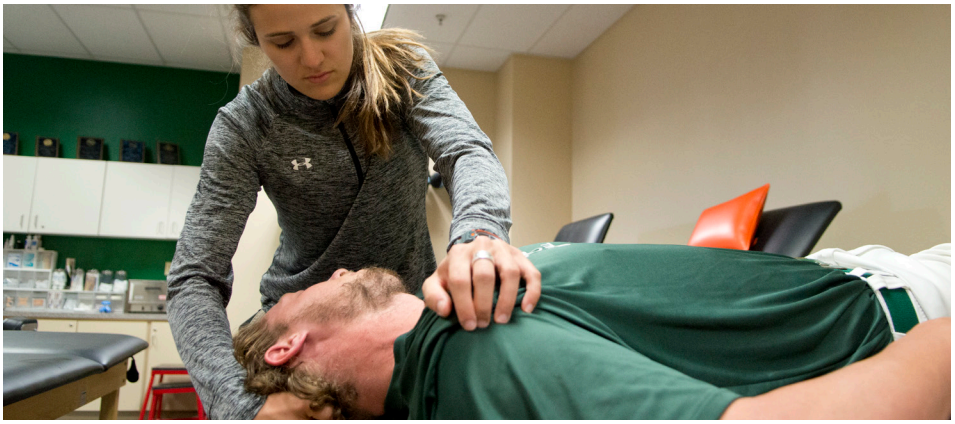
SPORTS MEDICINE

LEGAL DIGEST

QUARTERLY LEGAL NEWSLETTER FOR THE NATIONAL ATHLETIC TRAINERS' ASSOCIATION

SPRING 2020

NATA
NATIONAL ATHLETIC TRAINERS' ASSOCIATION



JAT Article Discusses the Legal Risks of the Sports Medicine Delivery Models

Medical model shown to have the lowest litigation, regulatory risks

According to a 2019 survey conducted by the NATA Intercollegiate Council for Sports Medicine of college and university athletic trainers, 51.73 percent of respondents said their sports program followed the NCAA-legislated independent medical model of care, which gives athletic health care providers autonomous authority to make decisions related to the health and safety of athletes without the influence of an athletic department.

The survey also showed that while 76.26 percent of respondents felt they have medical autonomy, 36.32 percent reported that a coach influences the hiring and firing of the sports medicine staff. Further, within a subset representing 17.37 percent of respondents, 57.81 percent said they have received pressure from an administrator, coach or member of the coaching staff to make a decision that wasn't in the best interest of the student athlete's health.

After the completion of the survey, a Meeting of the Minds was conducted to create the Best Practices in the Implementation and Structure of Medical Care for College Athletes, available at ***www.nata.org/professional-interests/job-settings/college-university/resources****. This document was created to describe an appropriate system of medical care that may be implemented within any organizational setting.*

While every institution may not have the ability to be in or have a medical model, the document states all institutions should have a model of care that is based on:

- *Patient-centered care*
- *Medical evaluation and supervision*
- *Autonomous medical decision-making*

This structure ensures ATs are reporting to a health care professional or a senior level administrator who is experienced and skilled in health care assessment. An appropriate system of medical care will not only allow ATs to provide the best care possible to their patients, it could also lower the institution's litigation risk.

A literature review published in the December 2019 Journal of Athletic Training *examined three health care models – athletics model, academic model and medical model – and how they fair against four types of legal risk: litigation, contract, regulatory and structural.*

To learn more about the legal risks associated with the different models of care, below is the literature review "Sports Medicine Delivery Models: Legal Risks," authored by Geoffrey Christopher Rapp, JD, and Christopher Ingersoll, PhD, AT, ATC, originally published in the Journal of Athletic Training, ***natajournals.org****. (Rapp GC, Ingersoll CD. Sports medicine delivery models: legal risks. Journal of Athletic Training. 2019; 54(12): 1237-1240.)*

IN THIS ISSUE

FEATURES

CASE SUMMARIES & LEGAL COMMENTARY

Q&A

REVIEWED BY

The content included in this issue was reviewed by the NATA Editorial Advisors: Pat Aronson, PhD, ATC; Scott Cheatham, DPT, PhD, ATC; Mike Goldenberg, MS, ATC; Eric McDonnell, MEd, ATC, LAT; Tim Weston, MEd, ATC; and Cari Wood, ATC, and the NATA Professional Responsibility in Athletic Training Committee.

