues. The first is the standard of care applied to the physician. King defined the team physician's standard of care as follows: "A team physician should perform with the level of knowledge, skill, and care that is expected of a reasonably competent medical practitioner under similar circumstances, taking into account reasonable limits that have been

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42 *See* WEISTART, *supra* note 13, at 985.

43 *See* Shilkret v. Annapolis Emergency Hosp. Ass'n., 276 Md. 187, 197, 349 A.2d 245, 251 (1975).

44 *Id.* at 194, 349 A.2d at 249 (citing Note, *An Evaluation of Changes In The Medical Standard of Care*, 23 VAND. L. REV. 729, 732 (1970)).

45 *Id.* at 197, 349 A.2d at 251.

46 *See* RESTATEMENT, *supra* note 14, § 299A comment d. *See also* Lewis v. Reed, 80 N.J. Super. 148, 193 A.2d 255 (App. Div. 1963); Simpson v. Davis, 219 Kan. 584, 549 P.2d 950 (1976); Butler v. Louisiana State Bd. of Educ., 331 So.2d 192 (La. App. 1976).

47 *See* WEISTART, *supra* note 13, at 985.

48 *Id.*

49 *Id.*

50 *Id.*

51 *Id. See also* Chumbler v. McClure, 505 F.2d 489, 492 (6th Cir. 1974).

placed on the scope of the physician's undertaking."[52] Although this formulation covers all the requisite bases, it offers little specific guidance. Underlying this formulation was King's belief that sports medicine was not a specialty for purposes of establishing a standard of care. He relied on two arguments: first, that the practice of sports medicine was not a subspecialty recognized by the Council on Medical Education of the American Medical Association;[53] second, that the training and involvement of various team physicians tended to differ too much to allow for such a standard.[54]

In the five years since King authored his article, the pendulum has swung toward finding sports medicine a specialty. Although it is still not a subspecialty designated by the American Medical Association (AMA), other factors would indicate that sports medicine has achieved specialty status for purposes of establishing a minimal standard of care.[55]

As previously discussed there has been a tremendous increase in the literature on the subject of sports medicine, and many authoritative texts have been published.[56] Courts have recognized sports medicine as a specialty when receiving expert testimony for the purpose of establishing damages. In *Fleischmann v. Hanover Insurance Company*,[57] the Court of Appeals of Louisiana held that in an accident case involving a bicyclist, the trial court did not err in qualifying a board certified orthopedist as an expert in sports medicine despite the fact that there are no AMA sanctioned specialty boards in that field.[58]

Courts should hold sports medicine physicians to a specialist's standard. The great diversity among practitioners of sports medicine dictates that the standard should be limited to the fundamentals which all practicing specialists in sports medicine should

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[52] *Team Physicians*, *supra* note 19, at 692. Also implicit in this definition is the question whether an orthopedist is considered "under similar circumstances" as a pediatrician, for example, if both advertise as specialists in sports medicine. If he is not, then application of King's suggested standard of care really requires finding many different standards of care depending upon the background of the specific physician.

[53] *Id.* at 694.

[54] *Id.*

[55] *See, e.g.*, Fleischmann v. Hanover Ins. Co., 470 So.2d 216, 217 (La. Ct. App. 1985).

[56] *See supra* notes 9-10, and accompanying text.

[57] 470 So.2d 216 (La. Ct. App. 1985).

[58] *Id.* at 217.

know, based on the types of athletes with whom the physician is involved. Physicians would still be held to higher standards of care corresponding to their actual specialty training; i.e., an orthopedic surgeon specializing in sports medicine would still be expected to act as a reasonable orthopedist.[59] However, this approach would establish the minimum standard of care required of physicians involved in sports medicine.

III. The Legal Relationship Of A Physician To A School Or Professional Team

As a preliminary determination, the legal nature of the relationship between the physician and the school or professional team must be established. This determination must be made on a case-by-case basis because of the virtually limitless variations in arrangements which may be made to provide medical care for the athlete. This type of inquiry has two aspects. The first deals with the contractual obligations between the parties,[60] and the second hinges on the degree of control the physician retains in his management of the patient-athlete.[61]

Contract law plays a more significant role on the professional level. The physician's duties and obligations to the team are usually well-defined in the terms of his contract with the club.[62] Preparticipation examinations, treatment of injuries, attending all practices and games, making appropriate referrals, rehabilitation of injured athletes, and certification of an injured athlete's fitness before return to competition are common responsibilities of the team physician.[63] On the amateur level, the duties of the physician are often not as well-defined. The physician may receive little or no compensation, and his ties to the team may be limited to preparticipation physicals and treating injuries on a referral basis.[64] The school's expectation should be spelled out in a written contract with the physician, but often they are not.[65] Obviously if the physician breaches the terms of his

59 *See* WEISTART, *supra* note 13, at 986.
60 *Id.* at 992.
61 *Id.*
62 *Id.*
63 *Id.* at 993.
64 *Id.* at 992.
65 *Id.*

contract on either the professional or amateur levels, he may be sued by the institution or team.

