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REVIEWED BY

The content included in this issue was reviewed by the NATA Editorial Advisors, Pat Aronson, PhD, ATC; A.J. Duffy III, MS, AT, PT; Michael Goldenberg, MS, ATC, CES; Eric McDonnell, MEd, LAT, ATC; Tim Weston, MEd, ATC; and Cari Wood, ATC; and members of the NATA Professional Responsibility in Athletic Training Committee.

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Playing It Safe in Secondary Schools

Why the best defense in secondary school lawsuits might be an athletic trainer

BY CLAIRE WILLIAMS

Although there are no national or state laws currently in place that require athletic training medical services for all secondary school student athletes, there is established support and precedent showing that athletic trainers not only minimize the risk of injuries in this population, but they can also minimize a school's risk of liability in potential lawsuits.



Even without laws that require athletic training medical services for student athletes at the secondary school level, the responsibility of a school district to protect the overall well-being of students is still present. Theoretically, and most simply, it could be argued that a school district being sued by the parents of an injured student athlete for medical negligence during a game without an AT present is responsible for their injuries.

With an example like this in mind, the support for hiring athletic trainers, who are health care providers licensed or otherwise regulated in all states excluding California and Washington, D.C., to secondary school athletic health care teams has been growing for decades.

ATs have the knowledge and experience to prepare secondary school athletics programs for safe game and practice play. This is evidenced by athletic training standards of care, which have been supported by national medical organizations and, more recently, legal cases that categorize athletic trainers as qualified medical professionals who minimize safety risks for student athletes.

Regardless of the lack of legal responsibility to provide athletic training services to secondary school student athletes, the health, safety and well-being of secondary school student athletes should be a school's top priority, according to Randall Cohen, DPT, ATC, who chaired the workgroup that created the NATA Liability Toolkit.

"The first thing you have to do is protect the student athlete; you should do everything you can to protect the athlete," he said. "Respect the dignity of your patient and give them the best possible care you could – those are the ones when patients don't sue."

He said that following athletic training standards of care as an athletic trainer in the secondary school setting is the best defense against potential lawsuits. Athletic trainers can reference the standards outlined in the Appropriate Medical Care Standards for Organizations Sponsoring Athletic Activity for the Secondary School Age Athlete (AMCS) document, published by NATA in 2019 and available at www.nata.org/sites/default/files/nata_appropriate_medical_care_standards.pdf, to show their value as health care providers specifically to secondary schools.

"Liability is about the standard set – you have to ask, 'What is the community standard here?'" Cohen said.

In the secondary school setting, because there is no regulatory standard set, ATs can turn to the medical standards published by a national organization, such as NATA, as part of their protection

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and, in turn, a school's defense from liability, as well. The standards outlined are the basis of an objective evaluation process that can help organizations measure, assess and improve athletic health care. They relate to athlete safety or quality of care; have a positive impact on health outcomes; meet or surpass law and regulation; and can be accurately and readily measured, according to the AMCS document.

An NATA task force set these standards in 2019, after a review of previous standards for secondary school age athletes, AT education standards, Board of Certification for the Athletic Trainer Inc. policies, value models and legal case summaries and law.

One standard recommends that secondary school "wellness programs promote a safe progression of physical fitness and improve long-term health across an athlete's lifespan."

It outlines that participation in sports and physical activity provides an opportunity for on-site qualified medical providers to serve as leaders in aiding adolescents to benefit from a physically active lifestyle and the benefits of sports participation. The standard also recommends that organizations ensure they have the ability to design safe and effective training programs that include athlete monitoring.

This standard is supported by one of the more extensive court opinions seen regarding the duty of an institution to care for its patients or athletes. In a 2017 lawsuit against the Pennsylvania Interscholastic Athletic Association (PIAA), the Commonwealth Court of Pennsylvania ruled the "PIAA and its members breached the duty to provide a 'safe environment' and by failing to provide long-term and/or complete medical or financial aid for student athletes who suffered concussion(s) while playing PIAA sports."

Additionally, the court stated, "PIAA has a legal duty to exercise reasonable care toward the student athletes under its authority. Such duty encompasses the duty to exercise reasonable care for the health and safety of student athletes."

Although the case arose due to high school student athletes who suffered long-term, severe concussion symptoms, the court ruled the association holds an overarching duty of care with regard to long-term health.

Another standard recommended in the AMCS document states "on-site prevention, recognition, evaluation and immediate care of athletic injuries and illnesses are provided with appropriate medical referrals."