Three general models for the delivery of sports medicine services in intercollegiate athletics have been described: the athletics model, the academic model, and the medical model.[1–4] These models are primarily distinguished by the reporting structure for sports medicine personnel. In the athletics model, the head athletic trainer reports to the athletics director. In the academic model, the head AT is part of the academic program and reports to a chairperson or dean. In the medical model, the head AT reports to another medical professional (e.g., team physician), and the supervising clinician reports to another clinician or health care administrator and not to the athletic director (or anyone else in the athletic department). In each model, staff ATs report to the head AT. In addition to these three broad-brush models, schools can develop hybrid models using portions of several models or using one model for financial oversight (i.e., who pays the bills) and another for operational and administrative oversight (i.e., who directs activities). Still, the straightforward three-alternatives schema is useful for thinking about the intersection of civil liability concerns and AT models.

The benefits and barriers of these organizational structures as well as the quality of life[3] for ATs in each model have been described.[1,2,4,5] Reports[6–8] of coaches influencing or attempting to influence medical decisions have appeared in the mass media. An instance of a coach firing or influencing the firing of ATs to make room for the AT(s) of his or her choice has been reported.[7] Whether such replacements were selected because they were believed to be able to provide a higher quality of care or because a powerful coach was more comfortable with certain personnel is unknown. Regardless, it is not clear whether the well-being of the student athletes was an appropriately central consideration. An athletics director might also influence the selection or activities of ATs. The National Collegiate Athletic Association (NCAA) endorses both the medical model and the academic model rather than the athletics model.[9]

Anecdotal concerns about each model have been discussed,[4,6–8] but we were unable to find a legal risk analysis for each model in the literature. Such a risk analysis may be helpful as institutions consider models of sports medicine care for their institutions. Therefore, the purpose of this review is to provide a legal risk analysis for each model of sports medicine delivery.

Athletic Trainers' Roles and Responsibilities

Athletic trainers' roles and responsibilities have been described in terms of a practice analysis[10] and as educational competencies in accredited academic programs.[11] The roles and responsibilities of ATs are defined by these documents and further described in individual state licensure or registration laws. State licensure or registration ultimately defines what ATs can and cannot do clinically, regardless of the sports medicine delivery model in which they are employed.

Types of Legal Risks

Different typologies of legal risk have been developed. Under one version, legal risk can be divided into four categories. Litigation risk captures the chances that an organization will be sued and the expected losses associated with a suit. The full measure of litigation risk includes the costs of defending such suits (e.g., legal fees), even if a university is ultimately successful. Contract risk involves a risk that an organization's contractual counterparties will breach agreements with the organization. Contract risk can be viewed as including any increased costs associated with negotiating contracts and monitoring counterparty performance. Regulatory risk measures the chances that the organization will face additional regulations that impose costs for compliance or otherwise interfere with the organization's achievement of strategic objectives. Structural risk refers to legal threats to the basic model of the organization.[12]

In measuring the legal risk under any model, organizational leadership needs to identify the probability of a particular legal outcome, the effect of that legal outcome on the organization and the controls or methods available to decrease the risk by reducing the probability of a bad outcome or its expected severity.[13]

Litigation Risk Under the Three Models

The most obvious effect of a different model of sports medicine delivery is on the chance that a university will be sued, the chance that a university will lose a suit and the amount of damages the university might be forced to pay. To establish liability on the part of a university for most injuries arising in connection with the treatment of athletes, a plaintiff needs to establish that the university itself was negligent or that the university was vicariously liable for an employee's negligence.

A university itself can be negligent in terms of how it hires, trains and supervises its employees.

continued on page 04

Q & A

EVALUATING SPORTS MEDICINE DELIVERY MODELS BY LEGAL RISK

Podcast examines ins and outs with researchers

Geoffrey Rapp, JD, and Christopher Ingersoll, PhD, AT, ATC, authors of the study, "Sports Medicine Delivery Models: Legal Risks," published in the December 2019 *Journal of Athletic Training*, sat down with host Kara Radzak, PhD, ATC, for the Jan. 27 episode of the JAT Chat podcast to review the legal implications of health care model selection in athletic training.

Below is an excerpt from that conversation, edited for clarity and brevity. Listen to the episode in its entirety at **natajournals.org**, on Apple Podcasts, Spotify, Podbean or wherever you get your podcast content.