The second aspect which must be considered is the degree to which the school or professional team controls the physician's treatment of a patient. If the physician maintains autonomy in his therapeutic decision-making, he will generally be found to be an independent contractor.[66] If this is the case, the doctrine of respondeat superior will not apply, and the employer will not be held vicariously liable for the physician's negligence.[67] In *Cramer v. Hoffman*,[68] for example, the evidence showed that a university retained no discretion to control the therapeutic decisions of the physician which it employed to treat its athletes.[69] The court held that the physician's negligence could not be imputed to the university because he was an independent contractor.[70] The same result was reached in the celebrated case of *Rosenzweig v. State*,[71] a case which dealt with the death of boxer George Flores. The physicians charged with malpractice for a negligent pre-fight examination were found to be independent contractors, thus relieving their employer, the State of New York, from liability.[72] Again, the doctors were found sufficiently autonomous to preclude application of the doctrine of respondeat superior.[73]

Although the team physician is typically found to be an independent contractor, this is not always the case. In *Chuy v. Philadelphia Eagles Football Club*,[74] the defendant team was held vicariously liable for the tortious conduct of its doctor. The physician detailed a story alleging that Chuy had a fatal disease and released the false story to the press.[75] The doctor was found liable for intentional infliction of emotional distress[76] and the team was held liable under respondeat superior. The court reasoned

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66 *Id.* at 992.

67 *Id.*

68 390 F.2d 19 (2d Cir. 1968).

69 *Id.* at 22.

70 *Id.* at 23.

71 208 Misc. 1065, 146 N.Y.S.2d 589 (1955), *rev'd*, 5 N.Y.2d 404, 158 N.E.2d 229 (1959).

72 *Id.* at 232-33.

73 *Id.*

74 431 F. Supp. 254 (E.D. Pa. 1977), *aff'd*, 595 F.2d 1265 (3d Cir. 1979).

75 *Id.* at 257-58.

76 *Id.* at 271.

that the team had, or should have had, control of actions such as releasing player information to the press.[77] At the non-professional level, *Welch v. Dunsmuir Joint Union High School District*,[78] held the school district vicariously liable for the negligence of a football coach and team doctor who used improper techniques to remove a player with a suspected neck fracture from the field, leading to further injury.[79]

The extent of the relationship between the physician and the school or team has a major practical importance: it can determine who is the "deep pocket" in the case. The two factors which make this determination so important are immunity on the amateur level, and workers' compensation on the professional level. The non-professional athlete who is injured may be unable to sue the school or municipality controlling the school because of the sovereign immunity doctrine.[80] In order for sovereign immunity to apply, one must be dealing with a governmental entity.[81] These have been broadly defined as "federal, state, or local governments, municipalities, or any activity that is under control of any of the above."[82] State universities, public high schools, and quasi-public associations such as high school athletic associations may be insulated.[83] Charitable immunity may insulate private schools, especially in cases where they are affiliated with religious orders.[84]

If the team physician is found to be an employee of the schools, and not an independent contractor, and he is found to be performing within the scope of his job responsibilities, then he also may be protected by the sovereign or charitable immunity statutes.[85] More likely, however, negligent acts or omissions

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77 *Id.* at 265.

78 326 P.2d 633 (Cal. Ct. App. 1958).

79 *Id.* at 639.

80 R. BERRY & G. WONG, LAW AND BUSINESS OF THE SPORTS INDUSTRIES, VOL. II: COMMON ISSUES IN AMATEUR AND PROFESSIONAL SPORTS 349 (1986) [hereinafter cited as BERRY & WONG].

81 *Id.*

82 *Id.*

83 *Id.*

84 *See* S. Methodist Univ. v. Clayton, 142 Tex. 179, 180, 176 S.W.2d 749, 751 (1943). The theory underlying this form of immunity is that "it is better for the individual to suffer injury without compensation than for the public to be deprived of the benefit of the charity." *Id.*

85 *See* W. PROSSER & W. KEETON, THE LAW OF TORTS 1048 (5th ed. 1984).

which constitute malpractice will be found to be outside the scope of his duties, thus removing the shield of immunity.[86] Thus, if the physician is an independent contractor and the school is immune from liability, then the physician is the "deep pocket" in the case.[87]

In the context of professional sports, the athletes are employees of the team. The liability of the team physician for injuries to the athlete may be affected by the status of the parties under the applicable workers' compensation statute.[88] Workers' Compensation provisions provide the exclusive remedy for the injured employee against his employer for injuries covered,[89] and these provisions have been extended to include negligent harm caused by co-workers in the course of employment.[90] Interpreting the team as "employer," the athlete as "employee," and the team physician as "co-employee" might, in certain cases, exempt a team physician from malpractice liability if the harm caused to the athlete occurs in the course of his employment and is subject to the workers' compensation statutes.[91] However, where the physician is not deemed a co-worker, or is otherwise not included in application of the exclusive remedy clause,[92] the employer may be liable only for the statutory remedy while the physician remains liable in tort and again becomes the "deep pocket" in the case.[93]

The fact that the team physician may wind up carrying the bulk of the exposure in cases involving athletic injuries is undoubtedly not known by many physicians who are interested in

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86 *Id.* at 1070.

