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TEAM PHYSICIANS AND COMPETITIVE ATHLETES: ALLOCATING LEGAL RESPONSIBILITY FOR ATHLETIC INJURIES

*Matthew J. Mitten**

I. INTRODUCTION

Within a two-week period in 1990, Hank Gathers[1] and Anthony Penny[2] collapsed and died of heart attacks during competitive basketball games. Gathers was Loyola Marymount University's star forward and a prospective National Basketball Association player. He was playing in a college game in California.[3] Penny was playing professional basketball in England.[4]

Before their deaths, both Gathers[5] and Penny[6] had been diagnosed as having a potentially life-threatening heart rhythm disorder known as cardiomyopathy.[7] Both chose to continue playing basketball. Before his death, Penny sued his cardiologist, claiming that misdiagnosis of his heart condition had resulted in an unnecessary two-year exclusion from college basketball.[8] Penny later voluntarily dismissed that suit.[9] After his death, Gathers' heirs sued his treating physicians, claiming that: Gathers was not fully informed of the seriousness of his heart condition; should not have been medically cleared to continue playing college

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1. Elliott Almond & Maryann Hudson, *The Death of Hank Gathers; Doctor Released Gathers to Play*, L.A. TIMES, Mar. 8, 1990, at C1; Frances Munnings, *The Death of Hank Gathers: A Legacy of Confusion*, THE PHYSICIAN & SPORTSMED., May 1990, at 97.

2. Lawrence K. Altman, *The Doctor's World; An Athlete's Health and a Doctor's Warning*, N.Y. TIMES, Mar. 13, 1990, at C3.

3. Almond & Hudson, *supra* note 1, at C1.

4. Altman, *supra* note 2, at C3.

5. Munnings, *supra* note 1, at 97.

6. Altman, *supra* note 2, at C3.

7. Cardiomyopathy is a disorder, of either known or unknown cause, resulting from disease of the heart muscle itself. 6 ROBERT K. AUSMAN, M.D. & DEAN E. SNYDER, J.D., AUSMAN & SNYDER'S MEDICAL LIBRARY—LAWYER'S EDITION § 9:43 (1990).

8. Altman, *supra* note 2, at C3. See *infra* notes 170-71 and accompanying text.

9. Altman, *supra* note 2, at C3.

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basketball; and was given a non-therapeutic dosage of heart medication to enable him to perform at a higher level.[10] These lawsuits ultimately were settled.[11]

Marc Buoniconti, a linebacker for The Citadel, was permanently paralyzed while making a tackle during a 1985 college football game.[12] Thereafter, Buoniconti filed a negligence action against the school's team physician for permitting him to play with ill-conceived equipment, a spine abnormality, and a serious neck injury.[13] In 1988, Buoniconti lost a jury trial on these claims.[14]

Reggie Lewis, captain of the Boston Celtics basketball team, recently died of cardiac arrest while shooting baskets at a gymnasium.[15] Two months earlier, Lewis had fainted during a Celtics' game. This episode resulted in several medical examinations, conflicting diagnoses of his medical condition, and extensive publicity regarding his health.[16] A team of twelve cardiologists assembled by the Celtics' team physician diagnosed Lewis as having cardiomyopathy, and concluded that his heart condition probably would prevent him from playing competitive basketball again.[17] A second medical opinion, rendered by other cardiologists at Lewis' behest, concluded that Lewis had a relatively benign neurological condition that affected his heart beat, but that he

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10. Gathers' death was followed by the filing of multimillion dollar lawsuits by his mother, minor son and other heirs against Loyola Marymount, its coach and athletics trainer as well as several physicians participating in Gathers' care and treatment. Plaintiffs alleged that the defendant physicians negligently diagnosed and treated Gathers. The lawsuits further contended that defendants conspired and fraudulently failed to inform Gathers of the seriousness of his heart condition and the danger of continuing to play competitive basketball. Plaintiffs further alleged that, at the urging of Loyola Marymount's coach, Gathers' heart medication was reduced below therapeutic levels to enable him to play better. *See* Complaint, Gathers v. Loyola Marymount Univ. (Los Angeles Cal. Super. Ct., filed Apr. 20, 1990) (No. C759027). In sum, plaintiffs contended that Gathers was "sacrificed on the altar of basketball" in Loyola Marymount's quest for basketball success, notoriety and economic gain. *Id.* at 49; Marianne Lavelle, *From Court to Court*, NAT'L L.J., Mar. 4, 1991, at 1; Munnings, *supra* note 1, at 98. *See generally* Shelley Smith, *A Bitter Legacy*, SPORTS ILLUSTRATED, Mar. 4, 1991, at 62.

11. All of plaintiff's claims were ultimately settled or dismissed prior to trial. *Gathers Family Suit Dismissed by Judge*, HOUS. CHRON., Sept. 10, 1992, at 8C; *Gathers' Mother Settles Lawsuit With University*, THE NCAA NEWS, Apr. 1, 1992, at 2.

12. William Nack, *Was Justice Paralyzed?*, SPORTS ILLUSTRATED, July 25, 1988, at 32.

13. *Id.*

14. *Id.*

15. Greg Boeck, *Autopsy: Lewis Had Abnormal Heart*, USA TODAY, Aug. 5, 1993, at C1; Judy Foreman, *Lewis Autopsy Reveals Enlarged, Scarred Heart*, HOUS. CHRON., Aug. 5, 1993, at C9.

16. William O. Johnson, *Heart of the Matter*, SPORTS ILLUSTRATED, May 24, 1993, at 36, 36-41.

17. *Id.*

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had "the normal heart of an athlete."[18] A third medical opinion found evidence to support both opinions.[19] Autopsy reports indicated that Lewis' heart had extensive scar tissue, consistent with a diagnosis of cardiomyopathy.[20]

Competitive athletes often feel invincible. They desire to play a sport for psychological or economic reasons and are willing to sacrifice their bodies to accomplish an athletic objective. The tragic deaths of Gathers, Penny, and Lewis, and the paralyzing injury suffered by Buoniconti, illustrate the potential risks an athlete faces while playing competitive athletics with a physical abnormality or injury.[21] On the other hand, an athlete may be able to play safely and successfully with a disease, injury or illness.[22] For example, Terry Cummings has played NBA basketball for many years with a heart condition.[23]

Team physicians have the sometimes conflicting objectives of protecting the athlete's health while minimizing the time spent on the sideline. Sports medicine is evolving and often lacks definite scientific data on which a team physician can rely in order to clear an athlete to play.[24] In addition to facing medical uncertainty, the team physician may be subjected to extreme pressure from the athlete and/or team officials to provide medical clearance or treatment necessary for the athlete to play.[25]

The Gathers, Penny and Buoniconti litigations demonstrate that providing medical clearance for sports participation and treating athletic injuries involves legal as well as medical issues.[26] Although each of

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18. *Id.*

19. Lawrence K. Altman, *Lewis's Doctor Says More Testing was in the Works*, N.Y. TIMES, Aug. 6, 1993, at B11, B11; E.M. Swift, *A City in Mourning*, SPORTS ILLUSTRATED, Aug. 9, 1993, at 20, 23-24.

20. Foreman, *supra* note 15.

21. These risks are further illustrated by the fact that Pete Maravich, a former NBA star, Flo Hyman, an Olympic volleyball player, and Chuck Hughes, a Detroit Lions' wide receiver, all died from sudden cardiac death while playing sports. Colleen M. Fay, M.D. & Joseph S. Torg, M.D., *Sudden Cardiac Death in the Athlete: A Review*, CONTEMP. ORTHOPAEDICS, June 1990, at 575, 575; *see also* Elliott Almond, *Sudden Death For Athletes Is Not Uncommon*, L.A. TIMES, Mar. 5, 1990, at C13.

22. *See generally* Matthew J. Mitten, *Amateur Athletes With Handicaps or Physical Abnormalities: Who Makes the Participation Decision?*, 71 NEB. L. REV. 987, 989 (1992).

23. Gerald Eskenazi, *Athlete and Health: Many at Risk*, N.Y. TIMES, Mar. 11, 1990, § 8, at 1.

24. *See infra* notes 69-74 and accompanying text.

25. *See infra* notes 77-80 and accompanying text.

26. As an additional example, the mother of former Oregon State University basketball star Earnest Killum recently sued the university, claiming her son was improperly cleared to resume playing basketball, which led to his death. Her allegations are similar to those made by Gathers'

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these cases raised important legal issues, none established binding precedent. The Gathers and Penny litigation settled before trial, and the Buoniconti jury verdict was not reviewed by an appellate court.[27] The allegations in the Gathers and Penny suits appear to argue for imposing inconsistent obligations on team physicians. The Lewis tragedy also raises several important, unresolved legal issues.

There are few reported judicial opinions concerning litigation between team physicians and competitive athletes. Athletes have asserted fraud and medical malpractice claims against team physicians. Team physicians, in turn, have asserted contributory negligence and assumption of the risk defenses against athletes. Few cases have created legal precedent or established clear guidelines for physicians and athletes regarding their respective obligations.

Section II of this article discusses a competitive athlete's willingness to assume heath risks in light of psychological and economic pressures to play a sport. Section III discusses an athlete's legal right to play a sport with a medical condition or physical abnormality. Section IV considers the team physician's frequently encountered pressures in advising and treating athletes, and potential conflicting obligations to the athlete and team. Section V discusses a team physician's legal obligations in treating an athlete and proposes a standard of care for team physicians and others practicing sports medicine to ensure that the athlete's health is protected adequately. Section VI addresses an athlete's duty to use reasonable care to protect his or her health and assumption of responsibility for choosing to play with an injury or abnormal physical condition.

Ideally, the team physician and a competitive athlete will develop a trusting relationship by working together to promote safely the athlete's health and avoid unnecessary exclusion from athletic competition. This article concludes that a team physician or a competitive athlete should bear legal responsibility if either violates his respective obligations. Liability should be apportioned between the physician and the athlete based on comparative responsibility principles.

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heirs. David L. Herbert, *Another Basketball Star Dies*, 5 Sports Med. Standards and Malpractice Rep. (Professional Reports Corp.) 17, 19 (Apr. 1993). *See generally Oregon St. Guard Killum Dead* at 20, HOUS. CHRON., Jan. 21, 1992, at 4B; Phil Taylor, *Inside College Basketball*, SPORTS ILLUSTRATED, Jan. 13, 1992, at 65.

27. The Buonicontis ultimately decided not to appeal a jury verdict in favor of the team physician. Buoniconti Suit, AP, Oct. 28, 1988, available in LEXIS, Nexis Library, AP File. *See infra* notes 259-64 and accompanying text for a discussion of this lawsuit.

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II. COMPETITIVE ATHLETE'S DESIRE TO PLAY

A "competitive athlete" has been defined as

> one who participates in an organized team or individual sport that requires regular competition against others as a central component, places a high premium on excellence and achievement and requires vigorous training in a systematic fashion. Another important facet of competitive activity is that the athlete may not be able to use proper judgment in determining whether to extricate himself or herself from the competitive event, should that become necessary. . . . [T]he athlete may not immediately terminate the physical exertion even when the need to do so is perceived, because of the unique circumstances and pressures of organized athletic competition.[28]

Competitive athletes may exist at the youth (less than twelve years old), interscholastic, intercollegiate, professional or masters (greater than 40 years old) levels of sports.[29]

Most athletes are risk takers by nature and accept some risk of injury merely by engaging in competitive sports. Competitive athletes are more likely to accept the risk of injury from sports participation than recreational athletes.[30] The possibility of bumps, bruises and even broken bones during play is a known, inherent risk willingly assumed by competitive athletes.[31] Serious injuries and some deaths annually occur in competitive sports.[32]

In addition to normal risks of injury, athletes with a physical abnormality, illness, or existing injury may be willing to assume an enhanced risk of harm to play a competitive sport. The joy of athletic

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28. Barry J. Maron et al., *Introduction to 16th Bethesda Conference: Cardiovascular Abnormalities in the Athlete: Recommendations Regarding Eligibility for Competition*, 6 J. AM. C. CARDIOLOGY 1189, 1189 (1985) [hereinafter *16th Bethesda Conference*]; *see also* Barry J. Maron, *Hypertrophic Cardiomyopathy in Athletes—Catching a Killer*, THE PHYSICIAN & SPORTSMED., Sept. 1993, at 83, 90 (" 'Competitive' refers to organized sports that involve regular competition, emphasize excellence, and require vigorous and systematic training.").

29. *16th Bethesda Conference*, *supra* note 28, at 1189.

30. Gerald J. Todaro, *Sports Medicine Malpractice—Informed Consent and the Recreational Athlete*, TRIAL, May 1985, at 34, 35.

31. Gerald Secor Couzens, *Football: A Painful Legacy for Players?*, THE PHYSICIAN & SPORTSMED., Oct. 1992, at 146, 152; Gerald J. Todaro, *Allocation of Risk Based on the Mechanics of Injury in Sports: A Proposed Presumption of Non-Fault*, 10 HASTINGS COMM. & ENT. L J 33, 41 n.37 (1987).