It outlines that each athletic injury should have immediate appropriate treatment and care to prevent further risk, and recommends it's in the best interest of the athlete that the person making

medical decisions be a qualified medical professional. This allows for "sound medical judgment that is not based on the player's importance or the significance of the contest but based on the signs and symptoms that the athlete shares and are presented to the [provider]."

To support this standard, the AMCS document references the *Williams v. Board of Supervisors of the University of Louisiana System*, in which a court found a university 100% negligent when a minor died of heat stroke complications after a team run when no athletic trainers were present. In this case, a court ruled that the student athlete would have survived if an AT had been on-site, recognized signs of heat stroke and immersed the student in an ice bath within 10 to 15 minutes.

Although *Williams v. Board of Supervisors of the University of Louisiana System* is a collegiate lawsuit provided as support for a secondary school standard, it was chosen due to lack of reported secondary school cases on this topic. However, the standards document states, a court's finding of fault in a college case may very well be used as legal precedent should similar secondary school incidents arise.

Because of the lack of national legal standard and of secondary school sports medicine-related cases, when a lawsuit does go to court, those rulings will be looked at most often for courts to determine legal fault.

While the outcomes of some cases that the AMCS document uses to support its standards may not have changed if an athletic trainer was present, they show that an athletic trainer can decrease their risk of liability.

Most recently, it's possible that legal precedence could be set after the ruling of *Wood v. Horry County School District* (South Carolina) in 2021, Cohen said. This case represents one of the first times a court determined gross negligence by a secondary school.

The district was found liable for failing to pull a concussed player from a middle school football game, which led to brain injury. The jury found two separate occurrences of gross negligence by the Horry County School District that caused the student athlete's brain injury. Most notably, the jury found that the district acted with gross negligence when it allowed him to play without an athletic trainer present for his team as well as when it failed to assess him for signs and symptoms associated with a concussion.

What makes the *Wood v. Horry County School District* case different from other sports medicine-related cases is that the district did have an athletic trainer on staff, but they were not present

Q&A

KOREY STRINGER INSTITUTE CEO OFFERS INSIGHT ON EXERTIONAL HEAT STROKE



Douglas Casa, PhD, ATC, CEO of the Korey Stringer Institute and a professor of kinesiology at the University of Connecticut, is a thought leader on the prevention and impact of exertional heat stroke among athletes. Casa has studied this important topic his entire professional

life, writing hundreds of scholarly articles and speaking at hundreds of different venues. *Sports Medicine Legal Digest* interviewed Casa about this topic and emergency preparedness in general.

Q. How important are emergency action plans in general in the sports medicine field?

It's critical. It's critical in all settings, but I think it's even extra critical in the high school settings, because at the high school level, the school might not have an athletic trainer, and other people are going to have to be responsible for that initial care. Thankfully, two-thirds of the high schools in America do have access to an athletic trainer, and that athletic trainer could have 600 athletes at their high school. They need to have that emergency action plan in place so that the entire coaching staff and the school system – whether it be local EMS/EMT services, the nurse, the athletic director, all the support staff – are all lockstep on what's going to take place if an emergency occurs.

If we're going to try to minimize the risk of sudden death happening during physical activity, the first step in that is having an effective emergency action plan that's been properly developed, properly rehearsed and then properly implemented, when needed.

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Q. What are the essential elements in a top-notch emergency action plan?

That's a good question, because people have to make sure that they understand the difference between an emergency action plan and policies and procedures. An emergency action plan would be a venue-specific plan that's usually one side of one piece of paper that's posted at the venue, reviewed with the coaches and staff that might be working at that venue so that they can implement it when necessary. Whereas policies and procedures are a much more in-depth overview of what you will do when a particular condition presents itself.

For instance, if someone has an exertional heat stroke, it would go through the exact mechanism for the recognition and treatment of that condition, and that could be multiple pages long. But both of those are key components of any good policy that would be in place at the high school, college and professional setting related to emergency preparedness.

Q. Are there any new techniques that have been developed in recent years to maximize performance in challenging circumstances while at the same time working to prevent needless tragedy during sports and physical activity?

The reality is that we have, thankfully, found something that is 100% successful. We've known this for more than 20 years: If you can get someone's body temperature under 104 degrees within 30 minutes of collapse from an exertional heat stroke, the evidence has shown that survivability is 100%, and also the person does not have long-term complications. So, the bigger effort in the past 20 years has been getting all of the constituents, whether they be sports medicine professionals, athletic trainers, sports medicine physicians, EMT/EMS personnel, emergency room physicians, on board with understanding the critical nature of rapid cooling, getting the body temperature down

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ATs IN SECONDARY SCHOOLS, *continued from page 03*

during the football game. Cohen said this adds another layer to the argument for athletic training support for secondary school athletes, and support for adequate coverage based on the level of risk for injury, not prestige of the sport.