87 Deaner v. Utica Community School Dist., 99 Mich. App. 103, 297 N.W.2d 625 (1980) is an ideal example of this situation. A high school student was paralyzed as a result of injuries during a wrestling class. An action was brought against the physician and the school district, and the trial court granted summary judgment in favor of both. On appeal, the court found material questions of fact and remanded. However, the appellate division also found the school district to enjoy sovereign immunity, leaving only the physician as an independent contractor to face a jury which would undoubtedly be sympathetic to the paralyzed high school student.

88 *See generally* WEISTART, *supra* note 13, at 1007-09 (workmen's compensation as applied to professional athletes). *See* N.J. STAT. ANN. § 34:15-8 (West 1940) for an example of such a statute.

89 *See Team Physicians*, *supra* note 19, at 660 n.17.

90 *See* LARSON, WORKERS' COMPENSATION LAW 491 (1984).

91 *See Team Physicians*, *supra* note 19, at 660 n.17.

92 *Id.*

93 *Id.*

sports medicine, and who eventually may serve as a team physician. This is especially true considering the nebulous nature of the relationship between team and physician at the amateur level. The cautious physician should require the school or team to pick up his additional malpractice insurance as a negotiated term in his contract for service.

IV. Preparticipation Examinations

The preparticipation examination of participants in athletics is the most common responsibility shared by team physicians on all levels of competition. It is also an area about which a significant amount of research has been done and for which a standard of care is capable of being defined. The AMA and the National Collegiate Athletic Association (NCAA) have both issued policy statements concerning preparticipation physicals. In its "Bill of Rights for School and College Athletes,"[94] the AMA stated that the athlete has a right to "a thorough preseason history and medical examination. Many of the sports tragedies which occur each year are due to unrecognized health problems. Medical contraindications to participation in contact sports must be respected."[95]

The NCAA has articulated its policy concerning preparticipation examinations in the 1985-86 NCAA Manual:[96]

> A preparticipation medical examination should be required upon a student-athlete's initial entrance into an institution's intercollegiate athletic program. This initial examination should include a review of the student-athlete's health history and relevant general and orthopedic physical examination. Medical records maintained during the student-athlete's collegiate career should include a record of injuries and illnesses sustained during the competitive season and off-season, medical referrals, subsequent care and clearances, and a completed yearly health status questionnaire. Provided there is a continuous awareness of the health status of the athlete, the traditional annual preparticipation physical examination for all student-athletes is not deemed necessary.[97]

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94 AMA, Committee on the Medical Aspect of Sports, *Preface* to D. O'DONOGHUE, TREATMENT OF INJURIES TO ATHLETES (4th ed. 1984).

95 *Id.*

96 1985-86 NCAA Manual, Recommended Policy 9, Medical Examinations, *cited in* BERRY & WONG, *supra* note 80, at 347.

97 *Id.*

Reading the two policy statements together indicates that the reasonably prudent institution should be expected to provide a preseason examination to athletes entering their sports program, and to track the health status of the athletes in the program. They could be held negligent for not so doing.

The issue at hand, however, is the standard of care owed to the athlete by the examining physician during a preparticipation physical, having established that the school is obligated to provide for one. As a practical matter, requiring an annual comprehensive physical examination for each athlete is beyond the capabilities of the current medical care system as the costs in manpower and lab work are prohibitive.[98] As a result,

> the perfunctory "locker room" type of mass examination has evolved as a pragmatic solution to this sports medicine dilemma, but it is the antithesis of good medical care—superficial and hurried, and often a defensive maneuver designed to fulfill legal requirements. . . . In addition, the lack of a standardized history form and physical examination to define the level of thoroughness required for this physically superior group has added to the confusion of physicians.[99]

It is apparent that in the context of a preparticipation physical, a physician-patient relationship will be found, even if the examination is non-therapeutic since it is, at least in part, for the direct benefit of the athlete. Applying the general formulation for the standard of care to this situation, the doctor is required to use the skill and care expected from a reasonably competent physician in carrying out the examination itself. As a result of increased research and the growth of sports medicine as a specialty, what should be known and done by a reasonably competent physician conducting preparticipation physicals has changed drastically in the last five years. Apparently, however, there is widespread deviation from the standard.

Based upon the volumes of medical literature discussing preparticipation examinations[100] the following observations regard-

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98 *See* Meyers & Garrick, *The Preseason Examination of School and College Athletes*, in SPORTS MEDICINE 237 (R. Strauss ed. 1984).