Kara Radzak: Could you give us an overview on the three different models that were evaluated in this sports medicine delivery model evaluation?

Christopher Ingersoll: I'll describe the models in terms of the reporting structure for the head athletic trainer. The first is the athletics model, and that's where the head athletic trainer reports to the athletics director and the budget resides in the athletics department. This is the most common model.

The academic model is where the head athletic trainer is in an academic unit and reports to either a chairperson or a dean, and then the budget would be in that academic unit.

And the medical model is where the head athletic trainer reports to another medical professional, who could be a team physician, and that supervising clinician reports to another clinician or a health care administrator, and the budget sits in that medical unit. So, this model may exist in a university's health system or in student health, for examples.

Hybrids do exist. For example, the head athletic trainer may report to the team physician and student health, but the budget might

continued on page 04

Q&A, *continued from page 03*

sit in athletics. So, there are all different variations of that.

I think the major finding is that the medical model presented the lowest legal risk. The academic model is in the middle, and the athletics model represents the greatest risk, legally to an institution.

Radzak: What was the impetus for this review and evaluation of the legal models?

Ingersoll: I think it started with a conversation of some of the things that were happening nationally and were in the national news about athletic trainers or other health care professionals being pressured to make decisions on student athletes that felt like people were interfering with that. So the conversation about how an institution would move forward – for example, changing to a medical model – how would they present that information? Certainly there's a plethora of literature about job satisfaction and staffing concerns, and even now there's some information coming out about clinical outcomes and so forth. One that is obviously an important one to senior administrators is legal risk. There wasn't anything available to present that, so I had a conversation with Professor Rapp, who's an expert in that area, and we did that analysis.

Radzak: Professor Rapp, can you give us a little bit of background of what you were looking for when you were evaluating the legal risk?

Geoffrey Rapp: One of the models that we found helpful breaks down types of legal risk into four categories: litigation risk, contract risk, regulatory risk and structural risk.

Litigation risk has to do with the risk that an institution will be sued and will have to pay lawyers to defend the lawsuit; it has to do with the risk that they will lose the lawsuit or be compelled to settle it and have to pay something to a plaintiff in the lawsuit who's

continued on page 05

DELIVERY MODEL STUDY, *continued from page 03*

In a negligent hiring, training or supervision case, the university's basic obligation is to act in a way that is consistent with reasonable care. When a custom exists for a particular matter, compliance with custom is evidence that the university has not breached a standard of care, but a defense based on compliance with custom can be rebutted by showing that the university's choices created risks that a reasonable person would have avoided. With respect to the three models of sports medicine, no clear custom likely exists. As such, a case asserting that a university's choice of organizational structure was negligent would point to the risks created by a particular choice of structure and its benefits. It is possible that the choice of model creates risks that cannot be justified by the model's benefits. For instance, in an extreme example of the athletics model gone awry, after phone interviews, a university's athletics director hired two ATs who lacked certifications or licenses. The people providing references for these two ATs viewed them as unprepared for the demands of working as football ATs.[14] Two injured players successfully convinced a court this could constitute negligent hiring on the university's part. Although a "bad hire" is also possible under the medical model, one would hope that those responsible for hiring would at least have a better understanding of the basic qualifications for the AT position. Moreover, credentialing of all health care providers is a common practice in traditional medical settings; this would seem to make it less likely that a university using the medical model would hire an unqualified person.

A university can also be held liable for the actions of its employees when those employees are acting within the scope of employment. Here, the athletics model raises the possibility that coaching preferences regarding return-to-play decisions may trump medical considerations. Case law[15] suggests that ATs – at least in states requiring licenses – are subject to the professional standard of care. This standard compels the professional to exercise the care, skill and diligence that would be exercised by a member of that profession in good standing.

One court described a case against an AT as a case of "healing art malpractice," triggering statutory provisions related to medical malpractice rather than ordinary negligence.[16] As in other cases of health care negligence, liability can be based on mistakes (misfeasance: doing something wrong) or omissions in the face of a duty to act (nonfeasance: failing to do something a person meeting the standard of care would do). Under some circumstances, intentional misconduct or abuse (malfeasance) can also occur within the scope of employment. The choice of reporting relationship will probably not affect the likelihood of malfeasance or the university's exposure.

