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Ethics and the NFL physician

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It goes without saying that a physician's first duty is to patients and that medical advice must be based solely on what is best for the patient. What if the physician's employment or other affiliations pull him or her in a different direction? Sally Jenkins and Rick Maese recently explored this scenario in a *Washington Post* column about the standards and practices of NFL team physicians. The article highlights Washington Redskins quarterback Robert Griffin III.

In a January playoff game against the Seattle Seahawks, Griffin strained a ligament in his right knee. As Griffin limped onto the field in the fourth quarter, it was obvious that he could barely run, much less play. While trying to corral a bad snap, he collapsed "like a doll with a broken spring," with torn anterior cruciate and lateral collateral ligaments.

NFL Commissioner Roger Goodell called the decision to return to the field "a medical decision," but Jenkins and Maese question how six team physicians and assorted other medical personnel could have allowed it. The answer, they argue, is a medical culture in the NFL "with conflicts of interest and competing pressures," in which players feel compelled to play through pain and team doctors use short-term "cures" to get them back on the field, regardless of the long-term costs.

Every team physician must confront what the NFL Physicians Society calls the "unique clinical challenges." Is it more important to get athletes back on the field or protect their long-term health? The inherent conflict can easily lead a doctor astray.

The American Medical Association's Code of Ethics explains that the relationship between patient and physician is based on trust and gives rise to a physician's ethical duty to place his patient's welfare above his or her own self-interest and above obligations to other groups. A physician, the code states, must use sound medical judgment and hold the patient's interests as paramount.

According to Drs. Nancy Cummings and Matthew Matava — writing in the September 2011 edition of *AAOS Now* — in the sports medicine context, the traditional physician-patient relationship has become a triad: "[a] doctor-patient-team relationship." The player-patient is an adult responsible for his own medical decisions. But the process is complicated by the influence of the potential monetary gain from playing with an injury. A player may fear being cut or losing leverage in contract talks if he doesn't play injured.

The team owners, however, can also influence a player's decision and the team doctor's advice. According to the *Washington Post* article, some health-care organizations pay seven figures for the ability to call themselves "official" team physicians. Some ethicists argue that no matter how honest the physician, the "triad" relationship can create subtle but powerful pressures. As former wide receiver Joe Horn stated: "We knew their job is to get us on the field by any means necessary."

Both articles cite Toradol injections as an example of a common conflict encountered by NFL physicians. Toradol is a potent nonsteroidal anti-inflammatory used principally for its analgesic properties after acute strains, sprains and overuse injuries, in addition to narcotics following surgery. Toradol injections have been used frequently in the NFL to treat musculoskeletal injuries and to prevent post-game soreness. The "Recommendations of the NFL Physicians Society Task Force on the Use of Toradol in the National Football League," a 2002 study, revealed that 28 of 30 teams that responded to a survey used intramuscular Toradol.

Cummings and Matava cite a 2002 study of use of local anesthetics in Australian rules football and rugby. On a per-game basis, an average of 10.7 percent of all players competed with an injury treated with a bupivicaine injection, including "high-risk" injuries such as ankle sprains, tendon injuries and first metacarpal injuries.

The International Rugby Board has since banned painkiller injections, but the NFL still leaves their use to the discretion of the individual team physician.

According to Cummings and Matava, there are no hard-and-fast rules in deciding whether to administer a game-day injection. "Sound medical principles should be used to guide the decision without consideration of the specifics of the game or contest." Injecting a lineman's dislocated finger is different than anesthetizing a running back's knee after an acute ligament injury. But they concede that "it could be argued quite persuasively" that informed consent is impossible in the context of a game-day injury when the pressure to play can overbear the player's ability to carefully consider the long- and short-term risks.

Jenkins and Maese cite meniscus surgery as a classic case in which an NFL physician may feel conflicted. A meniscus injury can be repaired in one of two ways. The first is to sew it back together. The second is to simply trim out the damaged portion. The former method requires about a six-month recovery, but it minimizes the risk of future degenerative changes. With the latter method, the athlete can be back on the field in three to six weeks, but at what future cost? The lesson is that the first obligation a team physician has is to the patient — not the team. ■

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