99 *Id.*

100 *See, e.g.*, Driscoll, *Cardiovascular Evaluation of Child and Adolescent Before Participation in Sports*, 60 MAYO CLIN. PROC. 867-873 (1985) [hereinafter cited as Driscoll]; Kennedy & Whitlock, *Sports Related Sudden Death in Young People*, 3 J. AM. COLL. CARDIOL. 622 (1984); Tsung, Huang, Chang, *Sudden Death in Young Athletes*, 106 ARCH. PATHOL. LAT. MED. 168 (1982); Linder & Durant, *Preparticipation Health*

ing the reasonably competent examination may be made: sports medicine programs as they exist in most schools are disjointed and incomplete, due largely to a lack of coordination between physicians, school administrators, coaches, physical therapists, and trainers.[101] The state high school athletic associations throughout the United States have quite different standards for physical examinations, ranging from clearly defined criteria to simply requiring any physician's signature on a statement that the student is fit.[102] A vast majority of schools are behind the times regarding the adequacy of their preparticipation examination requirements.

It is recommended that the preparticipation examination be used as a screening process; the routine preparticipation exam should, as its main objective, screen for conditions which could predispose the athlete to injury or death.[103] The following approach to the subject is representative:

> Although sudden unexpected death of children and adolescents is uncommon during athletic competition, identification of the rare person at risk for sudden death is critical to preventing this tragic event. If traumatic causes of sports' associated death are excluded, the most common underlying causes of such fatalities are related to identifiable abnormalities of the cardiovascular system.[104]

Cardiovascular problems are a key area of concern for the physicians conducting the preparticipation examination since dysfunction in this area is often not apparent on physical examination.[105]

Screening of Young Athletes, 3 AM. J. SP. MED., 187-91 (1981); Schofler, *The Health Examination for Participation in Sports*, 7 PEDIATR. ANN. 27-30 (1978).

101 Blackburn & Hunter, *Commentary* to Linder & Durant, *Preparticipation Health Screening of Young Athletes*, 3 A.M.J. SP. MED. 187, 191 (1981).

102 *Id.*

103 *See* Meyers & Garrick, *supra* note 98, at 238.

104 Driscoll, *supra* note 100, at 867. Driscoll recommends "a thorough cardiovascular examination before participation in athletes (1) to detect unsuspected major cardiovascular abnormalities in presumably healthy children and adolescents; and (2) to counsel patients with known cardiovascular abnormalities regarding the risk or safety of specific sporting events." *Id.*

105 The discovery of cardiovascular abnormalities is complicated by the fact that "athletic heart syndrome" can mimic pathological states. The well-trained athlete's heart may often show abnormalities on EKG that are normal variations in the athlete, but indications of pathology in sedentary individuals. *See* Wolff, Farner & Rinaldi, *Cardiologic Assessment of Participants of Pop Warner Junior League Football*, 3 A.M.J. SP. MED. 200, 201 (1981). Some of the following are considered critical cardiovascular conditions: Hypertrophic Cardiomyopathy (the most common cause of sud-

The taking of a complete medical history is therefore at the crux of the modern preparticipation physical. If the examinee gives a response which indicates a potential problem, he will be given an in-depth examination or will be referred to a specialist, if necessary. For example, a student who has fainting spells, or a history of sudden death in his immediate family would be flagged for a thorough cardiovascular examination.[106]

There appears to be a genuine concern that in the near future physicians who conduct the old style mass physicals in the locker-room may be held liable for not conducting the more thorough examination which the new standard of care requires. This is even more likely to occur as sports medicine becomes more deeply entrenched as a specialty, supporting the establishment of a national standard for the adequacy of examinations. Failure to take a detailed history is most likely to be found a deviation from the acceptable standard since it is at the heart of the modern examination process. It will also be increasingly important that appropriate restrictions be advised for athletes found to have medical problems.[107]

Very few courts have addressed the question of adequacy of preparticipation physicals. In *Speed v. State*,[108] the Iowa Supreme Court affirmed a decision in favor of a basketball player who became blind as a result of an intracranial infection.[109] The examining physician was found liable for not employing recognized tests and examinations to prescribe the proper course of treatment when confronted by the plaintiff's condition.[110] It was held that if the physician had conducted the indicated tests, appropriate antibiotics would have been administered to the athlete based on the test re-

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den death); Marfan's Syndrome (a common cause of aortic rupture in very tall individuals with disproportionately long limbs, most often occurring in basketball or volleyball players); Aortic Valve Stenosis; Primary Pulmonary Hypertension; and Hereditary Prolongation of the Aorta. *See* Driscoll, *supra* note 100, at 870. Driscoll points out that characteristics of some of the above disorders may be clinically indistinguishable from innocent organic murmurs. This is of interest to the attorney who must disprove malpractice for failure to detect such a dysfunction. The attorney dealing with any of the medical conditions mentioned must obviously obtain expert advice concerning their nature and relevance.

106 *See* Driscoll, *supra* note 100, at 871 for a more detailed discussion of suspect responses indicating potential cardiovascular problems.

107 *Id.*

108 240 N.W. 2d 902 (Iowa 1976).

109 *Id.* at 903-04.