The National Collegiate Athletic Association endorses both the medical model and the academic model rather than the athletics model.

It is possible, however, that the reporting relationship in the athletics model increases the likelihood of misfeasance or nonfeasance by sports medicine personnel if decisions are affected by school interests apart from the medical well-being of student athletes. Other interests might include achieving winning records, winning championships, or putting the best players on the field for games of particular interest for alumni who donate to the university, such as rivalry games. In concussion litigation involving the National Football League, for instance, players have alleged that "[c]lub doctors and trainers" influenced by nonmedical personnel "downplayed the seriousness of injuries … to convince players to return to play despite said injuries."[17] In spite of its amateur status, collegiate sports likely involves similar pressures to win, which could interfere with medical care. In collegiate sports, coaches may also feel pressure to influence ATs' decisions because of financial bonuses coaches are entitled to receive based on competitive results.

It has become common for coach's contracts to include built-in bonuses for winning conference championships, winning bowl games or advancing in NCAA tournament play. These bonuses might pressure a coach to ensure that he or she has assembled a team for a single game that presents the best chance of victory rather than considering the long-term health interests of the athletes. The athletics model creates

unnecessary conflicts of interest when such financial incentives are at work.

Schools might also find that the choice of model affects their ability to defend against legal claims asserting a failure to obtain informed consent. Athletic trainers, like other health care providers, must seek to obtain patient consent and provide a reasonable description of the risks associated with any particular course of treatment. Under a model in which coaches influence ATs – and pressure them to produce the desired return-to-play decisions – personnel could provide less-than-full disclosure of the risks associated with specific treatments or a return-to-play decision. Because most collegiate athletes are highly competitive and want to return to play for their own reasons, the pressure on an AT could be intense if both a supervising athletics department official and the student athlete want a positive decision. That pressure might lead personnel to cut corners when describing possible dangers to their student athlete patients. If ATs fail to provide necessary information to their student athlete patients, litigation relating to lack of informed consent against universities might be more successful.

Contract Risk

The effect of the sports medicine delivery model on contract risk is arguably less of a concern but potentially not trivial. Specifically, student athletes are often viewed as being in a contractual relationship with their schools. Student athletes contract to provide athletic services in exchange for participation opportunities and scholarship benefits. If student athletes come to doubt whether the university is acting in their best interests, they might be more likely to decide not to continue playing. Stories[18,19] of athletes retiring due to safety concerns – in some cases, in the middle of seasons or even the middle of games – may be growing more common at both the collegiate and professional levels. To the extent that a model may affect student athlete satisfaction, specifically how confident the student athlete is in the quality of care being provided, it may also affect how willing student athletes are to continue performing their contractual obligations to play.

Regulatory Risk

Regulatory risk arises if one model increases the chances that new or additional regulations may be imposed on colleges. It is possible, for instance, that a model that produces a higher rate of injuries for players would attract the attention of nongovernmental regulatory actors, such as the NCAA or even legislative bodies.

Regarding the rules of play, the NCAA has taken action after growing awareness of the long-term effects of traumatic brain injury. These actions have included rule changes: for example, shifting the spot of a collegiate football kickoff from the 35- to the 40-yard line. If a model increases the likelihood of high-profile injuries, it could also create the possibility of additional risks of regulatory intervention.

Regulatory intervention can sometimes take an unexpected direction. The recent death of a University of Maryland athlete led to legislative efforts to permit collegiate athletes in the state to unionize.[20] The point is that the regulatory reaction may not always involve new rules addressing the precise concern that prompted it.

Regulatory risk might also include violations of applicable regulations, such as federal regulations affecting health care delivery and the privacy of student records. One area of concern might be medical privacy rules, such as those in the Health Insurance Portability and Accountability Act (HIPAA). Because medical providers are typically accustomed to navigating the rules relating to HIPAA and privacy concerns, it seems logical that the medical model would carry the lowest risk of violating student athlete privacy rights. The Family Educational Rights and Privacy Act (FERPA) regulations on student records are another concern. Although athletics departments are likely growing increasingly savvy about FERPA concerns, the traditional culture of big-time collegiate sports, with its

continued on page 06

If ATs fail to provide necessary information to their student athlete patients, litigation relating to lack of informed consent against universities might be more successful.

Q&A, *continued from page 04*

been successful either at winning a jury verdict or in obtaining a settlement.