32. For sources listing death and injury statistics in various sports, *see* Mitten, *supra* note 22, at 988 n.2 and accompanying text; Gerald Eskenazi, *The Price of Disability in N.F.L. Has Few Guarantees*, N.Y. TIMES, Dec. 6, 1992, § 8, at 1, 2; Peter King, *The Unfortunate 500*, SPORTS ILLUSTRATED, Dec. 7, 1992, at 20, 21; *What's Going On With Football and Baseball Injuries*, THE SPORTS LAW, May/June 1993, at 6, 6; *Wrestling Injuries at Eight-Year High, Survey Reveals*, THE NCAA NEWS, May 12, 1993, at 7.

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participation, pursuit of excellence and prestige, psychological factors, potential economic gain and pressure may motivate competitive athletes to participate vigorously in competitive sports even if doing so exposes them to serious health risks.

Professional athletes have relatively short playing careers[33] and are paid to perform on the field, not spend time on the disabled list. Athletes are lauded for playing with pain[34] and may be ostracized if they refuse to do so.[35] Professional athletes are expected to sacrifice their bodies for the good of the team.[36]

Team managers and coaches, whose livelihoods depend on winning games, may pressure professional athletes to play while hurt.[37] For instance, a National Hockey League team threatened a player with a suspension if he refused to play while injured.[38] Pressure from fellow players or the team's fans also may motivate an injured professional athlete to play despite health risks.[39]

Professional athletes may have personal, psychological and economic reasons for playing despite pain or a physical malady. Positions on professional teams are limited, and there is substantial competition for the available positions. One may fear permanent loss of his position by sitting out a game. Wally Pipp forever lost his position to Lou Gehrig when he refused to play with a cold one day.[40] An athlete who spends significant time on the injury list is not, over the long run, paid as much as the person who is playing.

College athletes also are willing to play with injuries or physical

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33. The average career span is 3.5 years in the National Football League, four years in the National Basketball Association and National Hockey League, and 4.5 years in major league baseball. *Advice For College Athletes*, HOUS. CHRON., Aug. 24, 1992, at 7B, 7B.

34. Mitten, *supra* note 22, at 993-94.

35. Angelo Cataldi & Glen Macnow, *The Pitfalls of Playing With Pain*, PHILA. INQUIRER, June 20, 1989, at 1D, 8D; *see also* Steve Huffman & Rick Telander, *"I Deserve My Turn,"* SPORTS ILLUSTRATED, Aug. 27, 1990, at 26.

36. As a federal court observed: "Professional football players are conditioned to 'play with pain' and they are expected to perform even though they are hurt. The standard player contract imposes an obligation to play when the club physician determines that an injured player has the requisite physical ability." Hackbart v. Cincinnati Bengals, Inc., 435 F. Supp. 352, 355 (D. Colo. 1977), *rev'd on other grounds*, 601 F.2d 516 (10th Cir. 1979), *cert. denied*, 444 U.S. 931 (1979).

37. Morley B. Pitt, *Malpractice on the Sidelines: Developing a Standard of Care for Team Sports Physicians*, 2 HASTINGS COMM. & ENT. L.J. 579, 588 n.52 (1980); John Papanek, *Off on a Wronged Foot*, SPORTS ILLUSTRATED, Aug. 21, 1978, at 19, 22.

38. Robitaille v. Vancouver Hockey Club, Ltd., 124 D.L.R.3d 228, 230, 232 (B.C. Ct. App. 1981).

39. Pitt, *supra* note 37, at 588-89.

40. James H. Davis, *"Fixing" the Standard of Care: Motivated Athletes and Medical Malpractice*, 12 AM. J. TRIAL ADVOC. 215, 217-18 (1988); Eskenazi, *supra* note 23, at 1.

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abnormalities. Despite enormous odds,[41] many of them aspire to a future professional career and fear missing an opportunity to impress pro scouts by not playing. Like professional athletes, college athletes may be pressured by their coaches to play while hurt.[42] Renewable one-year scholarships give coaches the leverage to demand player obedience to their wishes.[43] One college coach allegedly pressured an athlete who did not play well because of an illness to give up his football scholarship the following season.[44]

Pressure from adoring fans,[45] love of the game, or an inability to appreciate the health risks of playing with an injury or illness may influence strongly a college player's willingness to play regardless of the consequences. For example, while being transported by ambulance to the hospital, a Temple University player who was temporarily paralyzed during a game, suddenly sprang up and desired to play.[46] An athlete played football for the University of Arkansas although doctors warned him he would never live a normal life if he continued to play with severe asthma.[47]

Even high school athletes have demonstrated a willingness to expose themselves to serious injury or death to play a chosen sport. One player's desire to play high school football with a serious heart condition was so strong that he told his mother, "Mother, if I have to die, I'd rather die playing ball. That's what I love to do."[48] Other high school athletes have rejected recommended medical treatment, thereby risking their health to continue playing interscholastic sports.[49] For instance,

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41. Fewer than one in a 100 college athletes will be able to earn a living from their athletic ability. KNIGHT FOUND.: COMMISSION ON INTERCOLLEGIATE ATHLETICS, KEEPING FAITH WITH THE STUDENT ATHLETE 27 (1991).

42. Huffman & Telander, *supra* note 35, at 26.

43. MURRAY SPERBER, COLLEGE SPORTS INC.: THE ATHLETIC DEPARTMENT VS. THE UNIVERSITY 7, 207-08 (1990).

44. Rutledge v. Ariz. Bd. of Regents, 660 F.2d 1345, 1347-48 (9th Cir. 1981), *aff'd sub nom.* Kush v. Rutledge, 460 U.S. 719 (1983).

45. A recent study revealed that college fans' moods and self-esteem swing like a pendulum depending on their favorite team's success. *Fans' Self-Esteem Tied to their Team's Performance*, THE NCAA NEWS, Dec. 30, 1992, at 3. This helps explain why fans revere talented college athletes.

46. Cataldi & Macnow, *supra* note 35, at 8D.

47. Jonathan Feigen, *Health Risk Can't Keep Phillips from Football*, HOUS. CHRON., Aug. 31, 1991, at 1B, 1B, 6B.

48. Mike Dodd, *Who Decides Health Risk is Too High?*, USA TODAY, Oct. 5, 1990, at 1C, 2C.

49. "Boobie" Miles, a fullback for Permian High School in Odessa, Texas, tore ligaments and cartilage in his knee during a preseason scrimmage. An orthopedic surgeon recommended that he have immediate reconstructive surgery. Instead, Miles chose a rehabilitation program allowing

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teenage gymnasts sometimes take health risks with long-term adverse consequences in their pursuit of stardom and Olympic medals.[50]

These examples demonstrate that amateur and professional athletes at all levels of competition have a strong desire to participate in their respective sports. A recent empirical study of seventy-two athletes with sports-related injuries ranging in age from twelve to fifty-four years old suggests that some injured athletes would rather play with physical pain than suffer the emotional pain of not playing.[51] Athletes may disregard the potential adverse consequences of playing with a medical condition or injury, and make decisions inconsistent with their best health interests.

III. COMPETITIVE ATHLETE'S LEGAL RIGHT TO PLAY

Professional athletes have successfully used state employment discrimination statutes to challenge professional sports league bylaws that prohibit athletes with certain physical impairments from playing.[52] Courts have rejected claims that such bylaws violate the federal antitrust laws, because their primary purpose is promoting player safety.[53] Physically impaired professional athletes may now challenge exclusion under the Americans With Disabilities Act of 1990 ("ADA"),[54] which is patterned after the Rehabilitation Act of 1973.[55]

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him to play football with a knee brace. He was willing to risk further injury to his knee and future arthritis to pursue his dream of a professional career. H.G. Bissinger, *Friday Night Lights*, SPORTS ILLUSTRATED, Sept. 17, 1990, at 82, 90. To keep playing high school baseball, Jeff Banister, now a catcher for the Pittsburgh Pirates, refused his physician's recommendation that his cancerous leg be amputated. He told his father, "I'd rather die than not be able to play baseball." *Bucs Make Dream Reality For UH Ex*, HOUS. POST, July 24, 1991, at C-7.

50. John P. Lopez, *Gymnastics' Unhealthy Obsession; Critics Say Overbearing Coaches Breed Disorders*, HOUS. CHRON., July 30, 1993, at 1B; Aric Press et al., *Old Too Soon, Wise Too Late*, NEWSWEEK, Aug. 10, 1992, at 22, 23-24.

51. A summary of the study by Aynsley M. Smith, a sports psychologist at the Mayo Clinic, is discussed in James J. Thornton, *Playing in Pain: When Should an Athlete Stop?*, THE PHYSICIAN & SPORTSMED., Sept. 1990, at 138, 141.

52. *See* Neeld v. Am. Hockey League, 439 F. Supp. 459, 462-63 (W.D.N.Y. 1977). The same court found no violation of the U.S. Constitution's equal protection clause because a professional sports league's conduct does not constitute state action. *Id.* at 461-62.

53. Neeld v. Nat'l Hockey League, 594 F.2d 1297, 1300 (9th Cir. 1979).

54. 42 U.S.C. §§ 12101-213 (Supp. II 1990 & Supp. III 1991). *See generally* Cathy J. Jones, *College Athletes: Illness or Injury and the Decision to Return to Play*, 40 BUFF. L. REV. 113, 189-97 (1992). For a discussion regarding whether HIV positive professional athletes have a legal right to play sports, *see* Matthew J. Mitten, *AIDS and Athletics*, 3 SETON HALL J. SPORT L. 5, 38 (1993).

55. 29 U.S.C. §§ 701-96 (1988, Supp. I 1989, Supp. II 1990 & Supp. III 1991). The ADA is not to be construed to apply a lesser standard than the standards applicable under the Rehabili-

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College and high school athletes have sued their schools claiming a legal right to participate in athletics with a medical condition or physical disability.[56] These suits are generally based on section 504 of the Rehabilitation Act of 1973,[57] which prohibits institutions receiving federal funds from engaging in unjustified discrimination against qualified handicapped athletes.[58]

In *Southeastern Community College v. Davis*, the Supreme Court held that an educational institution may require a person to possess "reasonable physical qualifications" to participate in its programs and activities.[59] Athletic teams and sponsors of sporting events generally require an athlete to pass a physical examination performed by a designated physician as a precondition to participating in a sport.[60] Most athletic teams permit an athlete to play a sport only if the team physician has given medical clearance.

Courts refuse to hold that an athlete with a physical abnormality or handicap has an absolute right to participate in school-sponsored athletics. A federal district court held that requiring a high school athlete to obtain a physician's certification of medical fitness to participate in a sport is legally permissible under the Rehabilitation Act.[61]

The Rehabilitation Act and ADA require that athletic teams provide reasonable accommodations to enable physically impaired athletes to participate in sporting events.[62] This author has argued that, to satisfy this requirement, sponsors of athletic events should permit an athlete with a medical condition or impairment to decide whether to participate in a sport if competent and respected medical experts disagree in their participation recommendations and the athlete is fully informed of all material medical risks.[63] Consistent with this position,

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tation Act of 1973. 42 U.S.C.A. § 12201(a) (Supp. III 1991). The ADA's regulations are required to be consistent with corresponding regulations in the Rehabilitation Act of 1973. 42 U.S.C. § 12134(b) (Supp. II 1990 & Supp. III 1991). In addition, the ADA regulations are not to be construed to apply a lesser standard. 28 C.F.R. § 36.103(a) (1992).

56. *See, e.g.*, Kampmeier v. Nyquist, 553 F.2d 296 (2d Cir. 1977); Grube v. Bethlehem Area Sch. Dist., 550 F. Supp. 418 (E.D. Pa. 1982); Wright v. Columbia Univ., 520 F. Supp. 789 (E.D. Pa. 1981); Poole v. S. Plainfield Bd. of Educ., 490 F. Supp. 948 (D.N.J. 1980).

57. 29 U.S.C. § 794 (1988).

58. *Id. See generally* Mitten, *supra* note 22, at 1007-26.

59. 442 U.S. 397, 414 (1979).

60. Mitten, *supra* note 22, at 1014-15.

61. Partial Transcript of Proceedings at 15-16, Larkin v. Archdiocese of Cincinnati (S.D. Ohio 1990) (No. C-1-90-619).

62. *See* Mitten, *supra* note 54, at 35-38.

63. *See* Mitten, *supra* note 22, at 1016-26.

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courts have permitted athletes to choose to participate in a sport contrary to the team physician's recommendation if other competent medical authority has approved participation.[64]

The Rehabilitation Act and the ADA's recognition of an athlete's personal autonomy interests may provide the athlete with a legal right to participate in a sport against the team physician's advice. An athlete with a medical condition may choose to accept an enhanced risk of injury if under the circumstances, reasonable and competent physicians disagree regarding the medical risks of athletic participation.