110 *Id.* at 904.

sults, and he would not have lost his vision.[111] In *Rosenzweig v. State*,[112] the trial court found physicians employed by the State of New York to have been negligent in their prefight examination of a boxer, and to be liable when the boxer died due to injuries which would not have occurred if the boxer was adequately examined.[113]

The issues discussed above are generally applicable to professional athletes. Professional athletes are in a more complicated situation due to the contractual nature of their relationship with the employer-team, and the discretion vested in the team to make employment decisions concerning the athlete.[114] If a player is found to lack the requisite athletic skill, he usually can be released from employment without any further obligation on the team.[115] Likewise, if a player is found unfit at the preseason physical, he can be released or otherwise penalized.[116] The potential problem area here arises when a player's skills are diminished by an injury which occurred during the previous season, or during the off-season while participating in activities allowed under his contract.[117] In this situation there may be strong pressure on the physician to find the athlete fit during the preparticipation examination. Then if the athlete can no longer compete, the team can release him based on lack of skill for which continued payment of salary is not required. Conversely, if the athlete is found physically unfit due to the injury, the team may be obligated to continue payment.[118] If the particular player's contract so specifies, the physician designated by the team may have absolute discretion in determining fitness.[119]

Tillman v. New Orleans Saints Football Club[120] illustrates the important distinction between a player's fitness and his level of skill. Tillman hurt his knee during preseason drills sanctioned by the

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111 *Id.* at 905-06.

112 208 Misc. 1065, 146 N.Y.S.2d 589 (1955), *rev'd*, 5 N.Y.2d 404, 158 N.E.2d 229 (1959).

113 *Id.* A finding of sovereign immunity led to an ultimate reversal, but the finding of negligence on the part of the physicians was not disturbed.

114 *See* WEISTART, *supra* note 13, at 216-22.

115 *Id.* at 217. The "no-cut" contract is an exception to this general rule. *Id.* at 220.

116 *Id.* at 217.

117 *Id.* at 223.

118 *Id.* at 228.

119 *Id.* at 229.

120 265 So.2d 284 (La. App. 1972). *See* WEISTART, *supra* note 13, at 228-29 for a further analysis of the *Tillman* case.

team.[121] After surgery and a period of rehabilitation, he was examined by the team physician and was declared fit to return to full competition.[122] He was subsequently released from the squad because he lacked the skill required to play on the professional level.[123] The team was therefore relieved of paying his salary.[124] Tillman challenged this result, claiming that he was entitled to the rest of his salary on the grounds that his injury caused the loss of skill and that the team physician was erroneous in declaring him fit.[125] The court, however, accepted the physician's determination of fitness and ruled against Tillman.[126] Given this decisive role that the team physician plays in the course of an athlete's career, professional athletes may attempt to diminish the role played by team physicians. Collective bargaining agreements between players and owners may eventually require the inclusion of neutral physicians in the process of preparticipation examinations.[127]

V. Post Injury Examination And Determination Of Fitness To Return To Competition

The ethical dilemma faced by team physicians due to their potentially conflicting obligations to their employers and the athletes becomes exacerbated when the school or professional team exerts pressure on the physician to make certain therapeutic decisions. The scope of this problem is illustrated by an enlightening statistic: during arbitration concerning injury grievances, the teams of the National Football League were found liable in thirty-nine of the sixty-seven grievances filed.[128] In each case, the team physician testified for the team, and against the athlete bringing the action.[129] It therefore seems naive at best to believe that the injured athlete can rely on the team physician to act in the athlete's best interest at all times.

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121 *Tillman*, 265 So.2d at 285.
122 *Id.* at 286.
123 *Id.* at 285.
124 *Id.*
125 *Id.*
126 *Id.* at 287.
127 *See generally* WEISTART, *supra* note 13, at 777-839 (discussion of collective bargaining and professional sports).
128 Naek, *Playing Hurt—The Doctor's Dilemma*, Sports Illustrated, June 11, 1979, at 35.
129 *Id.*

One commentator attempted to place the team physician's objectives in perspective: "it is the job of the [team] physician to minimize the time athletes have to stay out of action, but they have an even bigger obligation to keep athletes alive and free from further injury."[130] As demonstrated, however, the team physician is under pressure from the team, or the athlete himself, to reverse these priorities. Determinations concerning the injured athlete's return to competition must be analyzed in two categories: immediately after an injury of marginal severity which may not require removal from competition,[131] and after a serious injury which causes significant temporary disability.[132]

The team physician must use the skill, care, and knowledge of a reasonably competent specialist in the field of sports medicine when evaluating the condition of an injured athlete.[133] If the professional team, school, or a third party attempts to exert influence over the physician's judgment, it must be made clear that such action cannot be tolerated.[134] The prudent physician should demand, as a prerequisite to employment and as part of his contract terms, that his decisions be final, or not overruled without a competent conflicting second opinion made by an independent physician.[135] King suggests that if the sound decision of the team physician is overridden by the team, the physician should notify the athlete, and his parents if he is a minor, and consider terminating his relationship with the team.[136] Unfortunately, real life situations are rarely so clear cut. Management may indirectly pressure the physician through the athlete, or through subtle questioning of the physician's competence for failing to return the player to action. This may indirectly threaten the physician's continued employment.