Contractual risk primarily looks at whether it becomes harder for an institution to hold its contractual counterparties to the terms of the contract. So, does this make it more likely that people on the other side of contracts from an organization, in this case a university, would break their contractual obligations to a university? But as we thought about it, contract risk also involved the cost of contracting, so it doesn't become more expensive in the future as a result of a particular choice for a university or organization to enter into particular kinds of contracts.

Regulatory risk has to do with the chances that a particular approach to an activity triggers increased scrutiny from regulators. In most industries, we think about that primarily involving state or federal governmental agencies, but in the case of colleges, we have not only some of those external governmental regulators for some colleges and universities, we also have the NCAA or other athletics organizations, like conferences, that may change the rules applicable to those universities because of things that happen.

Then a structural risk would be a risk where the basic model of the organization is called into question because of legal concerns. If we have a gambling business and gambling becomes illegal, anything that would trigger that kind of a structural change, that would be something we put in that last category.

Radzak: You guys found that the medical model had the lowest risk in all four of those categories. What do you perceive as the primary barrier to switch away from the athletics model, and what are some barriers to the medical model?

Ingersoll: If you're interested in moving to the medical model, it's that any changes to the model that you currently have is an executive decision that's typically made by the president of the university, and this is because

continued on page 06

Q&A, *continued from page 05*

the sports medicine program will typically be moved from one vice presidential area to another. Therefore, the president and the president's cabinet need to be aware of the relevant issues.

Items like legal risks of each model; job satisfaction and work-life balance of the clinicians; and clinical outcomes, external pressure on medical decision-making, clinical pay, clinical staffing levels, all of those things should be considered.

I think it's helpful to summarize all of these findings into a one-page information sheet referencing supporting literature like case law or research papers or media reports and make that available to individuals. The amount of information and the various risks, not just legal ones, in terms of changing it from one area to the other is a complex decision, so the more information you can provide and the more clearly and concisely you can provide it is the best idea.

You may keep in mind, the president's cabinet – and there may be members who have an interest in this, like general counsel, may be concerned about the risk, especially now that we've delineated it in this paper – the athletics director, vice president for student affairs or clinical affairs, or others who may have access to the president should be pulled into the loop, like deans, donors, community leaders and so forth.

The moral of the story is it needs to be focused toward the best interests of the student athletes, and you need to keep in mind that the university president is most likely the decision-maker.

Radzak: What are the key characteristics that make a school situation consistent with the medical model? What are the defining factors of being in the medical model? What does the administrative structure look like?

Ingersoll: The clinicians will report up through a health system, whether it's your

continued on page 07

DELIVERY MODEL STUDY, *continued from page 05*

emphasis on transparency and strong relationships with the media, may not be ideally suited for protecting student privacy rights.

Structural Risk

Structural risk arises if a model threatens the existence of the industry, sector or type of business. The choice of model is not likely to affect the future of collegiate sports and could therefore be considered low risk under each approach.

The table below summarizes the types of legal risks under each sports medicine delivery model.

SUMMARY OF LEGAL RISK LEVELS IN SPORTS MEDICINE MODELS

	Model		
Risk	Athletics	Academic	Medical
Litigation	Highest	Moderate	Lowest
Contract	Moderate	Lowest	Lowest
Regulatory	Highest	Moderate	Lowest
Structural	Lowest	Lowest	Lowest

Conclusions

The athletics model presents the highest litigation and regulatory risks to the sponsoring institution. Contract risk is moderate in the athletics model, but still higher than in the academic or medical model. The academic model presents moderate litigation and regulatory risks. The medical model offers the lowest litigation, contract and regulatory risks of all models. Structural risk is low in all three models.