IV. TEAM PHYSICIAN'S CONFLICTING RESPONSIBILITIES

One commentator has defined a "team physician" as "a physician who undertakes to render professional medical services to athletic participants and whose services are either arranged for or paid for at least in part by an institution or entity other than the patient, the patient's family, or some surrogate."[65] Under this definition, a "team physician" includes one who volunteers gratuitously or is selected by a team to perform preparticipation physicals paid for by the player.[66]

Team physicians are generally either family practitioners or orthopedic surgeons.[67] Other specialists such as internists, cardiologists, pediatricians, dermatologists and gynecologists also practice sports medicine.[68] Currently, the American Board of Medical Specialties does not recognize a specialized practice area for sports medicine. However,

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64. A majority of the courts that have considered the issue have held that a school's exclusion of a handicapped athlete from a sport based on the team physician's recommendation violates the Rehabilitation Act if other competent medical authority approves participation. These cases involve situations in which amateur athletes seek to play a contact sport despite the loss of a functioning paired organ such as an eye or kidney. *See, e.g.*, Grube v. Bethlehem Area Sch. Dist., 550 F. Supp. 418 (E.D. Pa. 1982); Wright v. Columbia Univ., 520 F. Supp. 789 (E.D. Pa. 1981); Poole v. S. Plainfield Bd. of Educ., 490 F. Supp. 948 (D.N.J. 1980). *But see* Kampmeier v. Nyquist, 553 F.2d 296 (2d Cir. 1977) (upholding athlete's exclusion from a contact sport based on team physician's recommendation despite participation approval from other physicians). *See generally* Jones, *supra* note 54, at 177-89.

65. Joseph H. King, Jr., *The Duty and Standard of Care for Team Physicians*, 18 HOUS. L. REV. 657, 658 (1981).

66. *Id.* at 658-59.

67. Telephone interview with Thomas F. Miller, Executive Director, American Medical Society for Sports Medicine (June 23, 1993). For a general discussion of the historical evolution of sports medicine and its various aspects, *see* Allan J. Ryan, *Medical Practices in Sports*, 38 LAW & CONTEMP. PROBS. 99 (1973).

68. Charles Russell, *Legal and Ethical Conflicts Arising From the Team Physician's Dual Obligations to the Athlete and Management*, 10 SETON HALL LEGIS. J. 299, 300 (1987); Lawrence K. Altman, *Doctor's World; College Star's Death Puts Team Physicians Under Scrutiny*, N.Y. TIMES, May 1, 1990, at C3.

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the American Osteopathic Association is considering a proposal to establish a certification board for sports medicine.[69]

A physician certified by the American Board of Emergency Medicine, Internal Medicine, Family Practice or Pediatrics may earn a certificate of added qualification in sports medicine by passing a written examination.[70] Physicians may also obtain training in sports medicine by serving a one-year fellowship offered by various clinics.[71]

With the absence of a board-certified specialty in sports medicine, standardized education or training requirements, team physicians have diverse backgrounds and differing levels of experience in caring for athletes. Medical science lacks conclusive scientific and clinical data for certain medical conditions. Therefore, the team physician, perhaps with the assistance of consulting specialists, must make an individualized evaluation of the medical risks of participation for each competitive athlete.[72] Sports medicine guidelines formulated by medical specialty groups and organizations provide recommendations regarding whether an athlete should play with a particular medical condition, but also recognize the importance of the examining physician's clinical judgment and the athlete's unique physiology in determining the appropriate course of action.[73] Sports medicine physicians may disagree regarding the nature and magnitude of the risks of athletic participation with a particular medical condition. They may also disagree as to whether participation in a sport is medically reasonable.[74]

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69. Miller telephone interview, *supra* note 67. The American Board of Specialties certifies postgraduate training for allopathic (M.D.) programs; whereas, the American Osteopathic Association certifies corresponding osteopathic (D.O.) programs. *Id.*

70. *Id.*

71. *Id.*

72. Mitten, *supra* note 22, at 995-1000.

73. AMERICAN ACADEMY OF FAMILY PHYSICIANS ET AL., PREPARTICIPATION PHYSICAL EXAMINATION 3, 30-31 (Holly Swander ed., 1992) [hereinafter PPE]; Committee on Sports Medicine, *Recommendations for Participation in Competitive Sports*, 81 PEDIATRICS 737, 739 (1988) [hereinafter *Pediatric Recommendations*]; *16th Bethesda Conference*, *supra* note 28, at 1186, 1189-90.

74. In at least two instances physicians have disagreed as to whether college football players with spinal stenosis should be medically cleared to play college football because of the risk of paralysis. Because of differing medical opinions, Arizona State University officials permitted Mark Tingstad to decide whether to continue playing football. Richard Demak, *Was It Worth the Risk?*, SPORTS ILLUSTRATED, Dec. 18, 1989, at 76. In a similar case, the University of Wyoming refused to permit Steve Clayton to continue playing. Mitten, *supra* note 22, at 1005-07. Seven physicians recently cleared New York Jets' defensive end Jeff Lageman to keep playing football with a disk problem in his neck. Although an eighth physician warned him that he risked serious injury by playing, Lageman decided to continue playing. Mike Freeman, *Jets' Lageman to Play Despite Injury to Neck*, N.Y. TIMES, Oct. 20, 1993, at B10.

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One of the team physician's objectives is to avoid the unnecessary restriction of athletic activity,[75] but his or her paramount responsibility should be to protect the competitive athlete's health.[76] Team physicians may face extreme pressure from coaches,[77] team management,[78] fans,[79] or the athlete[80] to provide medical clearance to participate or treatment enabling immediate return to play. However, the team physician's judgment always "should be governed only by medical considerations,"[81] rather than the team's need for the services of the player or the athlete's strong desire to play.

Although the team physician is selected and paid by an athletic team, he or she must provide medical treatment and advice consistent with an individual athlete's best health interests because there is a physician-patient relationship between them. The physician-patient relationship is consensual in nature and both the physician and athlete must demonstrate by agreement or conduct their willingness to enter into such a relationship.[82] If the athlete seeks medical advice or treat-

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75. Thomas E. Shaffer, *So You've Been Asked to be the Team Physician*, THE PHYSICIAN & SPORTSMED., Dec. 1976, at 57, 61.

76. AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS AND CURRENT OPINIONS OF THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS—1989, § 3.06, *reprinted in* RENA A. GORLEN, CODES OF PROFESSIONAL RESPONSIBILITY 203 (2d ed. 1989) [hereinafter AMA PRINCIPLES]; PPE, *supra* note 73, at 2, 5; King, *supra* note 65, at 691; Eskenazi, *supra* note 23, at 1; Leland L. Fairbanks, *Return to Sports Participation*, THE PHYSICIAN & SPORTSMED., Aug. 1979 at 71, 71; W. Norman Scott, *Heartbreaking Art and Science of Sports Med.*, N.Y. TIMES, Aug. 1, 1993, § 8, at S9, S9.

77. *See* Angelo Cataldi & Glen Macnow, *A Question of Trust for Athletes*, PHILA. INQUIRER, June 19, 1988, at A1 [hereinafter *A Question of Trust*]; Angelo Cataldi & Glen Macnow, *Team Doctors: A Crisis in Ethics*, PHILA. INQUIRER, June 18, 1989, at A1 [hereinafter *A Crisis in Ethics*.].

78. Bruce C. Ogilvie, *Walking the Perilous Path of the Team Psychologist*, THE PHYSICIAN & SPORTSMED., April 1977, at 63, 64; Pitt, *supra* note 37, at 589.

79. Dr. Frank Bassett, Duke University's team physician, was ridiculed by Duke fans for holding star player Danny Ferry out of a 1989 basketball game because of back spasms. *A Question of Trust*, *supra* note 77, at A11.

80. A professional football player reportedly threatened a team physician with violence unless he gave him a painkiller to enable him to play in a game. Cataldi & Macnow, *supra* note 35, at D8.

81. AMA PRINCIPLES, *supra* note 76. Some sports medicine physicians appear to inappropriately consider factors other than the potential effects on an athlete's health in deciding whether to clear athletes to participate in a sport. For example, Karl Mecklenburg, a Denver Broncos football player, was cleared by an ear specialist to continue playing with an inner ear problem that may cause permanent hearing loss if he further injures a membrane. He stated: "The doctor has said all along that it's my decision what to do. . . . I was told if I was a high school player, she'd tell me not to play football again." *Ear Injury Sidelines Broncos' Mecklenburg*, DALLAS MORNING NEWS, Aug. 4, 1993, at 8B, 8B; *see also* Mitten, *supra* note 22, at 996.

82. King, *supra* note 65, at 662-65.

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ment and the team physician undertakes to provide either, the physician owes the athlete a duty of care even though the team selects or pays the physician or benefits from the medical care rendered to the athlete.[83]

Competitive athletes, especially youthful ones, may rationalize the potential health consequences of playing with a physical abnormality or injury.[84] The team physician must recommend against athletic participation that he or she believes will pose a medically unreasonable risk of harm to the athlete. Many athletes trust the team physician and rely on his or her recommendation regarding whether athletic participation is medically advisable under the circumstances.[85]

Athletic teams must use reasonable care in operating their programs and protecting the health and safety of their players.[86] Professional[87] and amateur[88] team officials generally rely on the opinion of the team physician, and her chosen consulting specialists regarding the medical risks of participation and the athlete's physical ability to com-

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83. *Id.* at 664-65; Russell, *supra* note 68, at 302-03. For an in-depth discussion of the scope of the physician-patient relationship created by a preparticipation physical examination at the bequest of a third party, *see* King, *supra* note 65, at 665-71. *But see* Murphy v. Blum, 554 N.Y.S.2d 640 (App. Div. 1990) (holding that no physician-patient relationship arose out of preseason physical exam of NBA referee conducted solely to advise league regarding referee's physical capabilities).

84. Discussing his decision to continue playing football despite being diagnosed as having spinal stenosis, Mark Tingstad explained: "When you're an athlete and you're involved in sports with a physical activity, you think you're impervious, you're talented and you think nothing can happen to you." Eskenazi, *supra* note 23, at 1. Mark later gave up college football after suffering temporary paralysis caused by making a tackle. *Id.*; *see also supra* notes 46-50 and accompanying text.

85. Thornton, *supra* note 51, at 138. Some professional players have contended that team physicians consider the team's needs first and approve continued participation or provide medical treatment that jeopardizes a player's health. A 1988 *Los Angeles Times* survey of former NFL players found that 53% of the respondents believed their health interests were compromised by a team physician during their pro careers. Team physicians generally side with the team in injury grievance proceedings brought by NFL players. *A Crisis in Ethics*, *supra* note 77, at A01; Nack, *supra* note 12, at 33; *see also* Chris Dufresne & Gene Wojciechowski, *Delicate Procedures; NFL Team Physicians Must Provide Proper Care to Injured Players and Please Management at Same Time*, L.A. TIMES, June 26, 1988, § 3, at 12.

86. *See generally* JOHN C. WEISTART & CYM H. LOWELL, THE LAW OF SPORTS § 8.05, at 970 (1979).

87. The Houston Rockets suspended Hakeem Olajuwon without pay for refusing to play despite medical clearance from the team physician. Olajuwon claimed to have a hamstring injury that prevented him from playing. The Rockets contended his claimed injury was merely a contract negotiation ploy. *See* Eddie Sefko, *Olajuwon, Rockets in Stalemate; All-Star Hints at 3-Week Recovery*, HOUS. CHRON., Mar. 25, 1992, at 1C; Eddie Sefko, *Olajuwon Suspended Without Pay; Star's Agent Says He Will File Grievance*, HOUS. CHRON., Mar. 24, 1992, at 1A.

88. Mitten, *supra* note 22, at 1000-03.

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pete in a sport. Team officials generally grant the team physician the authority to medically disqualify a competitive athlete from a sport.[89]

Recent litigation challenging medical clearance recommendations, diagnoses, and injury treatment procedures by sports medicine physicians has created uncertainty regarding the nature and scope of the team physician's legal obligations. Athletes have sued team physicians for refusing to medically clear them to play a sport.[90] On the other hand, some team physicians have been sued for clearing athletes to play when participation results in the athlete's death or injury,[91] providing inadequate medication or equipment,[92] or failing to disclose the long-term effects of playing with a medical condition or injury to the athlete's health.[93] The threat of lawsuits challenging sports medicine decisions and practices looms over team physicians,[94] whether they deny or permit participation. Controlling legal principles need to be established.

V. TEAM PHYSICIAN'S LEGAL RESPONSIBILITY

This section first considers the team physician's duty to screen athletes for potentially harmful medical conditions, properly diagnose their condition, and provide appropriate medical treatment. A physician's responsibility to provide sound medical clearance recommendations and inform an athlete of the risks of athletic participation and medical treatment will then be discussed. Finally, the circumstances under which team physicians may be immune from malpractice claims will be discussed.