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130 Fairbanks, RETURN TO SPORTS PARTICIPATION, PHYSICIAN & SP. MED. 71, 71 (1979).

131 Examples of this category would include the high school football player who "had his bell rung" and might have a minor concussion (or subdural hematoma); or a basketball player who twists his ankle and completes the game on it, but in doing so, worsens the injury. *See generally* Fairbanks, *supra* note 130, at 72-73.

132 *Id.* at 73. Examples of this category would be any injury which causes the athlete to miss training or competition, i.e., serious ankle sprain, broken bone, or a concussion with loss of consciousness.

133 *See* WEISTART, *supra* note 13, at 986.

134 *See Team Physicians*, *supra* note 19, at 698.

135 *Id.*

136 *Id.*

When it is the athlete who wants to ignore the team physician's judgment concerning participation, the issue is more complicated. An athlete may insist on participation even with the presence of medically unacceptable risks.[137] Team spirit, pressure from management, or fear of losing his starting position may motivate the player. Some would argue that the player should be able to control his own destiny, including taking risks which others deem unacceptable.[138] King attempted to deal with this conflict by formulating the following approach:

> Athletes, who because of age or mental capacity are not legally capable of giving valid consent, should be afforded the same protection as non-athletes. They should not be approved for participation when similar activities would be contraindicated for nonathletes. Athletes legally capable of consenting should not be authorized by a team physician to participate in at least the following situations. First, when there are significant risks of harm from participation, the athlete should not be approved for participation, irrespective of what the athlete may ostensibly want. Second, when there is a question as to the athlete's lucidity or capacity for sound judgment, the physician should not approve participation when a similar level of activity would be contraindicated for the non-athlete.[139]

Although the above formulation is useful in organizing an approach to this problem, it does not go far enough if a professional standard of care is applied to the sports medicine specialist in this situation. There are other factors to consider. The unique physiology and degree of cardiovascular and musculoskeletal conditioning of the trained athlete are relevant and distinguish the athlete from the non-athlete. King ignores this fundamental difference. Athletes are generally more in touch with their bodies and may be better able to make determinations about the magnitude of the risks of participation than either the non-athlete or the team physician. Finally, athletes have, in many cases, previous exposure to injuries, giving them experiential background to rely on in making their decisions. The sports medicine physician should take these factors into consideration and have a detailed discussion with the athlete, team man-

137 *Id.* at 692-93.
138 *Id.*
139 *Id.* at 699.

agement, coach, and the athlete's parents if he is a minor.[140] This discussion should specifically identify the physiological injury in terms which can be understood by laymen, explain why the physician recommends against participation, and list what the significant possible adverse effects of participating might be.[141] This approach is designed to be flexible enough to cover severe injuries, and relatively minor ones which might become severe through premature return to participation. It respects the athlete's autonomy while fulfilling the physician's duty to give the patient all the facts concerning his condition, and to facilitate an informed decision.[142] The prudent physician would reduce the substance of his discussion to writing, and have the injured athlete sign it, signifying his having understood the contents.[143] It would also be wise to include a separate waiver of liability for the player to sign which includes substantially the same information as the above mentioned document.[144]

The above suggested approach would have to be modified for judgments made on the spot concerning continued participation after an arguably minor injury.[145] The physician must judge if the player is capable of making a rational decision under the circumstances: the player who is in the heat of competition may be incapable of making a sound choice.[146] Also, certain injuries, such as head trauma, heat illness, and dehydration can effect mentation.[147] Here, the physician must make his determinations against the reasonably competent standard of care based on all the circumstances.

Special consideration must be given to the use of pain modifying drugs to allow continued participation or to allow earlier return after injury.[148] The physician faces liability under two theories in this context. Pain is a very important part of the body's defense system. By eliminating the body's early warning mechanism, the physician may be inviting further injury.[149] For example, an athlete with

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140 *See* WEISTART, *supra* note 13, at 988.

141 *Id.* at 989.

142 *Id.*

143 *Id.*

144 *Id.* Separate documents are recommended to avoid the appearance of forcing the waiver on the injured athlete.

145 *Team Physicians*, *supra* note 19, at 700.

146 *Id.*

147 *Id.*

148 *Id.* at 700-02.

149 *Id.* at 702.

microtears of the achilles tendon may be given a pain reducing anti-inflammatory drug such as Naprosyn. The athlete then competes and further injures the tendon, severing it, resulting in extreme disability. The physician in this case could be found negligent in his treatment of the athlete. Proximate causation, which is usually a major obstacle when suing a team physician, would be simple to prove in this instance.[150]

Perhaps the best known instance of a professional athlete suing for misuse of painkillers involves Bill Walton, the former center for the Portland Trail Blazers of the National Basketball Association. Walton, who suffers from congenital defects in the structure of his feet, alleged, among other charges, that the team physician negligently injected his feet with xylocaine, an anesthetic, to facilitate his continued participation. Walton alleged that the subsequent fracture of a bone in his left foot would not have occurred if he had not been negligently treated.[151] The suit was eventually settled.