"It's an outlier, and it puts a bigger burden on the athletic trainers who are working solo in secondary schools," Cohen said. "This was middle school football, not a high school game, not varsity, not JV – and an athletic trainer was not present to intervene."

Because there isn't national or state legislation that outlines athletic training medical services for secondary school student athletes, the possibility of a lawsuit, however legitimate, is possible. Cohen said that being prepared before a season starts can be the best protection.

This includes appropriate time to develop and organize policies and procedures as well as emergency action plans and complete pre-participation exams, when needed.

"Following best practices, doing everything you're supposed to do, taking care of the patient [with the highest standard of care] does not prevent yourself from being sued, but it gives you something to defend when you do get sued," Cohen said.

To minimize the risk of a lawsuit against themselves and the school, Cohen recommends that athletic trainers document how they will handle injury prevention, treatment and rehabilitation, as well as how they organize safe, clean facilities, and have those policies and procedures approved before a season.

"Schools need to give ATs the time to organize this and have things in place that are needed," Cohen said. "ATs should be prepared before a season starts. Don't set an AT or a district up to fail by not giving them the time and resources to prepare for injuries, emergencies and risks."

To provide a specific example around a medical standard that has been controversial in the secondary school setting, developing protocol for using a rectal thermistor to diagnose exertional heat illness (EHI) in a minor should be approved by school administration and risk management before practice or game play begins.

It is widely accepted, and supported in research and interprofessional health care standards, that using a rectal thermistor to determine core body temperature is the clinical gold standard. It's stated in the NATA Position Statement on Exertional Heat Illness that "no other field-expedient methods of obtaining core body temperature (e.g., oral, axillary, tympanic, forehead sticker, temporal) are valid or reliable after intense exercise in the heat."

Although it has been determined that EHI is most accurately diagnosed through rectal

thermometry, not all school administrators or parents will provide approval of such an invasive treatment. In these cases, Cohen said it's most important to recognize the issue before an incident becomes apparent and create approved policy that clearly states what an AT will do when heat illness is suspected instead.

"In court, the athletic trainer would want a decision to be made on the plan that was in place, and not solely only on the care they provided. You want the question answered by the jury to be, 'Did the policy and procedure that was developed and signed off by the physician, the athletic director and the AT follow the standard of care?' and not just, 'Did the individual AT follow the standard of care?'"

NATA provides a heat stroke authorization form template for secondary school student athletes that ATs can print and have parents/guardians complete. Members can access the form at www.nata.org/sites/default/files/heat-stroke-treatment-authorization-form.pdf. ATs should work with their overseeing physician to implement standing orders and ATs should have the policy approved by school administrators and risk management or legal teams. (Read the case summary on p. 9 for insight into how one AT advocated with his administration to update their EHI policy to follow best practice.)

Without the direction of law that requires or mandates athletic training coverage for secondary school athletes, the liability of safety falls onto not only athletic trainers and medical staff, but also the school districts that employ or contract them.

By having an on-site athletic trainer, who has the opportunity to develop policies and procedures based on standards and best practices, secondary school districts can minimize their risk of litigation should an unexpected lawsuit occur.

Athletic trainers can advocate for their position at secondary schools by ensuring district administration is aware of the unique skill set ATs possess, their extensive education and their knowledge of injury and risk prevention, treatment and rehabilitation. NATA provides resources that members can use to effectively show their value to secondary school administrators and increase

Watch 'Liability and the AT' Timely Topics On-Demand

A recent NATA Timely Topics event, "The AT and Liability," featured Randy Cohen, DPT, ATC, and fellow AT expert witnesses is available to watch on-demand. Learn more at www.nata.org/nata-timely-topics.

the probability of improving the safety and well-being of young student athletes.

In addition to the resources specific to secondary school athletic trainers available at www.nata.org/professional-interests/job-settings/secondary-school/resources, members have access to the NATA Liability Toolkit (www.nata.org/practice-patient-care/

risk-liability) and Program Assessment for Safety in Sport (pass.nata.org). These resources, as well as the NATA Appropriate Medical Care Standards for Organizations Sponsoring Athletic Activity for the Secondary School Age Athlete document and their state laws and regulations can be used to show the need for athletic trainers in the secondary school settings. \$

CASE SUMMARY

High School Football Player Sues for Reinjury When No AT Was Present

Editor's note: To ensure readers have access to unbiased, valuable content, the real-life case summaries published in Sports Medicine Legal Digest have been deidentified. Case summaries are shared for educational purposes to provide insight into legal proceedings and lawsuits relevant to athletic trainers as health care providers.