A. Screening, Diagnosis, and Treatment

This section discusses general medical malpractice principles and their application to sports medicine. The traditional legal standard of requiring a team physician to follow customary sports medicine practice is then examined. The adoption of "accepted sports medicine prac-

89. *Id.* at 1001.

90. *See supra* notes 8-9, *infra* note 170 and accompanying text; *see also* Sitomer v. Half Hollow Hills Cent. Sch. Dist., 520 N.Y.S.2d 37, 38 (App. Div. 1987) (dismissing claim alleging physician negligence resulting in school's refusal to permit junior high school student to play on high school tennis team).

91. *See supra* notes 10-14, *infra* notes 139-47, 259-62 and accompanying text.

92. *See infra* notes 113, 135-37, 259-62 and accompanying text.

93. *See infra* notes 196-98 and accompanying text.

94. *See* Dufresne & Wojciechowski, *supra* note 85.

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tice" as the controlling legal standard is proposed as a better alternative.

1. General Principles

During the care of a patient, a physician "must have and use the knowledge, skill and care ordinarily possessed and employed by members of the [medical] profession in good standing."[95] Malpractice liability is based on harm caused by a physician's negligent conduct in light of the general knowledge and skill of the medical profession.[96] The law generally permits the medical profession to establish the bounds of appropriate physician care and treatment under the circumstances.[97]

Until the middle of this century, the standard of care was based on the medical practices in the defendant physician's local community.[98] Physicians were required to exercise the level of care prevailing in the locality where they practiced. The rationale for this rule was to avoid treating rural physicians unfairly by holding them to the standard of doctors practicing in large cities, who generally had more modern treatment facilities and better access to knowledge of medical advances.[99]

Most states have now modified this locality rule because of advances in communication and transportation as well as the wide availability of medical literature. These advances enable all physicians to keep abreast of medical developments.[100] For general practitioners, states have either broadened the relevant geographical community to include localities of similar size or treated the defendant physician's

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95. W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 32, at 187 (5th ed. 1984) [hereinafter PROSSER].

96. In any medical malpractice case, the plaintiff must prove that his harm probably would not have occurred without the defendant physician's negligent conduct. *Id.*, § 41, at 264-72.

97. Page Keeton, *Medical Negligence—The Standard of Care*, 10 TEX. TECH L. REV. 351 (1979); Richard N. Pearson, *The Role of Custom in Medical Malpractice Cases*, 51 IND. L.J 528, 535-37 (1976). In some states, the standard is whether the physician's conduct was reasonable under the circumstances, with medical expert testimony being admissible but not conclusive. Hood v. Phillips, 554 S.W.2d 160, 165-66 (Tex. 1977); Harris v. Robert Groth, M.D., Inc., 663 P.2d 113, 117-18 (Wash. 1983). *But see* Helling v. Carey, 519 P.2d 981 (1974) (holding ophthalmologist negligent as a matter of law for failing to administer glaucoma test even though he conformed to medical custom). *Helling* has not been followed by other courts and has been validly criticized. Joseph H. King, Jr., *In Search of a Standard of Care for the Medical Profession: The "Accepted Practice" Formula*, 28 VAND. L. REV. 1213, 1247-51 (1975); Pearson, *supra* at 528-34.

98. *See* Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408 (1969).

99. *See, e.g.*, Brune v. Belinkoff, 235 N.E.2d 793, 796 (Mass. 1968).

100. PROSSER, *supra* note 95, § 32, at 188, 256.

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local community as merely one factor to be considered in determining the standard of care.[101] For specialists, the trend is to apply a national standard of care because national specialty certification boards, standardized training and certification procedures exist.[102]

Courts have not recognized sports medicine as a separate medical specialty,[103] presumably because there is no national medical specialty board certification or standardized training.[104] Some commentators argue that the team physician should be held to the standard of a "reasonably competent general practitioner" unless he provides services performed exclusively by specialists or holds himself out as possessing special competence in sports medicine.[105] Others assert that the team physician should be treated as a specialist aware of "fundamentals which all practicing specialists in sports medicine should know, based on the types of athletes with whom the physician is involved."[106] A team physician implicitly holds herself out as having special competence in sports medicine and therefore should be held to this higher standard. Team physicians also should conform to the standard of care corresponding to their actual specialty training; for example, an orthopedic surgeon should be held to the standard of an orthopedist specializing in sports medicine.[107]

A national standard of care for team physicians is preferable to a local community standard because appropriate care should not vary with the geographic location of sports medicine care and treatment. For example, proper treatment of a sprained ankle should be the same whether occurring during a home or away game.[108]

2. *Customary Sports Medicine Practice*

The applicable legal standard of physician conduct is "good medical practice" within the physician's type of practice.[109] In other words,

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101. *See* James O. Pearson, Annotation, *Modern Status of "Locality Rule" in Malpractice Action Against Physician Who Is Not A Specialist*, 99 A.L.R.3d 1133 (1980 & Supp. 1992).

102. *See* Jay M. Zitter, Annotation, *Standard of Care Owed to Patient by Medical Specialist as Determined by Local, "Like Community," State, National, or Other Standards*, 18 A.L.R. 4th 603 (1982 & Supp. 1992).

103. *See, e.g.*, Fleischmann v. Hanover Ins. Co., 470 So. 2d 216-17 (La. Ct. App. 1985).

104. *See supra* notes 67-69 and accompanying text.

105. King, *supra* note 65, at 695.

106. Russell, *supra* note 68, at 306-07; *see also* WEISTART & LOWELL, *supra* note 86, § 8.08, at 986-87.

107. Russell, *supra* note 68, at 307.

108. King, *supra* note 65, at 695-96.

109. PROSSER, *supra* note 95, § 32, at 189.

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what is commonly done by physicians in the same specialty generally serves as the standard by which a physician's conduct is measured. Courts traditionally have equated "good medical practice" with what is customarily and usually done by physicians under the circumstances.[110] This rule has been adopted because medical decisions require professional judgment, and it has been considered infeasible to permit lay jurors "to evaluate the ethical quality of the trade-offs that a doctor must make in the diagnosis and treatment of patients."[111]

There are few reported cases discussing the appropriate standard of care for evaluating and diagnosing an athlete's physical condition and treating his injuries. There have been several allegations of physician negligence in providing medical care to athletes. Allegations include physician failure to discover latent injuries or physical defects,[112] medically unjustified administration of drugs to enable athletic participation,[113] and improper treatment of athletic injuries.[114]

To avoid malpractice liability, courts traditionally have required a physician to follow customary sports medicine practice. In *Rosensweig v. State*,[115] a boxer died from a brain hemorrhage after being knocked unconscious during a boxing match. One of the allegations by the decedent's estate was that physicians negligently failed to discover a brain injury he suffered in a prior fight.[116] The New York Court of Claims held the State of New York liable based on the examining physicians' negligence.[117] The court found that merely giving the decedent an electroencephalogram and a standard pre-fight physical exam was negligent under the circumstances.[118]

An intermediate appellate court reversed the finding of negligence liability because the examining physicians had provided the decedent with the customary pre-fight medical examination.[119] This court re-

110. *Id.*

111. Keeton, *supra* note 97, at 359.

112. *See infra* notes 115-16 and accompanying text; *see also* Deaner v. Utica Community Sch. Dist., 297 N.W.2d 625, 627 (Mich. Ct. App. 1980).

113. Fisher v. United States, 451 F. Supp. 918, 919 (E.D.N.Y. 1987); Pitt, *supra* note 37, at 594; Russell, *supra* note 68, at 320-21.

114. Sherwin v. Indianapolis Colts, Inc., 752 F. Supp. 1172, 1173 (N.D.N.Y. 1990); Welch v. Dunsmuir Joint Union High School Dist., 326 P.2d 633, 635 (Cal. Ct. App. 1958).

115. 146 N.Y.S.2d 589 (Ct. Cl. 1955), *rev'd*, 171 N.Y.S.2d 912 (N.Y. App. Div. 1958), *aff'd*, 158 N.E.2d 229 (N.Y. 1959).

116. *Id.* at 594-95.

117. *Id.* at 599.

118. *Id.* at 595-97.

119. 171 N.Y.S.2d at 914.

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fused to hold these physicians to some other standard of care. The New York Court of Appeals affirmed the appellate court's decision on other grounds.[120]

3. *Accepted Sports Medicine Practice*

The use of custom as the legal standard in a medical malpractice case has been criticized as difficult to determine, unduly deferential to a mere professional habit, and uncertain to produce optimal health care.[121] Some commentators have argued that a better approach would require conformity to an "accepted practice" professional standard of care,[122] which has been adopted by some courts.[123] Under this standard, acceptable practices constituting medical care consistent with physicians' collective reasonable expectations are controlling.[124] In other words, what should have been done under the circumstances, not what is commonly done, controls.[125]

The accepted practice standard would have several advantages in the sports medicine context. It focuses on the current state of the medical art, rather than the historical conduct of sports medicine physicians.[126] It enables a physician to deviate from an undesirable custom inconsistent with his best judgment, thereby facilitating the development of sound sports medicine practices.[127] It also alleviates the need to search for a discernible custom among a diverse group of sports medicine physicians, and provides a standard absent such a custom.[128] Some recent sports medicine malpractice cases appear to adopt the "accepted practice" standard of care rather than the customary medical practice standard developed by the *Rosensweig* appellate court.[129]

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120. 158 N.E.2d at 233.

121. King, *supra* note 97, at 1237, 1239-41.

122. Keeton, *supra* note 97, at 362-69; King, *supra* note 97, at 1236-44.

123. *See, e.g.*, James v. Woolley, 523 So. 2d 110, 113 (Ala. 1988); Cornfeldt v. Tongen, 262 N.W.2d 684, 695 (Minn. 1977); Francois v. Mokrohisky, 226 N.W.2d 470, 470 (Wis. 1975).

124. King, *supra* note 97, at 1241.

125. Keeton, *supra* note 97, at 363-64.

126. King, *supra* note 97, at 1238.

127. *Id.*

128. *Id.* at 1238-41.

129. Classen v. State, 500 N.Y.S.2d 460, 466 (Ct. Cl. 1985). In many situations, customary practices reflect accepted medical practices. Like custom, proof of accepted practice for litigation purposes will require expert medical testimony, but the basis of an expert's testimony will be broader. In addition to surveying the relevant medical tradition and habit, a medical expert may utilize her own education, training, and experience as well as relevant medical literature and medical association guidelines to determine acceptable medical practice. King, *supra* note 97, at 1241-43.

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In providing medical care to a competitive athlete, the team physician should adhere to accepted sports medicine standards under the circumstances. The level of competition at which an athlete is playing appears to be a relevant factor in determining the accepted medical practice. Professional and college players receive more comprehensive medical examinations because of the extreme physical demands of these levels of play and the economic ability of teams to pay for extensive examinations. Players at these levels also may be able to recover from injuries more rapidly because of their superior conditioning, physical development and team-provided rehabilitation.

Conversely, youth and high school athletic activities generally are less physically demanding. It may not be economically feasible to provide extensive medical examinations to all participants, especially those who, based on a screening examination, do not appear to be medically at risk.[130] Due to their still-developing bodies, different rehabilitation procedures and longer periods of inactivity may be appropriate for these athletes.

A physician generally does not warrant the correctness of a diagnosis or success of a treatment, and a doctor is not liable for honest mistakes of judgment if the appropriate diagnosis or treatment is in reasonable doubt.[131] In some instances it may be necessary to consult with specialists, and the team physician may be negligent for failing to do so.[132] If there are various recognized methods of treatment, a physician may select the one she deems best, and is not liable for malpractice because some physicians utilize other alternatives.[133]

Under these principles a team physician would not necessarily be liable for negligence if he misdiagnosed an athlete's physical condition. For example, if a physician erroneously concluded that Reggie Lewis had "the normal heart of an athlete,"[134] he would not be liable for a negligent diagnosis if he performed appropriate tests and merely made

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130. *See* Allan J. Ryan, *Qualifying Exams: A Continuing Dilemma*, THE PHYSICIAN & SPORTSMED., Aug. 1980, at 10, 10. Any physical examination should be reasonable under the circumstances. Jones, *supra* note 54, at 137. For a discussion of the objectives of a preparticipation screening examination, *see* PPE, *supra* note 76, at 5-8; *see also* Mimi D. Johnson et al., *Keys to Successful Preparticipation Exams*, THE PHYSICIAN & SPORTSMED., Sept. 1993, at 108.

131. PROSSER, *supra* note 95, § 32, at 186.

132. *See, e.g.*, Keir v. United States, 853 F.2d 398, 412-14 (6th Cir. 1988). The team physician also has the duty to inform an athlete of the risks of failing to see a recommended specialist. Moore v. Preventive Medicine Medical Group, Inc., 223 Cal. Rptr. 859, 863-64 (App. 3d 1986).