The Walton case also illustrates the second area where the physician must be wary: the physician must allow the patient to make an intelligent choice concerning the risks and benefits of a proposed treatment. This is known as informed consent.[152] Bill Walton's coach at Portland, Jack Ramsey, typified the attitude which prevails in many front offices: "[T]his is their job. A professional basketball player is capable of deciding for himself whether he should take an injection or not. He knows the risks involved. If he doesn't he should ask."[153] The burden, however, is clearly on the physician to explain, not on the athlete to ask. Failure to obtain informed consent is a common basis for liability in medical malpractice actions. The team physician who conveniently forgets to mention the significant potential adverse effects of treatment to appease his employer is subject to liability for subsequent occurrence of that event.[154]

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150 *Id.* at 703.

151 *See generally* HALBERSTAM, THE BREAKS OF THE GAME (1981) for a detailed discussion of the circumstances surrounding Bill Walton's subsequent lawsuit.

152 *See* WEISTART, *supra* note 13, at 989.

153 BERRY & WONG, *supra* note 80, at 357 n.1 (citing *Off the Wronged Foot*, Sports Illustrated, Aug. 21, 1978, at 18).

154 The majority of states apply an objective evaluation to this situation. Would a reasonable person, properly informed, choose not to undergo the treatment if he knew what he should have been told. The minority view is a subjective approach focusing on the individual plaintiff's likely choice if properly informed. *See* KING, *supra* note 12, at 152-58.

Where the physician prescribes drugs which also have arguable therapeutic value, the questions remain the same, but the lines are less easily delineated. For example, Dick Butkus, a football player who was a perennial all-star, had a chronic knee injury.[155] He was treated with cortisone, which allowed his continued participation but resulted in permanent damage to the joint.[156] Both the "negligent prescription" and "lack of informed consent" aspects discussed above were alleged by Butkus.[157] His case also settled out of court.[158] Application of the suggested standard of care requiring use of the requisite care, knowledge, and skill of the reasonably competent sports medicine practitioner would most likely result in liability on both counts if the facts alleged by Butkus were true.

The *Tillman* case discussed above is a good illustration of the business realities which might tempt a professional team's management to exert influence on a team physician's classification of an athlete's status after an injury.[159] As discussed above, once the player is disabled by an injury received while performing under contract, he is entitled to continue to receive his salary as long as the team physician declares him to be unfit to return to full playing duty, or until his contract expires. Once the team physician says the athlete is fit, however, he can be ordered to return to competition and be subsequently released by the team for lack of skill.[160]

Other ethical decisions within the scope of the team physician's authority may result in liability if the physician opts to follow the management's wishes at the expense of the athlete's well-being. For example, the decision not to reveal the full extent of an athlete's injuries to the athlete has engendered lawsuits. Bill Walton alleged that the true extent of his injuries was withheld from him.[161] A more outrageous example is the case of Otis Armstrong, a running back with the Denver Broncos of the National Football League.[162] In 1980, Armstrong hurt his neck during a game and was told by the physician that he had a congenital defect in the structure of his neck

155 N.Y. Times, Sept. 14, 1976, at 50, col. 5.
156 *Id.*
157 *Id.*
158 *Id.*
159 *See supra* notes 120-26 and accompanying text.
160 *See supra* notes 115-19 and accompanying text.
161 BERRY & WONG, *supra* note 80, at 373 n.6.
162 *Id.* at 374 n.9 (citing N.Y. Times, Nov. 3, 1983, at 21).

which could lead to his being paralyzed if he were injured further.[163] He retired on the advice of this physician.[164] During an extensive neurological exam in 1983, it was revealed that he had sustained a cranial fracture, three fractures of the neck, a fractured spinal column, and five broken ribs.[165] He subsequently sued the team physician and six others who withheld the truth from him.[166] Withholding information relevant to illness or injury violates even the lowest level of care required of an ordinary physician, regardless of the context.[167]

If a physician makes false representations concerning an athlete's fitness to a third party who then relies on the misrepresentations to his detriment, the physician may be liable for negligence.[168] Once again, Bill Walton's medical odyssey provides an example.[169] As a result of the allegedly poor medical treatment discussed above, Walton demanded to be traded by the Trail Blazers.[170] Walton and two physicians certified that he was fit and a major deal was consummated with the San Diego Clippers.[171] Walton's congenital foot defects sidelined him and forced him into temporary retirement. The Clipper's owner sued Walton and the two physicians for erroneously certifying Walton's foot to be fit.[172] The owner contended that the three knew or reasonably should have known of the defects before certifying Walton's fitness.[173] This third party reliance may very well be extended to impose liability upon a physician who examines potential professional athletes while they are still in college.[174] One can even envision a case where a drug rehabilitation facility is sued for certifying that a player is fit to return to action when in fact he is still using drugs.