Ahigh school football player in Massachusetts has filed a lawsuit against his school, requesting more than \$5.5 million in damages, after reinjuring a torn anterior cruciate ligament (ACL) during a full-contact drill.

According to a court filing for the case, which is still in litigation, the athlete wasn't supposed to take part in the drill at all and the complaint specifically noted that no athletic trainer was present at the time of the reinjury.

The complaint filed in the case states the reinjury occurred just days after the student athlete and his parents provided multiple copies of a doctor's note from a local children's hospital to school employees, which indicated that the teen wasn't to take part in any contact drills while recovering from surgery to repair a torn ACL.

The lawsuit also states that the student athlete's parents were particularly concerned that coaches and athletic trainers keep a close eye on the teen because he was so eager to "go full tilt before he was ready."

According to the complaint, the student athlete's father emailed and had a phone conversation with the then-incoming coach about his son's situation. This coach is named in the suit, along with an assistant coach and an athletic director.

The complaint states that, during the call, the coach assured the student athlete's father that he

would enforce all medical orders and restrictions. Without these assurances from the coach, the parents wouldn't have allowed their son to participate at all, according to the lawsuit.

Despite these assurances, the student athlete was allowed to participate in full-contact special teams drills. As a result, the complaint states, the student athlete immediately suffered an ACL re-tear that would ultimately end his high school athletic career.

The student athlete was a three-sport athlete, showing tremendous promise, according to the lawsuit. The effects of this debilitating, albeit avoidable, injury will likely plague the student athlete for the rest of his life, according to the complaint, which also states that the injury continues to cause him pain.

In the short term, the suit claims, the injury cost him a \$38,750 athletic scholarship and prevented him from playing high school football, which he was set to start just one month from his injury.

Specifically, the suit states the school and its athletic director were negligent or grossly negligent in multiple areas, citing the coach's lack of high school coaching experience prior to being hired by the school.

An assistant coach, who was involved in special teams drills, was a science teacher who had no prior experience in high school coaching, the suit says. Neither coach had any medical training.

On the day of the reinjury, the suit specifically states, neither of the school's athletic trainers were present, in violation of their league rules regarding the attendance of ATs.

In addition to multiple negligence claims against the employees and the school, the suit alleges that the school also never refunded a \$3,850 payment the family made, attempted to collect an additional amount of money from the family and violated the state's consumer protection law. \$

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as fast as humanly possible and knowing that the outcome will be favorable if we can implement strategies like that.

Things that we've addressed recently have been the concept of rectal temperatures. Rectal temperatures are the gold standard for assessing core body temperature at the point of collapse of an exertional heat stroke. It's something we need to make sure that all medical professionals are doing on-site to make sure we're accurately diagnosing the condition, and then, too, being able to monitor the temperature while we cool them.

Second is cold water immersion, having the tubs available on-site so that we're cooling them immediately upon collapse and recognition of the heat stroke.

The third concept is "cool first, transport second." That's something we're trying to mobilize around the country. We have three states right now that have it as part of their state EMS plans. But we need to make sure that when an ambulance service comes to a high school setting and a heat stroke is being cared for by an athletic trainer, that cooling will continue on-site before you transport them, because you don't want to lose those valuable minutes of cooling and the optimal modality. So, that concept of "cool first, transport second" is something we're working really hard on now to make sure everyone's adapting. Even if the state doesn't have the policy, people, thankfully, are adopting that locally within their school districts and their local ambulance services.

If people want to get the trifecta to make sure they can assure survivability of their patient with heat stroke, those are the three things that we're really trying to have people move on.

Q. What are the best resources that ATs should consult to learn more about this issue?

I would definitely point people to the Korey Stringer Institute website (ksu.uconn.edu) because we update that on a daily basis with the best information. Additionally, NATA has awesome resources with its consensus statements and policy statements. The 2013 document, Preventing Sudden

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Death in Secondary School Athletics, has an entire section on exertional heat stroke, and that is really the gold standard on how to prevent sudden death at the high school setting. It was endorsed by 14 organizations, including NATA and the national governing body for high school sports, the National Federation of State High School Associations. The 2015 position statement by NATA on exertional heat illnesses is another good resource. There'll be a forthcoming resource specific to trying to reduce heat stroke issues specific to football players at the high school setting that will be coming out in the next half-year. NATA always has the best practice consensus and position statements available for its members on its website (Learn more at www.nata.org/practice-patient-care/health-issues/heat-illness).