133. James v. Worlley, 523 So. 2d 110, 112-13 (Ala. 1988).

134. *See supra* note 18 and accompanying text.

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an honest mistake interpreting the results. A physician would be liable only if the diagnosis were not based on accepted medical practice.

Team physicians should be particularly careful regarding the use of anesthetics and pain killers to facilitate athletic participation. Medication to relieve pain masks the seriousness of an injury, and may cause aggravation or reinjury of a preexisting condition.[135] In prescribing drugs to athletes, team physicians should follow accepted medical practices regarding the appropriate type and dosage of pharmaceutical treatment.[136] They should prescribe drugs to enable athletic participation only if doing so is consistent with an athlete's best health interests. If physicians prescribed a non-therapeutic dosage of heart medication for Hank Gathers to enable him to play college basketball games at a higher level, this should constitute actionable negligence.[137]

B. Medical Clearance Recommendations

This section assumes that an athlete's medical condition has been properly diagnosed and addresses the circumstances under which the team physician should be held liable for providing medical clearance to play a sport.

Sports medicine physicians have primary responsibility for medically clearing athletes to participate in sports or return to play.[138] By having responsibility for such an important medical decision, they also should assume legal responsibility for harm to an athlete resulting from failure to conform to accepted sports medicine practices. The legal standard of care should provide an incentive for physicians to provide a sound medical clearance recommendation to an athlete without unduly inhibiting or second guessing the exercise of their professional judgment in individual cases.

Athletes have sued team physicians and other sports medicine physicians for alleged negligent medical clearance recommendations. In

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135. King, *supra* note 65, at 702-04; Thornton, *supra* note 51, at 140.

136. WEISTART & LOWELL, *supra* note 86, § 8.08, at 995.

137. *See supra* note 10 and accompanying text.

138. PPE, *supra* note 73, at 30-31; *16th Bethesda Conference*, *supra* note 28, at 1189-90; Barry J. Maron, *Sudden Death in Young Athletes—Lessons from the Hank Gathers Affair*, THE NEW ENG. J. MED., July 1, 1993, at 55, 56; James T. Marron & James B. Tucker, *Fieldside Management of Athletic Injuries*, 34 AM. FAM. PHYSICIAN 137, 138 (1986); Douglas B. McKeag, *Criteria for Return to Competition After Musculoskeletal Injury* in AMERICAN COLLEGE OF SPORTS MEDICINE, ACSM'S GUIDELINES FOR THE TEAM PHYSICIAN 196, 196 (Robert C. Cantu, M.D. & Lyle J. Micheli, M.D. eds., 1991).

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Rosensweig v. State,[139] one of the allegations was that examining physicians improperly cleared a boxer to fight less than two weeks after he was knocked out in a prior fight. Relying on conclusive expert testimony that good medical practice requires a six-week to two-month suspension from fighting for boxers suffering a knockout or severe head beating in a prior fight,[140] the New York Court of Claims found that these physicians were negligent.

The Court of Claims refused to recognize the physicians' claimed defense of adherence to the professional custom of not suspending a boxer if the attending physician at the boxer's prior fight medically cleared him to resume boxing.[141] It observed that such an unsound custom

> calls for a doctor, who at the time is the sole master of the patient's fate, to discard his own medical knowledge and experience, to push aside his own observations and to submerge his own conscience, to defer to the judgment of someone else. This type of reasoning opens the door to such tragic and foreseeable consequences that we hold it to be negligence.[142]

On appeal, a New York intermediate appellate court reversed the lower court's finding of negligence. The appellate court held that medically clearing the boxer to fight was "an honest error of judgment" insufficient to impose medical malpractice liability.[143]

In *Mikkelsen v. Haslam*,[144] the plaintiff alleged that a physician negligently provided her with medical clearance to snow ski after hip replacement surgery. The jury found the physician negligent based on undisputed testimony that advising a total hip replacement patient that skiing is permissible "is a departure from orthopedic medical profession standards."[145]

Hank Gathers' heirs[146] and Marc Buoniconti[147] alleged that team physicians negligently provided them with medical clearance to participate in college sports. On the other hand, Anthony Penny sued a cardi-

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139. 146 N.Y.S.2d 589 (Ct. Cl. 1955), *rev'd*, 171 N.Y.S.2d 912 (App. Div. 1958), *aff'd*, 158 N.E.2d 229 (N.Y. 1959). *See also* Classen v. State, 500 N.Y.S.2d 460 (Ct. Cl. 1985) (discussing liability of ring-side physician for permitting boxer to continue fighting).

140. 146 N.Y.S.2d at 596-97.

141. *Id.* at 597.

142. *Id.*

143. 171 N.Y.S.2d at 914.

144. 764 P.2d 1384 (Utah Ct. App. 1988).

145. *Id.* at 1386.

146. *See supra* notes 10-11 and accompanying text.

147. *See supra* notes 12-14, *infra* notes 259-62 and accompanying text.

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ologist claiming that he negligently refused to medically clear him to play college basketball with a heart condition.[148]

To enhance the quality and consistency of sports medicine practice, medical societies and specialty boards have promulgated medical eligibility guidelines for use by physicians making athletic participation recommendations.[149] Sports generally are characterized by the intensity and type of physical exertion required as well as the nature of contact or collision inherent in the sport. The law should encourage the development of sports medicine participation guidelines and physician adherence to them by giving such guidelines appropriate deference.[150]

Guidelines should be developed that reflect the medical profession's consensus regarding the level of participation that may be permitted with a given medical condition. These guidelines should provide explicit guidance to physicians, facilitate the provision of quality health care, and improve self-regulation of the medical profession.[151] Guidelines have the beneficial effect of pooling medical knowledge, distilling research and clinical experience, and enabling physicians to base participation recommendations on something other than their own background and experience.[152]

Commentators have advocated that applicable guidelines or standards should constitute some evidence[153] or conclusive evidence[154] of the standard of care in malpractice cases. Furthermore, courts have admitted standards and guidelines established by national medical associations as evidence of good medical practice.[155]

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148. *See supra* notes 8-9, *infra* note 170 and accompanying text.

149. *See, e.g.*, PPE, *supra* note 73 and accompanying text; *16th Bethesda Conference*, *supra* note 28.

150. Commentators have argued in favor of the establishment of sports medicine standards by medical organizations. *See* David L. Herbert et al., *A Trial Lawyer's Guide to the Legal Implications of Recreational, Preventive and Rehabilitative Exercise Program Standards of Care*, 11 AM. J. TRIAL ADVOC. 433, 436 (1988); Pitt, *supra* note 37, at 598-99; John C. Weistart, *Legal Consequences of Standard Setting for Competitive Athletes with Cardiovascular Abnormalities*, 6 J. AM. C. CARDIOLOGY 1191, 1195 (1985).

151. Clark C. Havighurst, *Practice Guidelines as Legal Standards Governing Physician Liability*, 54 LAW & CONTEMP. PROBS. 87, 96-100 (1991); Eleanor D. Kinney & Marilynn M. Wilder, *Medical Standard Setting in the Current Medical Malpractice Environment: Problems and Possibilities*, 22 U.C. DAVIS L. REV. 421, 449-50 (1989).

152. David M. Eddy, *Practice Policies—What Are They?*, 263 J. AM. MED. ASS'N 877, 878 (1990).

153. Havighurst, *supra* note 151, at 100-03; Kinney & Wilder, *supra* note 151, at 446.

154. *See* Richard E. Leahy, *Rational Health Policy and the Legal Standard of Care: A Call for Judicial Deference to Medical Practice Guidelines*, 77 CAL. L. REV. 1483, 1506-09 (1989).

155. James v. Woolley, 523 So. 2d 110, 112 (Ala. 1988); Pollard v. Goldsmith, 572 P.2d

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If a medical society's participation standard or guideline reflects accepted practice based on the medical state of the art at the time of clearance to play a sport, it should be judicially treated as conclusive evidence of proper care if followed by the team physician. Such guidelines are the product of a physician consensus regarding the medical risks of participation in a sport based on existing scientific data and clinical experience.[156] They provide objective guidance to a team physician encountering psychological or economic pressure from a competitive athlete or third party to take action inconsistent with the athlete's physical well being.[157]

Judicial recognition of medical standards and guidelines as the legal standard of care would inform physicians what the law expects of them and prevent retrospective second guessing of the team physician's conduct by lay jurors.[158] This proposal would encourage sports medicine physicians to engage in self-regulation and formulate collectively determined principles to guide an eclectic group of team physicians.[159]

Physician adherence to outdated sports medicine guidelines should not be a recognized defense. Standards should be updated and modified periodically as the practice of sports medicine evolves to promote the health and safety of athletes[160] and prevent unnecessary exclusion from sports activities.[161] Giving legal effect only to guidelines consistent with

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1201, 1203 (Ariz. Ct. App. 1977); Darling v. Charleston Community Memorial Hosp., 211 N.E.2d 253, 256-57 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966); Davenport v. Ephraim McDowell Memorial Hospital, 769 S.W.2d 56, 61-62 (Ky. Ct. App. 1988); Cornfeldt v. Tongen, 262 N.W.2d 684, 703-04 (Minn. 1977); Stone v. Proctor, 131 S.E.2d 297, 299 (N.C. 1963). *But see* Swank v. Halivopoulos, 260 A.2d 240, 242-43 (N.J. Super. Ct. App. Div. 1969) (holding that nonspecific medical society general recommendations that leave individual treatment decisions to a physician's own judgment are not admissible evidence).

156. *See* PPE, *supra* note 73, at 2; *16th Bethesda Conference*, *supra* note 28, at 1189-90.

157. *See supra* notes 77-80 and accompanying text.

158. Havighurst, *supra* note 151, at 96; Leahy, *supra* note 154, at 1506-07. Courts have relied upon sports medicine guidelines in evaluating the propriety of athletic participation recommendations by physicians. *See, e.g.*, Kampmeier v. Nyquist, 553 F.2d 296, 298 (2d Cir. 1977).

159. *See supra* notes 67-68 and accompanying text.

160. For example, recommendations regarding the use of prophylactic knee braces have changed as more empirical evidence becomes available. Elizabeth M. Gallup, *Sports Medicine Law: Staying In Bounds and Out of Court*, THE PHYSICIAN & SPORTSMED., Nov. 1991, at 145, 146.

161. The American Medical Association's 1976 Disqualifying Conditions for Sports Participation have become increasingly obsolete, and many of them are currently considered overly restrictive. Paul G. Dyment, *New Guidelines for Sports Participation*, THE PHYSICIAN & SPORTSMED., May 1988, at 45, 45. Doctors recently cleared Monty Williams to resume playing basketball for Notre Dame University with a heart condition after new medical research revealed

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the medical state of the art provides an incentive to medical organizations to revise them consistent with advances in sports medicine.

To provide the flexibility necessary for individualized medical care of an athlete, guidelines could permit variations in individual circumstances consistent with acceptable medical practices.[162] This will allow a team physician to exercise his or her own clinical judgment to protect the competitive athlete's health without unnecessarily restricting athletic participation. The jury may need to consider whether the team physician's participation recommendation is within the range of acceptable medical practices established by the guidelines. It is, however, important to consider the alleged negligence in light of existing circumstances at the time of medical clearance, not in light of an after-the-fact tragedy.

Non-compliance with an applicable sports medicine guideline should not necessarily be a breach of the team physician's duty of care. Even if there is a deviation, no physician negligence should be found if a considerable number of recognized and respected physicians disagree with the scientific basis of the standard,[163] or a departure from the standard is justified based on the athlete's individual medical condition and physiology.[164] This would permit a team physician to make a participation recommendation consistent with an athlete's physical health and safety.

If there is no applicable medical guideline, or if a team physician deviates from an applicable guideline, accepted sports medicine practice under the circumstances should be the legal standard of care.[165]

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he is in an extremely low risk group. He was not medically cleared to play during the 1990-1991 and 1991-1992 basketball seasons. Phil Taylor, *Inside College Basketball*, SPORTS ILLUSTRATED, Jan. 18, 1993, at 52, 52.

162. *See, e.g.*, PPE, *supra* note 73, at 3, 30-31; *Pediatrics Recommendations*, *supra* note 73, at 738-39; *16th Bethesda Conference*, *supra* note 28, at 1189-90.

163. This proposal is based on a variation of the so-called "respectable minority" standard permitting a physician to adopt a course of treatment followed by a considerable number of her peers if competent medical authority is divided regarding the appropriate treatment. *See, e.g.*, Jones v. Chidester, 610 A.2d 964 (Pa. 1992). *See generally* Keeton, *supra* note 97, at 365.