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163 *Id.*

164 *Id.*

165 *Id.*

166 *Id.*

167 See text accompanying *supra* notes 21-59, discussing the standard of care generally.

168 *See* WEISTART, *supra* note 13, at 989-90.

169 *See* BERRY & WONG, *supra* note 80, at 373 n.6.

170 *Id.*

171 *Id.*

172 *Id.*

173 *Id.* Walton's case was resolved without testing the merits, though the theory advanced by the plaintiff seems sound.

174 *See generally* WEISTART, *supra* note 13, at 989-91.

VI. Conclusion

There is a significant gap between the science of sports medicine and the sophistication of its practice, especially at the high school and college levels. In theory, sports medicine has become a highly specialized field. Practitioners will be held to a higher standard of care than general physicians. Unfortunately those practicing sports medicine may deviate from this higher standard, simply by doing things the way they always have been done. The volunteer, part-time team doctor may be leaving himself open for a malpractice action by not performing to the professional standard of care required of the sports medicine specialist. This is especially true of doctors who conduct the old style superficial preparticipation exam. The wise team physician should realize that what used to be a hobby is now a specialty. He should either adhere to the higher standard of care, or stop treating athletes. He should take demonstrable steps to assure that his skill and knowledge is that of the reasonably competent sports medicine specialist. Professional affiliations, conferences, and publications can be used as vehicles toward this end.

The sports doctor must shed the traditional or customary conceptions of duty and realize that each contact with the athlete may be construed as establishing a physician-patient relationship. Nothing is lost by erring on the side of caution in this context. The team physician should attempt to clearly define responsibilities and expectations in the form of a written contract with his employer. It should be unambiguously stated that the physician's primary duty is to the well-being of the athlete, notwithstanding the potentially conflicting business interests of the employer.

Fundamental changes must occur before the gap between the current practice and the standard of conduct proposed above can be narrowed. The courts are clearly the least suitable forum for these changes to be effected. The sparsity of case law is evident; it would take decades before each jurisdiction would have an adequately developed judicial approach to these issues. The most efficient approach would involve educating the parties involved regarding the need for change and then pursuing establishment of statutory requirements and guidelines.

The first group to act should be the physicians themselves.

It is a simple matter of self-preservation to nip this potential source of malpractice liability in the bud. Sports medicine practitioners should pressure the AMA Committee on Sports Medicine to lobby for official accreditation in the field of sports medicine based upon a demonstration of proficiency in the field, i.e., through a qualifying exam. Although it is unlikely that sports medicine would be designated as a subspecialty requiring board certification, the qualifying exam might be used to designate sports-related proficiency in addition to the physician's primary specialty. For example, a physician who is board certified in internal medicine would be able to represent himself as a "board certified internist specializing in the practice of sports medicine." Those who do not pass the qualifying exam would be precluded from making such a representation. This approach would allow the public to discern the underlying training of the "sports doctor" and would serve to weed out those who do not possess the minimum required proficiency. Continuing education credits could be required to retain the right to specialize in sports medicine.

The AMA, in conjunction with the Sports Law Section of the American Bar Association, should propose statutory guidelines defining the nature of the relationship between the team physician and his employer. Included in these guidelines should be an affirmation of the autonomy of the physician's decision-making authority and strict sanctions for attempting to influence the physician's judgment. A nationwide effort to encourage state legislatures to adopt these guidelines as statutory provisions should then follow. The legislatures are the most viable forums for effecting meaningful change. Some states have preparticipation examination requirements; all states should be urged to follow suit.

It is a sad commentary on the state of sports in general that player injuries are routinely used as part of a team's tactical arsenal. One glaring example is the flagrant manipulation of the "injured reserve list" to make roster changes. Feigning injury to stop the clock is another example. These practices help create a climate which is indifferent to the necessity of truthfulness when dealing with athletic injuries. If a change in the mindset which tolerates the abuses which affect an athlete's career is truly a priority, then all practices which minimize the seriousness of inju-

ries should be eliminated. Rulemaking bodies at every level of competition should discourage any lack of truthfulness regarding injuries by heavily penalizing violators.

Players' unions must continue to press their rights in areas where the team physician's discretionary decisions can affect the player's career. The trend toward requiring independent verification in such instances should be encouraged in collective bargaining.

More radical alternatives might well be explored. One such alternative is to have all team physicians work for the league, and not individual teams. This would allow the physician a greater degree of autonomy. Physicians could be rotated every few years to minimize partisanship to one team. As a group, the league's physicians could pool their expertise and offer a higher level of care than a smaller group or individual could.

Another possibility would be for each team to retain its own team doctor, with express provisions for his autonomy in therapeutic decision-making. The league could have a pool of independent specialists who would give second opinions in major cases and police the owners to reduce their interfering with the team doctor's determinations.

The ultimate issue is one of ethics. The business considerations which motivate management decisions must be factored out of the medical care of injured athletes. If they are not, the physician will continue to be in a very vulnerable position. Bad medicine will not be tolerated as good business if these cases start reaching the jury.