Q. You are incredibly passionate and knowledgeable in this area, which, in part, comes from a personal experience you had. Briefly describe that experience and the effect that it's had on you professionally.

When I was 16 years old, I was competing in the Empire State Games, which is kind of a Summer Olympics sports festival in the state of New York. It's something you have to qualify for, and I qualified out of the Long Island region. I was running in the 10K race, which is a 25-lap race on the track. I was running an amazingly good race, but they had the not-so-great common sense to have the race at noontime in August. So, middle of the summer, really hot day, and we're running 25 laps on a track. On the final lap, with 200 meters to go, I collapsed. Got back up, ran the turn, collapsed again with 50 meters to go and then I was in a coma all afternoon.

So, that experience, I guess now 37 years ago, obviously transformed everything. That evening in the hospital room, I knew that I wanted to try to understand this better and more, and so I dedicated my life to that.

I did my degrees and became an athletic trainer. I'll go to places where heat strokes

COLUMN

NCAA Bylaws, Guidelines and Recommendations as Part of Athletic Training Best Practices

BY ROD WALTERS, DA, ATC, AND DAVID COHEN, ATC, ESQ., NATA PROFESSIONAL RESPONSIBILITY IN ATHLETIC TRAINING COMMITTEE

Best practices are principles that must be embraced by health care providers and supervising administrators as not the gold standard, but the standard of care. By definition, best practice is a standard or set of guidelines known to produce positive outcomes if followed. Best practices in collegiate athletic training should be established after reviewing multiple factors, including regulations set by a governing body, such as the National Collegiate Athletic Association (NCAA), as well as relevant data and research, consensus statements and recommendations and resources from NATA.

Required regulatory acts must be reviewed and incorporated accordingly as violators can face civil or criminal penalty. Statutes, as well as regulatory acts, are law, and if violated, may involve a civil penalty, such as a fine, or a criminal penalty that may be an infraction, misdemeanors or felony and carry a host of different criminal penalties including fines, imprisonment or both.

Some best practices are determined by rules set by organizations that regulate certain professions. The U.S. Drug Enforcement Agency (DEA) is a good example of a specific agency that creates rulemaking regulations. When a new rule is proposed, there is a formal process to establish the regulation that generally involves posting the proposed regulation, allowing public comments, holding public hearings, reposting a revised regulation and then issuing the final regulations.

Administrative agencies, such as the DEA, provide regulations, or rules, as part of law because they often provide detail on how a rule will be carried out. These agencies may also issue guidelines, which are basic and often non-binding information regarding procedural rules, or changes of interest while rulemaking is taking place.

Similar to how the DEA sets regulations for federal and state legislatures to incorporate into best practice to prevent drug distribution, NCAA provides bylaws and guidelines that regulate

collegiate athletics. In this case, NCAA bylaws are like the DEA's regulations.

NCAA was founded on the premise of student athlete health and welfare dating back to a response by President Theodore Roosevelt in 1905 after 18 traumatic college football deaths the previous year.

NCAA regulates student athlete competition and championships for more than 12,090 institutions and conferences divided among three divisions (I, II and III). While budgets may vary among divisions, all divisions share common safety rules and principles of governance.

NCAA bylaws are proposed and voted on by membership. NCAA guidelines and recommendations are drafted by NCAA committees and task forces based on requests by membership, institutions and conference leaders. NCAA membership is responsive to bylaws, but aren't compelled to follow recommendations or guidelines.

The parallel between NCAA and the DEA is acute as both membership and population are sensitive to regulations.

Prudent institutions follow best practices, and best practices are safe practices. NCAA has several bylaws related to health care, including mandatory pre-participation medical examinations (adopted January 2007); sickle cell trait screening and education (adopted January 2012); certification of strength and conditioning coaches (adopted April 2014); independent medical care (adopted January 2016); and acclimatization period, which was extended to seven days for August football practices in 2021.

Additionally, the Interassociation Recommendations on Preventing Catastrophic Injury and Death in Collegiate Athletes was unanimously endorsed by the NCAA Board of Governors as association-wide policy in May 2019.

For athletic trainers working in the college setting, the health care bylaws set by NCAA are important to know and to follow, ensuring they're addressed in their institution's best practices.