164. Clark C. Havighurst, *Practice Guidelines for Medical Care: The Policy Rationale*, 34 ST. LOUIS U. L.J. 777, 786 (1990) (noting that a dominant view of practice guidelines recognizes that the "professional norm . . . expressly contemplates that physicians may sometimes deviate from guidelines in the interest of the patient"). In most cases, the appropriate application of sports medicine principles involves an individualized consideration of an athlete's physical condition. Leland L. Fairbanks, *Return to Sports Participation*, THE PHYSICIAN & SPORTSMED., Aug. 1979, at 71; Kenneth S. Vereschagin, *Expanding Sports Medicine's Role in Primary Care*, THE PHYSICIAN AND SPORTSMED., May 1993, at 121, 122.

165. King, *supra* note 65, at 690. Assume that the American College of Cardiology formu-

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Professional custom should not be controlling because it may not exist in the diverse field of sports medicine and may reflect non-medical factors because of competing loyalties faced by the team physician.[166] The bounds of acceptable sports medicine practice should be limited by the team physician's paramount obligation to protect the competitive athlete from medically unreasonable risks of harm.[167]

In making a participation recommendation, the team physician should only consider the athlete's medical best interest. The physician may appropriately consider the following factors: the intensity and physical demands of a sport; the athlete's unique physiology; whether the athlete has previously participated in the sport with his physical condition; available clinical evidence; the probability and severity of harm from athletic participation with the subject condition; and whether medication or protective equipment will minimize the health risks of participation.

The team physician should not permit the athlete's strong desire to play or the coach's obsession with winning to override his professional judgment and ethical obligation to protect the competitive athlete's health. The team physician should refuse to clear an athlete to participate if she believes there is a significant medical risk of harm from participation, irrespective of the team's need for the player or the player's psychological or economic motivation to play.[168]

In cases in which there is an uncertain potential for life-threatening or permanently disabling harm, it appears advisable to err on the side of caution and recommend against athletic participation. Even if the team physician approves athletic participation by a competitive athlete with a physical abnormality or injury because of his opinion that there is no medically unreasonable risk, he should fully explain all material risks of playing to the athlete.[169]

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lated a standard advising against vigorous competitive athletic activity by persons with coronary artery disease, but that a sizable number of recognized and respected cardiologists would not impose such a restriction on their patients. Assume further that a cardiologist permits a patient with diagnosed coronary artery disease to regularly play in a YMCA basketball league and that the patient dies while doing so. Weistart, *supra* note 150, at 1195. This article proposes that the cardiologist's legal liability for the patient's death would depend upon whether his provision of medical clearance to participate in competitive basketball was an acceptable practice under the circumstances and whether he properly informed the patient of the risks of such participation. *See supra* note 63, *infra* notes 183-87 and accompanying text.

166. King, *supra* note 65, at 690-91; *see also supra* notes 75-81 and accompanying text.

167. *See also supra* notes 75-81 and accompanying text.

168. King, *supra* note 65, at 699.

169. *See infra* notes 183-91 and accompanying text.

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A team physician should not be held negligent for refusing to medically clear an athlete to participate in sports with a properly diagnosed injury, physical disability or medical condition. In *Penny v. Sands*,[170] Anthony Penny alleged that a cardiologist was negligent for withholding medical clearance to play college basketball with a potentially life-threatening heart condition. Even if an applicable medical organization guideline generally allows participation, legal recognition of such claims would unduly impair the team physician's professional judgment and may cause her to place greater weight on legal rather than medical considerations. The athlete may seek a second medical opinion, as Anthony Penny did, if he disagrees with the team physician's participation recommendation. This second opinion may provide him with a legal right to play the desired sport.[171]

C. Informed Consent to Risks of Athletic Participation and Medical Treatment

In addition to following accepted sports medicine practice regarding diagnosis, clearance to participate, and treatment, the team physician must fully inform an athlete of the risks of playing a sport in light of his physical condition. Failure to do so may expose the team physician to liability based on intentional tort or negligence principles.

The team physician must have an athlete's informed consent before providing medical treatment. A competent adult athlete can provide consent to medical care, but consent for treatment of athletes who are minors generally must be obtained from a parent or guardian.[172] Consent may be implied under the circumstances—for example, when an athlete has been rendered unconscious during play and needs emer-

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170. Complaint (D. Conn. filed May 3, 1989) (No. H89-280) (voluntarily dismissed by Penny before the court decided the merits of his claims); *see supra* notes 2, 4, 8-9 and accompanying text.

171. Other cardiologists had cleared Penny to play college basketball with his heart condition. Altman, *supra* note 2, at C3. Conflicting medical opinions may give rise to a right to participate in athletics under the ADA or Rehabilitation Act of 1973. *See supra* notes 56-63 and accompanying text. Accordingly, Penny threatened to sue Central Connecticut State University unless he was allowed to play on its basketball team. Central Connecticut permitted Penny to play basketball provided that he continued to receive medical clearance from his chosen cardiologists and further agreed to release the school from liability for harm caused by his playing with a medical condition. Mitten, *supra* note 22, at 999. Because of this available remedy and the speculative nature of claimed economic harm from athletic exclusion, courts should not recognize claims asserting that medical care of athletes was too conservative.

172. WEISTART & LOWELL, *supra* note 86, § 8.08(b), at 988.

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gency medical treatment.[173] In such a case, the law generally assumes that the injured athlete, if competent, would have authorized ordinary treatment for his or her care.[174]

For an athlete's consent to be valid, it must represent the product of an informed decision regarding the proposed medical treatment. Historically, the law considered a physician's failure to disclose the inherent risks of a medical treatment as a battery because the patient's consent to treatment was invalidated by this omission.[175] Today, inadvertent physician failure to fully disclose the risks of medical treatment or participation in an activity with a medical condition generally is analyzed under negligence principles.[176]

The informed consent doctrine is based on principles of individual autonomy, namely that a competent adult has the legal right to determine what to do with her body. This autonomy includes the right to accept or refuse medical treatment.[177] The average person has little understanding of medicine and relies upon her physician to provide the knowledge and information necessary to make a responsible decision.[178] Therefore, some courts have placed an affirmative duty on physicians to disclose the risks of medical treatment and athletic participation under the circumstances.[179]

The extent of the physician's duty to disclose traditionally has been determined by prevailing practices in the medical profession. Physician custom or what a reasonable physician would disclose under the circumstances has been the controlling legal standard.[180] The recent judicial trend is to require physicians to disclose all material information to enable the patient to make an informed decision.[181]

In the leading case representing the current trend, *Canterbury v. Spence*, the court stated: "[A] risk is thus material when a reasonable person, in what the physician knows or should know to be the patient's

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173. *Id.* at 989.

174. *Id.*

175. PROSSER, *supra* note 95, § 18, at 120-21.

176. *Id.*

177. *See, e.g.*, Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261, 261 (1990); *see* PROSSER, *supra* note 95, § 32, at 190.

178. Truman v. Thomas, 611 P.2d 902, 905 (Cal. 1980).

179. *See* Krueger v. San Francisco Forty-Niners, 234 Cal. Rptr. 579 (Ct. App. 1987).

180. PROSSER, *supra* note 95, § 32, at 191.

181. *Id.*

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position, would be likely to attach significance to the risk or cluster of risks in deciding whether or not to forego the proposed therapy."[182]

General informed consent principles should apply in the sports medicine context and should govern the necessary disclosure of information by the team physician to a competitive athlete.[183] The *Canterbury v. Spence* patient-based standard of disclosure should apply in this context because of the competing loyalties faced by the team physician.[184] There may be an undesirable custom of suppressing or minimizing certain medical risks to encourage an athlete to play.[185] Moreover, the focus should be on the factors that would be important to a reasonable athlete in making an informed participation or medical treatment decision.

A team physician should fully disclose to an athlete the material medical risks of playing with an injury, illness, or physical abnormality, and the potential health consequences of a given medication or treatment. To enable the athlete to make an informed decision, the team physician providing medical clearance to play[186] should clearly warn of all material, short and long-term, medical risks of continued athletic participation under the circumstances.[187] For example, treating physi-

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182. 464 F.2d 772, 787 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (quoting Jon R. Waltz & Thomas W. Scheuneman, *Informed Consent to Therapy*, 64 NW. U. L. REV. 628, 640 (1970)). The physician has no legal duty to disclose risks already known to the patient, obvious to the average patient, or not material to an informed treatment decision under the circumstances. *Id.* at 788. If the materiality of a nondisclosed risk is reasonably debatable, it is a fact issue to be resolved at trial. *Id.*

183. Jones, *supra* note 54, at 137-38, 144-45 (arguing that informed consent issues for college athletes should be the same as for any competent adult regarding medical treatment and return to normal life activities). For a discussion of informed consent principles as applied to the recreational athlete, *see* Todaro, *supra* note 30.

184. *See supra* notes 75-81 and accompanying text.

185. *See, e.g.*, Sherwin v. Indianapolis Colts, Inc., 752 F. Supp. 1172, 1174 (N.D.N.Y. 1990). There are also several media accounts of player allegations that team physicians misled them regarding the nature of an injury or did not inform them of potential adverse consequences of taking medication to keep them playing. Elliott Almond, *How Medication Can Be Bitter Pill*, L.A. TIMES, Aug. 12, 1990, at C1, C14; William Nack, *Playing Hurt—The Doctor's Dilemma*, SPORTS ILLUSTRATED, June 11, 1979, at 30.

186. In cases where the team physician does not provide medical clearance to play, the physician should fully inform the athlete of her reasons for refusing to provide medical clearance. However, the physician should not disclose this information to third parties without the athlete's permission. Unauthorized disclosure of an athlete's medical condition to third parties violates the team physician's ethical obligation to maintain patient confidences. AMA PRINCIPLES, *supra* note 76, §§ 5.05, 5.09, at 207, 210. Furthermore, such unauthorized disclosure may expose the team physician to legal liability. Chuy v. Phila. Eagles Football Club, 431 F. Supp. 254, 263 (E.D. Pa. 1977), *aff'd*, 595 F.2d 1265 (3d Cir. 1979); Horne v. Patton, 287 So. 2d 824, 829-30 (Ala. 1973).

187. If the athlete is incapable of making a sound decision because of a head injury or

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cians should have fully informed Reggie Lewis, Hank Gathers, and Marc Buoniconti of the potentially life-threatening or permanently disabling health consequences of playing competitive sports with their respective medical conditions.

The team physician has a duty to disclose material medical risks to the athlete in plain and simple language.[188] Courts generally do not require physicians to determine whether patients understand the disclosed information.[189] One commentator has forcefully argued that the law should impose a duty on health care providers, including team physicians, to take affirmative steps to ensure patient understanding of medical information and assist them in making medical treatment decisions.[190] Such a duty appears necessary to enable competitive athletes to make an informed and responsible decision, in light of the psychological and economic pressures they face, regarding whether to participate in a sport with a medical condition or injury or accept treatment enabling a return to competition with accompanying potential adverse heath consequences.[191]

The team physician should take affirmative steps to ensure that an athlete understands the potential consequences of playing with his medical condition. Information concerning the athlete's medical condition, proposed treatment and alternatives, probability of injury or re-injury, severity of harm, and potential long-term health effects should be tape recorded when provided orally and also given in writing.[192] It also is advisable to inform an athlete about any conflicting second opinions rendered by other physicians, particularly those that advise against playing. It is important not to downplay others' conclusions about the athlete's medical condition and potential consequences of playing.

An athlete should be informed of the tragedies suffered by Gath-

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involvement in the heat of battle during a game, it may be appropriate for the team physician to prohibit continued participation against the athlete's wishes. King, *supra* note 65, at 699-700. *See also* Tucker & Marron, *supra* note 138, at 138 (fieldside physician's decision regarding return of injured player to game must prevail).

188. *See, e.g.*, Natanson v. Kline, 350 P.2d 1093, 1106 (Kan. 1960).

189. Canterbury v. Spence, 464 F.2d 772, 780 n.15 (D.C. Cir. 1972), *cert. denied*, 409 U.S. 1064 (1972) (stating that "physician discharges the duty [to disclose] when he makes a reasonable effort to convey sufficient information although the patient, without fault of the physician, may not fully grasp it").

190. Jones, *supra* note 54, at 127-28. *See generally* Cathy J. Jones, *Autonomy and Informed Consent in Medical Decisionmaking: Toward a New Self-Fulfilling Prophecy*, 47 WASH. & LEE L. REV. 379 (1990).

191. Jones, *supra* note 54, at 127-28.

192. *Id.* at 145.

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ers, Penny, Lewis, Buoniconti, and others if athletic participation with his physical condition presents such potential risks.[193] Athletes should be encouraged to ask questions and be permitted to bring family members, attorneys, or trusted friends to disclosure sessions for support and assistance.[194] It also may be appropriate to test an athlete's comprehension of the information, perhaps by requiring the athlete to write down his or her understanding of the pertinent risks of playing or undergoing the proposed treatment.[195]

Courts have held that a team physician's failure to provide an athlete with full disclosure of material information about playing with his medical condition or the potential consequences of proposed treatment creates liability for negligence or fraud. In *Krueger v. San Francisco Forty Niners*,[196] a California intermediate appellate court held that a professional football team's conscious failure to inform a player that he risked a permanent knee injury by continuing to play was fraudulent concealment. The court found that the plaintiff was not informed by team physicians of the true nature and extent of his knee injuries, the consequences of steroid injection treatment, or the long-term dangers associated with playing professional football with his medical condition.[197] The court found that the purpose of this nondisclosure was to induce plaintiff to continue playing football despite his injuries, thereby constituting fraud.[198]

To prevail against a team physician for negligent or fraudulent failure to disclose medical information, an athlete must prove he would not have played or undergone the medical treatment that caused his harm if he had been properly informed of the material risks of doing so.[199] Most courts require a plaintiff to prove that a reasonable person in his position would have refused to participate in an activity or have

193. *See supra* notes 1-20 and accompanying text.

194. Jones, *supra* note 54, at 200.

195. *Id.* at 145, 200-01.

196. 234 Cal. Rptr. 579 (Ct. App. 1987). In denying review, the California Supreme Court ordered that this opinion not be officially published, thereby negating its precedential value. *Id.* at 579. Krueger ultimately was awarded $2.366 million in damages by a trial court but settled his claim for between $1 million and $1.5 million. Jennifer L. Woodlief, *The Trouble With Charlie—Fraudulent Concealment of Medical Information in Professional Football*, 9 ENT. & SPORTS LAW 3, 3 (1991).

197. 234 Cal. Rptr. at 581-83.

198. *Id.* at 582. *But see* Martin v. Casagrande, 559 N.Y.S.2d 68 (App. Div. 1990) (finding no fraud because initial x-rays and arthrograms did not reveal ligament damage to player's knee, and team physician did not order or suggest player's return to competition).

199. PROSSER, *supra* note 95, § 32, at 191-92.

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rejected the proposed medical treatment if the material risks were disclosed.[200] Other courts have held that what the particular plaintiff individually would have done after full disclosure of the material risks is controlling.[201] In *Krueger*, the court found undisputed evidence that the plaintiff would have followed physician recommendations to discontinue playing football,[202] thereby satisfying the necessary causal link between nondisclosure of material risks and his harm.

D. Immunity Issues

In some instances, team physicians may be immune from legal liability for malpractice claims brought by athletes. Several states have enacted qualified immunity statutes protecting volunteer team physicians from negligence liability arising from the rendering of emergency care to athletes.[203] Some states have expanded their Good Samaritan laws to include physicians rendering emergency care at athletic events.[204] These statutes are designed to encourage physicians to volunteer their services to elementary and high school athletic programs. Statutory immunity generally covers only team physicians who provide emergency medical care in good faith and without compensation to an athlete with an apparent life-threatening condition or serious injury.[205] Wilful or wanton emergency treatment or gross negligence by the physician is not immune from liability.[206] Pre-participation physical exams, general non-emergency medical care rendered to athletes, and physician decisions regarding whether an athlete may return to a game are not normally subject to immunity.[207]

Team physicians employed by public universities may be protected by state law qualified immunity covering discretionary acts of public officials. In *Sorey v. Kellett*,[208] the Fifth Circuit held that this doctrine

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200. *Id.* at 191.

201. *Id.* at 191-92.

202. 234 Cal. Rptr. at 581, 584-85.

203. ARK. CODE ANN. § 17-93-101(c) (Michie 1992); CAL. EDUC. CODE §§ 49409, 76407(b) (West 1993); FLA. STAT. ANN. § 768.135 (West 1986 & Supp. 1993); OHIO REV. CODE ANN. § 2305.231 (Page's Baldwin 1990); VA. CODE ANN. § 8.01-225.1 (Michie 1992 & Supp. 1993).

204. Gerald J. Todaro, *The Volunteer Team Physician: When Are You Exempt From Civil Liability?*, THE PHYSICIAN & SPORTSMED., Feb. 1986, at 147, 147. The author notes that Kansas, Missouri and Tennessee have Good Samaritan laws that cover athletic events. *Id.* at 150.

205. *Id.* at 147-48.

206. *Id.* at 150-152.

207. *Id.* at 153.

208. 849 F.2d 960 (5th Cir. 1988).

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barred suit against a team physician alleging negligent medical treatment of a college football player. The court relied upon Mississippi law providing immunity to state-employed physicians for discretionary aspects of administered medical care.[209]

Professional athletes' claims against team physicians for negligent medical care may be barred by state workmen's compensation laws. In *Hendy v. Losse*,[210] a professional football player sued team physicians for negligently diagnosing and treating a knee injury suffered during a game and advising him to continue playing football. In dismissing these claims, the California Supreme Court held that California's workmen's compensation law bars tort suits between co-employees for injuries caused within the scope of employment.[211] The court found that plaintiff and defendant were both employed by the San Diego Chargers and that the defendant acted within the scope of his employment in treating the plaintiff.[212] Thus, the plaintiff's exclusive remedy for his harm was workmen's compensation.[213]

Some workmen's compensation laws do not bar tort claims for work-related injuries aggravated by fraudulent concealment of the existence of the injury.[214] Claims for fraudulent concealment of medical information against professional team physicians, similar to those raised in *Krueger v. San Francisco Forty Niners*, are actionable.[215]

A professional team physician may be subject to a tort suit if she is found to be an independent contractor rather than an employee of a professional sports team covered by the workmen's compensation laws.[216] Team physicians who are employees of professional teams are subject to common law tort claims for medical services provided to athletes that are outside the scope of the physician's employment agreement.[217]

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209. *Id.* at 963-964.

210. 819 P.2d 1 (Cal. 1992).

211. *Id.* at 10.

212. *Id.* at 12.

213. *Id.*

214. *See, e.g.*, CAL. LAB. CODE § 3602(b)(c) (West 1989).

215. *See supra* notes 196-98 and accompanying text. In some jurisdictions, workmen's compensation laws bar common law intentional tort claims against professional sports team employees. Ellis v. Rocky Mountain Empire Sports, Inc., 602 P.2d 895 (Colo. Ct. App. 1979).

216. Bryant v. Fox, 515 N.E.2d 775 (Ill. Ct. App. 1987).

217. *See* Hendy v. Losse, 819 P.2d 1, 12 (Cal. 1991).

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VI. COMPETITIVE ATHLETE'S RESPONSIBILITY

Competitive athletes often possess a fanatical drive to participate in sports and may be willing to take medical risks with short or long-term health consequences. Winning often takes precedence over health. When athletes make this choice, they should, depending upon the circumstances, bear some or all of the legal responsibility for their harm.

A. Contributory Negligence

A leading torts treatise defines contributory negligence as "conduct on the part of the plaintiff, contributing as a legal cause to the harm he has suffered, which falls below the standard to which he is required to conform for his own protection."[218] Contributory negligence involves exposing one's self to an unreasonable risk of harm.[219]

One court has defined a patient's duties regarding the receipt of medical care as follows:

> A patient is required to cooperate in a reasonable manner with his treatment. This means that a patient has a duty to listen to his doctor, truthfully provide information to his doctor upon request, follow reasonable advice given by his doctor, and cooperate in a reasonable manner with his treatment. A patient also has a duty to disclose material and significant information about his condition or habits when requested to do so by his physician.[220]

A competitive athlete must satisfy the above obligations to comply with his duty to reasonably protect his own health.

The team physician has a duty to obtain a complete and accurate medical history from an athlete.[221] In turn, an athlete must exercise due care for his own safety by truthfully relating his medical history to the team physician.[222] An athlete has no general duty to diagnose his own condition or divulge information, but he should volunteer information if he knows the team physician has failed to ascertain an aspect of his medical history known to involve a risk of future harm.[223] For example, an athlete fails to exercise reasonable care for his own safety if

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218. PROSSER, *supra* note 95, § 65, at 451.

219. *Id.* at 453.

220. Benedict v. St. Luke's Hosp., 365 N.W.2d 499, 505 (N.D. 1985).

221. *See* Mackey v. Greenview Hosp., Inc., 587 S.W.2d 249, 255 (Ky. Ct. App. 1979); *see also* PPE, *supra* note 73, at 12-17 (noting that the "medical history is the cornerstone of any medical evaluation and examination" and providing suggested contents of an athlete's medical history).

222. *See* 587 S.W.2d at 254-56.

223. *See id.* at 255.

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he minimizes his heart symptoms to avoid medical restriction of athletic participation.[224]

An athlete generally may rely upon the recommendations of the team physician or her designated consulting specialists without seeking a second medical opinion.[225] An athlete's reliance on the team physicians' recommendations ordinarily is reasonable because of the latter's sports medicine expertise.[226] An athlete is not contributorily negligent if he engages in an athletic activity based on physician approval, even if he does not pursue any other source of information.[227]

An athlete's failure to follow the team physician's instructions regarding treatment or rehabilitation of an injury constitutes contributory negligence.[228] If Hank Gathers failed to take his prescribed heart medication in the required dosage or took steps to reduce its therapeutic effects,[229] such conduct would be an unreasonable disregard for his own safety.

A competitive athlete's decision to keep playing despite pain may not be unreasonable conduct if done with the team physician's approval.[230] However, an athlete's decision to continue playing with pain may be a valid defense for the physician, if the athlete could foresee the specific injury he suffered.[231] Physician representations concerning the medical risks of playing with pain and the athlete's understanding of those risks are important factors in determining whether an athlete exposed himself to an unreasonable risk. A Canadian court held that a professional hockey player's decision to continue playing with a severely painful injury, before the team physician examined and diag-

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224. *See* Melvin D. Cheitlin, *Evaluating Athletes who Have Heart Symptoms*, THE PHYSICIAN & SPORTSMED., Mar. 1993, at 150 (warning physicians that athletes may minimize heart symptoms to avoid medical restrictions).

225. Mikkelsen v. Haslam, 764 P.2d 1384, 1387-88 (Utah Ct. App. 1988); *see also* Krueger v. San Francisco Forty Niners, 234 Cal. Rptr. 579, 584 (Cal. Ct. App. 1987).

226. Truman v. Thomas, 611 P.2d 902, 905 (Cal. 1980); Morrison v. MacNamara, 407 A.2d 555, 567-68 (D.C. 1979); Keomaka v. Zakaib, 811 P.2d 478, 486 (Haw. Ct. App. 1991).

227. *See Mikkelsen*, 764 P.2d.

228. *See* Lee v. Mirbaha, 722 S.W.2d 80 (Mo. 1986); Gillespie v. S. Utah State College, 669 P.2d 861 (Utah 1983).

229. There was speculation about these issues after Gathers' death. Shelley Smith, *A Bitter Legacy*, SPORTS ILLUSTRATED, March 4, 1991, at 62, 64, 74.

230. Krueger v. San Francisco Forty Niners, 234 Cal. Rptr. 579, 584-85 (Ct. App. 1987).

231. *Id.* at 584-85; *accord* Jarreau v. Orleans Parish School Bd., 600 So. 2d 1389, 1393-94 (La. Ct. App. 1992) (reducing high school athlete's recovery by one-third for continuing to play football with injury and pain that interfered with on-field performance); *cf.* McKinley v. Slenderalla, 165 A.2d 207, 215 (N.J. Ct. App. 1960) (continuing to reduce salon treatment with full knowledge of harmful effects may be contributory negligence).

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nosed his condition, was an unreasonable failure to protect his health.[232]

B. Assumption of the Risk

1. Implied Acceptance by Conduct

An athlete may assume the risk of harm by choosing to play a sport with a known medical condition or injury. The implied assumption of risk defense has been narrowly applied by courts. It requires that an athlete knows and appreciates the specific risk of harm from athletic participation and freely and voluntarily accepts such risk by playing.[233]

In *Gehling v. St. George University School of Medicine*,[234] a medical student collapsed and died while running in a school-sponsored race in Grenada. His estate claimed that the school negligently did not require runners to submit to pre-race physical examinations.[235] It also asserted that the school did not provide proper supervision or medical care during the race.[236] The court held that the decedent's voluntary race entry, with a known heart ailment, in tropical conditions, was relevant in determining legal responsibility for his death.[237]

An athlete need not foresee the exact manner in which an athletic injury occurs, but must be aware of the general nature and severity of threatened harm from athletic participation for the assumption of risk doctrine to be applicable.[238] The athlete's maturity and experience are considered in determining his awareness and appreciation of the risk of an athletic injury.[239] A higher degree of awareness generally will be imputed to an adult professional athlete than to a minor amateur ath-

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232. Robitaille v. Vancouver Hockey Club Ltd., 124 D.L.R.3d 228, 230-31, 253 (B.C. Ct. App. 1981). Michael Robitaille played hockey for almost three months with severe neck, shoulder and arm pain, as well as a "rubbery feeling" in his right leg. He ultimately suffered a spinal cord injury that left him permanently disabled. *Id.* at 230-32.