Institution sports medicine staff of athletic trainers and team physicians commonly establish

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operating procedures based on evidenced-based best practices. Areas of focus include emergency action plans, exertional heat illness, concussions, spinal injury, fractures and/or dislocations of major joints and other areas of practice. Guidelines and recommendations set by NCAA are only as good as the moral compass of people implementing them. The legitimacy of NCAA bylaws goes only as far as the level of enforcement.

Data has shown that athlete deaths are not occurring during football games, but in preseason and out-of-season conditioning periods. While rule modifications have the potential to decrease exertional deaths in certain situations, such as screening and education of sickle cell trait, the policy and procedures to prevent exertional catastrophic death haven't kept pace with strength and conditioning sessions and practice sessions producing high school and college athlete deaths.¹

With this in mind, athletic trainers should consider shifting the focus to acclimatization to address conditioning principles and the difference in the bodies of student athletes. Many exertional injuries are simply the cause of the inability to dissipate heat from within these large bodies to the surface.²

Twenty-seven non-traumatic deaths occurred to NCAA football players from 2000 to 2017.³ Deaths of student athletes – secondary to exertion – have occurred at all levels from Division III to Power Five institutions.

The July 2019 publication and mandate from the NCAA Board of Governors, Preventing Catastrophic Injury and Death in Collegiate Athletes, addressed institutional activities during transition periods.

The current acclimatization bylaws only pertain to football and only addresses preseason practices, which take place in August. Transition

is defined as the first seven to 10 days of any new conditioning cycle including, but not limited to, return in January, after spring break, return in summer and return after an injury. Some institutions fail to follow established transition mandates.

Institutions are challenged with providing equitable care of student athletes by employing licensed and credentialed health care professionals operating within the framework of state practice acts. Many practice acts also identify standards for clinical practice.

NCAA's Sports Medicine Handbook is a compilation of guidelines on topics from administration, medical issues and special populations to equipment and facilities. NCAA tasked institutions with the responsibility of creating a safe environment for their student athletes to participate in an intercollegiate athletics program.

While many prudent health care providers embrace and implement the Sports Medicine Handbook guidelines, this isn't done across the board and, thus, the gray areas of interpretation and institutional latitude. The lack of clarity has long been a challenge, and until acclimatization and transition periods are enforced as bylaw, such as concussions and sickle cell trait screening, there will continue to be challenges.⁴

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Independent Medical Care as an NCAA Bylaw

Independent medical care, or care independent from coach or administrator influence, is addressed in NCAA bylaw 3.2.4.19 and states: "An active member institution shall establish an administrative structure that provides independent medical care and affirms the unchallengeable autonomous authority of primary athletics health care providers (team physicians and athletic trainers) to determine medical management and return-to-play decisions related to student-athletes. An active institution shall designate an athletics health care administrator to oversee the institution's athletic health care administration and delivery."

This bylaw was voted on and approved by all three divisions within the NCAA. NCAA Chief Medical Officer Dr. Brian Hainline was interviewed in 2018 and stated, "NCAA legislation is indeed a 'rule' that member institutions are supposed to follow." That year, Hainline also told ESPN's Outside the Lines that schools that don't follow the rules should self-report an NCAA violation. Learn more at www.espn.com/espn/otl/story/_/id/28116817/documents-claims-bring-ncaa-medical-care-issues-question.

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take place. I have treated, successfully, 337 cases of exertional heat stroke without a death. I've published about 400 peer-reviewed papers or chapters in edited books related to exercise in the heat or heat illnesses and hydration. Then, we work passionately as advocates to try to upgrade policies and procedures for high school sports, college sports, international things like with the International Olympic Committee and NCAA and other entities that can influence a lot of people. But we also, at KSI, work closely with the country's military and laborers who have to do exercise in the heat. So, warfighters, laborers and athletes are the clientele we try to assist.

Q. You've spent your whole life on this issue, and you've done amazing work. Speak directly to athletic trainers and share a takeaway about exertional heat stroke. What would that takeaway or takeaways be?