233. PROSSER, *supra* note 95, § 68, at 484-92.

234. 698 F. Supp. 419 (E.D.N.Y. 1988).

235. *Id.* at 421.

236. *Id.*

237. *Id.* at 427.

238. Maddox v. City of N.Y., 487 N.E.2d 553, 557 (N.Y. 1985).

239. Benitez v. N.Y. Bd. of Educ., 541 N.E.2d 29, 32-33 (N.Y. 1989); *Maddox*, 487 N.E.2d at 556-57; Dillard v. Little League Baseball, 390 N.Y.S.2d 735, 737 (App. Div. 1977), *superseded by statute as stated in* Akins v. Glen Falls City Sch. Dist., 424 N.E.2d 531, 533 (N.Y. 1981) (stating that enactment of comparative negligence statute eliminates assumption of risk as a complete bar).

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lete.[240] Under these principles, age, maturity, and experience of an athlete, as well as the level of play, are important factors in determining whether he or she knew and appreciated the risks of playing with a medical condition or injury.

The athlete's decision to play with a medical condition also must be "voluntary." This essentially means that the athlete freely chooses to participate in a sport without any compulsion from third parties.[241] If the team physician assures an athlete that it is medically safe to play or inappropriately minimizes the risks of participation, and the athlete surrenders his own judgment to that of the physician's, there is no voluntary acceptance of the risk.[242] However, a participation decision may be deemed voluntary if the danger of playing with a particular medical condition is so obvious to the athlete that there can be no reasonable reliance upon the team physician's medical clearance to play.[243]

The growing trend is for courts to abolish implied assumption of the risk as a separate affirmative defense and to merge it with the contributory negligence doctrine.[244] Under this approach, a plaintiff's choice to encounter a known risk must be unreasonable to constitute a valid defense.[245] A physician's medical clearance of an athlete to play is an important factor in determining the reasonableness of an athlete's decision to play with a medical condition.[246] Courts have held that athletes may reasonably rely upon the medical advice of the team physician, thereby negating the contributory negligence defense if an athlete acts consistently with that advice.[247]

2. *Express Acceptance by Contract*

The parties generally may allocate their respective legal responsibility to each other by contract. A person may prospectively agree to knowingly and voluntarily waive his legal right to recover for future harm attributable to another's wrongful conduct unless such an agree-

240. *Benitez*, 541 N.E.2d at 32-33; *Maddox*, 487 N.E.2d at 556-57.

241. *See* PROSSER, *supra* note 95, § 68, at 490-92.

242. *See* RESTATEMENT (SECOND) TORTS § 496E cmt. a (1977); PROSSER, *supra* note 95, § 11, at 49.

243. RESTATEMENT (SECOND) TORTS § 496E cmt. a (1977); PROSSER, *supra* note 95, § 68, at 490.

244. PROSSER, *supra* note 95, § 68, at 493-95.

245. *Id.* at 497.

246. King, *supra* note 65, at 694.

247. Krueger v. San Francisco Forty Niners, 234 Cal. Rptr. 579, 581, 584-85 (Ct. App. 1987).

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ment violates public policy.[248] Some courts uphold releases of liability from future negligence but not more culpable conduct such as intentional, reckless, or grossly negligent torts.[249]

Generally, courts have invalidated contracts releasing physicians from liability for negligent medical care of their patients.[250] Such contracts have been held to violate public policy because medical services are essential public services; the physician holds himself out as willing and able to provide such services; the patient places herself under the physician's control but remains subject to the risks of his carelessness; and the physician has the bargaining power to require a release from negligence liability as a condition of providing medical treatment. A court probably would follow these cases and invalidate a waiver that purports to release a team physician from negligence liability for medical care rendered to a competitive athlete.

C. Allocation of Legal Responsibility

In providing medical care to a competitive athlete, if the team physician conforms to standards or guidelines established by a recognized medical association or specialty board or accepted sports medicine practice,[251] the athlete should bear the harm resulting from athletic participation with a medical condition or injury if he or she is fully informed of the material risks.[252] A team physician should not be held liable merely because his medical judgment was wrong or the athlete suffers unfortunate harm on the playing field.[253] The athlete assumes the risk of harm that occurs from playing a sport despite receiving proper sports medicine care.[254]

The team physician should bear substantial responsibility for harm caused by permitting non-medical factors such as the team's needs, player's stature, or economic considerations to impair the exercise of

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248. PROSSER, *supra* note 95, § 68, at 482-84.

249. *Id.*

250. *See, e.g.*, Tunkl v. Regents of Univ. of Cal., 383 P.2d 441, 447 (Cal. 1963); Belshaw v. Feinstein, 65 Cal. Rptr. 788, 798 (Ct. App. 1968); Meiman v. Rehabilitation Center, Inc., 444 S.W.2d 78, 80 (Ky. Ct. App. 1969); Olson v. Molzen, 558 S.W.2d 429, 432 (Tenn. 1979). *See generally* A.M. Swarthout, *Validity and Construction of Contract Exempting Hospital or Doctor From Liability for Negligence to Patient*, 6 A.L.R.3d 704 (1966 & 1992 Supp.).

251. *See supra* notes 155-56, 165 and accompanying text.

252. *See supra* notes 183-91, 233-43 and accompanying text.

253. *See supra* notes 131-33 and accompanying text.

254. *See supra* notes 30-32, 233-43 and accompanying text.

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his professional judgment.[255] Succumbing to these factors breaches the physician's paramount responsibility to protect the athlete's health. Fraudulently concealing material information about an athlete's medical condition[256] or grossly deviating from accepted sports medicine principles to induce or enable an athlete to play a sport are extreme situations that would fall within this category. An award of punitive damages would be appropriate to deter and punish this irresponsible breach of the trust that an athlete places in the team physician.[257]

In many instances, the team physician and a competitive athlete should share responsibility for harm resulting from playing with a medical condition or injury. The comparative negligence systems adopted by most states [258] would apportion legal responsibility for harm caused by a team physician's deviation from good sports medicine practice and an athlete's failure to use reasonable care to protect his health or voluntary assumption of the known risks of playing.

Marc Buoniconti's negligence lawsuit against Dr. E.K. Wallace, Jr., the Citadel's team physician,[259] is a case in which the application of comparative negligence principles may have resulted in a fairer result than the jury's conclusion that Buoniconti was not entitled to any damages for permanent paralysis suffered while making a tackle during a football game. Buoniconti asserted that Dr. Wallace failed to inform him of his spinal abnormality and permitted him to play with a serious neck injury and to use equipment that placed his neck in a position making it vulnerable to being broken.[260] Dr. Wallace contended that Buoniconti's dangerous and illegal tackling technique, not any improper medical clearance or treatment, caused his injury.[261]

The jury found Dr. Wallace not liable for Buoniconti's injuries,[262] but implicit in the jury's finding is that Buoniconti assumed the risk of his tragic injury by choosing to play football with a painful neck injury.

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255. *See supra* notes 76, 81, 167-68 and accompanying text.

256. *See supra* notes 196-98 and accompanying text.

257. Courts generally require that defendant's conduct be shown to be more than merely negligent to recover punitive damages. Grossly negligent, reckless, wilful and wanton, or intentional conduct ordinarily justifies imposition of punitive damages. PROSSER, *supra* note 95, § 2, at 9-15.

258. For a discussion of the various forms of comparative negligence systems adopted by different states, *see* PROSSER, *supra* note 95, § 67, at 468-79; VICTOR E. SCHWARTZ, COMPARATIVE NEGLIGENCE 30-32, 47-49, 67-72 (2d ed. 1986).

259. *See generally* Nack, *supra* note 12.

260. *Id.* at 33.

261. *Id.*

262. *Id.*

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South Carolina is one of the few states that has not adopted comparative negligence principles.[263] As a result, a jury finding of *any* contributory negligence or assumption of risk on Buoniconti's part would have barred *any* recovery against Dr. Wallace even if he were negligent.[264] It is difficult to determine whether the jury reached this conclusion or merely found that Dr. Wallace did not provide negligent medical care.

Assuming the conduct of both Buoniconti and Dr. Wallace exposed Buoniconti to an unreasonable risk of harm and their actions jointly caused his tragic injury, they should share legal responsibility for such harm. In this manner, individual responsibility and legal accountability are consistent.

The following hypothetical illustrates a proposed application of comparative responsibility principles to athletic injuries in the sports medicine context. Assume the team physician discovers that a college soccer player has a heart condition during a pre-season physical examination. After performing some tests, the physician, who is a cardiologist, tells the athlete he does not believe his condition is serious enough to justify excluding him from soccer for medical reasons. The team physician warns the athlete not to overexert himself and prescribes medication for the athlete's heart condition to alleviate any adverse effects from engaging in strenuous exercise. Before continuing to play soccer, the athlete is examined by another respected cardiologist who agrees with the team physician's diagnosis but believes that the medical risks of playing soccer with his heart condition are unreasonable. This cardiologist recommends against playing a strenuous competitive sport.

The university's athletic director requires medical clearance from the team physician before allowing the athlete to play on the school's soccer team. The team physician does so but requires the athlete to sign a waiver releasing him from any legal liability (including negligent medical care) for future harm including death or serious permanent injury arising out of the athlete's medical condition while playing soccer. One week later the athlete dies of cardiac arrest during soccer practice.

This article's proposed application of comparative responsibility principles would resolve a negligence suit against the team physician as follows. The waiver should be judicially declared invalid to the extent it

263. In a 1985 decision, the South Carolina Supreme Court quashed an intermediate appellate court's adoption of pure comparative fault, suggesting that this is an issue for the legislature. Langley v. Bayter, 332 S.E.2d 100, 101 (S.C. 1985).

264. PROSSER, *supra* note 95, §§ 65, 68, at 451-53, 481-82.

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purports to release the team physician from all liability for negligent medical care of the athlete.[265] If expert medical testimony supports a jury finding that the team physician's participation recommendation fell outside of the bounds of good sports medicine practice by a competent cardiologist under the circumstances, he should be liable for some percentage of the harm caused by his negligence.

The athlete also should bear some legal responsibility for choosing to play soccer with a known heart condition.[266] The athlete was warned not to play soccer by another cardiologist although the team physician medically cleared him to play. The law should require an athlete to incur some legal responsibility for voluntarily choosing to play with a known, potentially fatal condition.[267] The athlete's age and maturity, level of competition, and degree of awareness of the material risks of playing based on information provided by the team physician and other consulting physicians should be considered by the jury in apportioning the athlete's percentage of responsibility.

VII. CONCLUSION

There currently are many sports medicine issues that are medically and legally unresolved. Because of the strong psychological and economic rewards of athletic participation, competitive athletes sometimes are willing to take serious health risks by playing a chosen sport with a physical abnormality or injury. Although often faced with conflicting loyalties to the team and athlete, a team physician must provide medical care consistent with the athlete's best health interests and not allow non-medical considerations to influence her judgment. A competitive athlete must use reasonable care to protect his own health and carefully consider the possibility of unfortunate consequences such as

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265. *See supra* note 250 and accompanying text.

266. The trial judge typically instructs the jury to allocate fault for plaintiff's harm if it finds that both plaintiff and defendant bear legal responsibility for this harm. SCHWARTZ, *supra* note 258, at 293-94.

267. *See, e.g.*, Knight v. Jewett, 894 P.2d 696, 707 (Cal. 1992) (athlete's voluntary choice to take a known risk by playing a sport is to be considered in allocating comparative fault whether or not decision to take risk is unreasonable under circumstances). Many state courts have merged implied assumption of risk into contributory negligence or abolished it as a separate defense after adoption of comparative negligence. SCHWARTZ, *supra* note 258, at 170-73. In these jurisdictions, plaintiff's reasonable assumption of a known risk is not a valid defense. *Id.* at 173. In many instances, it appears appropriate to characterize an athlete's decision to play with a potential life-threatening condition or risk permanent crippling injury as unreasonable conduct, barring or reducing recovery of damages against a team physician in a negligence suit.

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permanent injury or even death that may result from athletic participation with a known injury or medical condition.

The team physician and a competitive athlete should work together to develop a trusting relationship to safely promote the athlete's health and avoid unnecessary exclusion from athletic competition. An individualized, thoughtful and practical consideration of the demands of participation in a particular sport and potential harmful effects on an athlete's health is required. Hopefully the number of avoidable tragedies on the playing field will be reduced if competitive athletes and team physicians adhere to their individual moral and legal obligations.

Medical societies and specialty boards should develop consensus guidelines to assist sports medicine physicians in making participation recommendations and providing medical care to athletes. Courts should provide appropriate deference to such guidelines and standards to encourage their development and inform physicians what the law expects of them. Such collectively determined principles will provide guidance to a diverse group of team physicians.

Hopefully, this article will generate awareness and discussion of this recurring societal problem, and moreover, result in a satisfactory solution that protects the health and safety of competitive athletes by encouraging the exercise of proper medical judgment by team physicians and responsible decisions by competitive athletes.

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