That's a good question. The biggest thing would be "overcome the obstacles" that are in front of you. So, if you have a principal telling you they don't want you to do rectal temperature, then you've got to get a team physician for your high school, and you've got to have meetings to make sure that you overcome that obstacle. If you have local ambulance services saying, "We're going to transport right away," you've got to set up meetings and have the key people in the room to overcome that obstacle. If you don't have a water source at a particular field and you can't rapidly cool someone, you've got to overcome that obstacle and have coolers there with ice water and towels or other alternative ways of cooling. Often, people tell me about the obstacles they face instead of focusing on the ways to overcome the obstacles. If we know they can survive if we do the right thing, I think it's worth the effort to overcome the obstacle that's in front of us.⁵

The Importance of Professional Liability Insurance

Insurance 101 is a continuation of Sports Medicine Legal Digest's Law 101 series. Law 101 was created to break down some of the legal issues athletic trainers may face to help ATs better understand the risks and responsibilities that come with being a health care provider to a wide variety of patient populations. Insurance 101 aims to do the same in regards to what ATs need to know about professional liability insurance.

As an athletic trainer, the decision of whether to get insurance should be a no-brainer. Experts are unanimous in their viewpoint on this issue: Athletic trainers face unique injury and treatment challenges for athletes that may leave them increasingly exposed to malpractice lawsuits or disciplinary actions. Any professional without insurance may risk out of pocket costs, according to attorneys and insurance professionals.

There are situations, however, involving insurance issues that athletic trainers should know about. For example, when an athletic trainer is employed, is that employer obligated by state law or any regulatory body to provide insurance to the AT? The answer is, well, it depends – on state statutes and regulations as well as specific employer policies.

For example, Florida's statute specifically states professional liability insurance is required, unless the employer provides that professional liability. Additionally, each school district, university or employer may have policies and procedures pertaining to insurance.

It's unclear whether it would be more expensive for an AT to get insurance through an employer as opposed to private insurance. The reason for this uncertainty is due to the multitude of different insurance companies, rates, limits, occurrence-based versus claims-made and self-insurance/financial-responsibility options.

Then, there is the degree of protection that an AT really needs. If an athletic trainer is relying solely on their employer's professional liability insurance, they may not have enough protection. An employer's professional liability insurance plan often is a shared limit. This may dilute the coverage available when multiple covered employees or covered entities are named in the same claim or suit and dilute the annual aggregate depending on the number of claims made in the policy term.

Maintaining individual professional liability coverage will offer protection for losses that you



may be required to pay out of pocket if the employer's coverage does not cover a loss in full due to the dilution of limits of liability. Again, the decision of whether to get this supplemental insurance can be complicated.

What happens if an AT already has personal insurance, and then an employer offers to provide insurance? Should the AT drop their personal coverage?

There are a few questions ATs should ask their employer to help them determine if it would be best to have their own additional insurance. First, the AT should consider the types of professional liability coverage an employer may have:

- **Occurrence-based coverage** provides protection for a covered loss as long as the loss occurred while a policy was active. This gives you the ability to file a claim any time, even after your policy has expired or lapsed. Occurrence-based policies may appear to be more expensive than a claims-made policy as there are additional endorsements available for purchase to ensure proper coverage.

- **Claims-made policy** provides protection for a covered loss as long as the claim is filed during the policy term, or after the retroactive date while you still have an active policy in force. The retroactive date is the earliest date of your consecutive policies. If the coverage doesn't have a retroactive date, a prior act's endorsement may be purchased for covered events that precede the policy period. When it is time to end your claims-made coverage, you must purchase tail-end coverage to ensure you have coverage for covered events that occurred during the policy period but allows you to report/file a claim

after the policy is expired or lapsed. This coverage is usually called tail-end coverage or an extended reporting period. This coverage usually has a time limit, typically extending the reporting period up to one to five years. The number of months or years of the extension will depend on the cost of this important optional endorsement. If you are covered under your employer's claims-made coverage, your coverage will end at the end of your employment and you should ask your employer about purchasing tail-end coverage. Do not assume your employer will automatically purchase or provide tail-end coverage for you on a claims-made policy.

- **Self-insurance coverage** from a large company also may be an option. This means the entity has decided they don't want to purchase a policy but would rather set aside a specific amount of funds to pay for losses. The entity has evidence of coverage usually in the form of a "letter of credit" or "proof of financial responsibility" stating the amount set aside for losses.

Athletic trainers currently employed should ask their employer these questions about their professional liability insurance:

- Am I covered under your insurance for work provided on behalf of the employer?
- Does this include volunteer work or any per diem services?
- What are the limits of liability?
- Does the coverage include depositions and/or board complaints?
- Is the coverage occurrence-based, claims-made or self-insurance?

- If the coverage is claims-made, do I have the option to purchase tail-end coverage for myself and, if so, will the employer pay for this?

When an employer offers insurance coverage to an AT, the employer may have to pay the cost of the insurance or the AT may have to pay the cost of the insurance. This will depend on the employer or may be a case-by-case determination.

What if the AT is hired as a part-time contractor or only employed during the summer? Should they still have personal insurance?

According to Proliability, a Mercer Consumer company that offers professional liability and medical malpractice insurance, an employer's professional liability insurance is intended to cover services while working for the employer. Asking your employer if your work is covered under their policy is the first place to start.

So, here's the bottom line: It will always be in the best interest of any AT to maintain their own professional liability insurance. An occurrence-based policy is a recommended option to avoid surprise costs of tail coverage. Athletic trainers should have conversations with their employer about the type of coverage held to determine if having their own coverage, in addition to the employer's, will be beneficial. \$

CASE SUMMARY

AT's Use of Rectal Thermometer Prevented Serious Harm – and Led to Major Change in District Policy

Editor's note: This real-life example, although not a legal case, demonstrates the value of the NATA Position Statement on Exertional Heat Illness (www.nata.org/news-publications/pressroom/statements/position) and the deployment of rectal thermometers and affirms the critical role of ATs in implementing relevant school district policy that could result in saving athletes' lives.

A high school in Virginia was hosting the district cross country championship when a runner collapsed on the course. They were picked up by a trailing golf cart and transported to the medical tent at the start/finish line for the race.

The medical team present for the championship included a host athletic trainer, four other ATs and three EMS volunteers. The runner was vomiting and noticeably confused and disoriented. Suspecting exertional heat stroke (EHS), one of the ATs decided to measure the runner's core body temperature with a rectal thermistor to confirm this diagnosis.

The AT's instincts were right: The runner's core temperature measured 107.7 degrees. The medical team immediately placed the runner into a cold water immersion tub that was already set up at the medical tent. The ATs worked as a team to continuously monitor the runner's core body temperature, circulate the water, keep them calm and hold their head out of the water by using a towel under their armpits.

Meanwhile, the EMS volunteers were monitoring the runner's vitals. An ambulance arrived about five minutes after 911 was called. The EMTs wanted to remove the runner from the tub and transport them to an emergency

department. However, the AT asserted that it would be best not to remove the runner from the tub until their core temperature was lowered to 102 degrees.

When the runner's core temperature reached 102 degrees, they were removed from cold water immersion and transported to a local emergency department.

The AT who made the crucial decision to use the rectal thermometer and not to remove the runner from the tub until his temperature was sufficiently lowered, visited the runner in the emergency department and was relieved to find that they were doing fine, with no organ damage, and would be released that evening.

"I'm convinced that if we did not follow the NATA's EHS guidelines and didn't measure core temperature with a rectal thermistor and didn't use [cold water immersion], the outcome for that runner may have been catastrophic," the AT said.

Previous to this incident, the AT had been actively working with the school administration in his school district, as well as the local EMS and hospital, to update their EHS protocols. At the time, none of the county's ambulances carried rectal thermometers, but rather used temporal/tympanic thermometers and evaporative cooling as their standard protocol.

In addition, at that time, the school district's administration continued to deny permission for ATs to purchase and use rectal thermometers.

Frustrated, the AT decided to purchase his own rectal thermistor a year prior to this incident, knowing that if he ever had an athlete suffer EHS, he would use it.

"Needless to say, following this incident and finding out I used a rectal thermometer to treat

this runner, our administration was not happy with me," the AT said.

"During a meeting with my principal and a higher-level administrator, although they praised me for the outcome of the incident and did not suspend or fire me, they made it perfectly clear that if I ever used it again, there would be severe consequences.

"However, at this point and the position they now put me in, I was very angry and extremely uncomfortable. I decided that day that I was going to make it my mission to help educate our administration on the dangers of EHS and, if not properly diagnosed with rectal thermometry and treated with [cold water immersion] within 30 minutes, the outcomes can be catastrophic and deadly."

With the help from many health care professionals, including notable athletic trainers and heat illness thought leaders, the AT sent his administrators and local EMS emails with numerous articles on best practice guidelines for the treatment of EHS. He also presented to upper-level administrators.

About eight months after the incident, the district changed its policy and approved more appropriate EHS protocols in the student athlete handbook that more closely followed the NATA position statement, such as including the use of rectal thermometry as part of the standard of care.

In addition, following a presentation and meeting with the county's chief emergency medical director, the county changed its policy and protocol to defer to the AT on-site on treating student athletes with suspected EHS. The county also purchased rectal thermistors for all squad supervisors to carry on their ambulances. \$