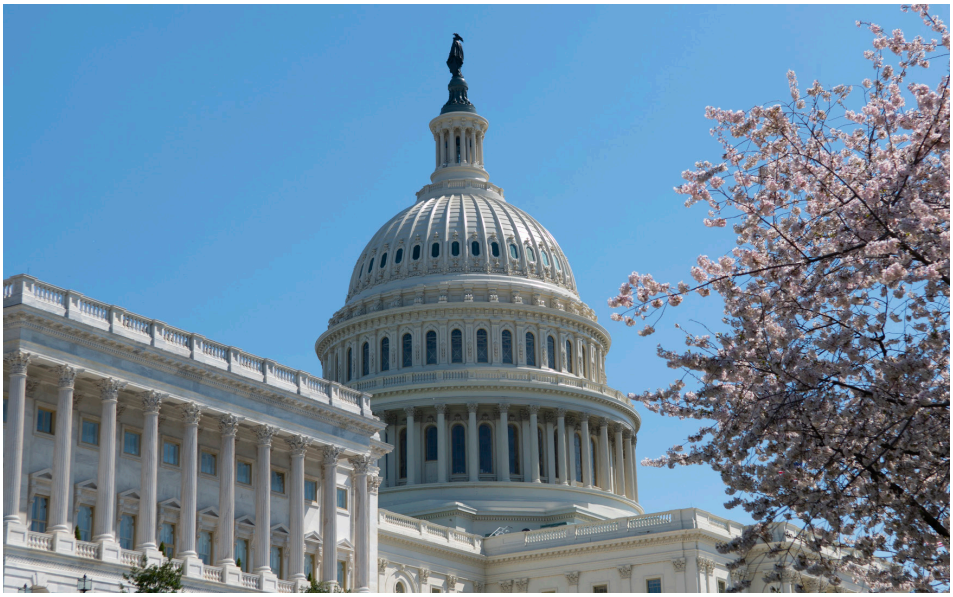
The medical model presents the lowest legal risk for institutions. The athletics model, which is most common, presents the highest legal risk. University officials should understand the legal risks of their respective sports medicine delivery models and consider changes to minimize these risks to the institution. Such decisions should also take into account factors including clinical outcomes, staffing and employee satisfaction.

Importantly, legal risk must be a dynamic consideration for universities. As more universities move away from the athletics model of AT supervision, those that continue to adhere to this model may face even more danger in terms of litigation risk or contract risk. University leaders should be proactive and responsive regarding AT supervision to ensure exposure to only appropriate levels of legal risk. §

References

1. Eason CM, Mazerolle SM, Goodman A. Organizational infrastructure in the collegiate athletic training setting, part III: benefits of and barriers in the medical and academic models. J Athl Train. 2017;52(1):35–44.
2. Goodman A, Mazerolle SM, Eason CM. Organizational infrastructure in the collegiate athletic training setting, part II: benefits of and barriers in the athletics model. J Athl Train. 2017;52(1):23–34.
3. Mazerolle SM, Eason CM, Goodman A. Organizational infrastructure in the collegiate athletic training setting, part I: quality-of-life comparisons and commonalities among the models. J Athl Train. 2017;52(1):12–22.
4. Laursen RM. A patient-centered model for delivery of athletic training services. Athl Ther Today. 2010;15(3):1–3.
5. Shepherd A. In the right place. Training Conditioning Web site. http://training-conditioning.com/2009/08/31/in_the_right_place/index.php. Published January 29, 2015. Accessed September 20, 2019.
6. Wolverton B. Coach makes the call. The Chronical of Higher Education Web site. https://www.chronicle.com/article/Trainers-Butt-Heads-With/141333. Published September 2, 2013. Accessed September 20, 2019.
7. Bradley B. Almost half of college trainers feel compromised by coaches. NFL Web site. http://www.nfl.com http://www.nflevolution.com/article/almosthalfofcollegetrainersfeel compromisedby-coaches?ref¼0ap1000000237767. Published 2013. Accessed August 22, 2019.
8. Brice J. Are coaches endangering players by taking more control of staff? National Football Post Web site. http://gridironnow.com/are- coaches-endangering-student-athletes-by-taking-more-control-of-training-staffs/2/. Published 2018. Accessed August 22, 2019.
9. Sport Science Institute. Athletic health care administration best practices. National Collegiate Athletic Association Web site. http://www.ncaa.org/sport-science-institute/athletics-health-careadministration-best-practices-0. Accessed August 22, 2019.
10. Henderson J. The 2015 Athletic Trainer Practice Analysis Study. 7th ed. Omaha, NE: Board of Certification; 2015.
11. National Athletic Trainers' Association. Athletic Training Education Competencies. 5th ed. Dallas, TX: National Athletic Trainers' Association; 2011.
12. Little M. How to measure and manage legal risk. Berkman Solutions Web site. https://www.berkmansolutions.com/risk/howto-measure-and-manage-legal-risk. Accessed August 22, 2019.
13. Stevens J. It's a risky business. The importance of legal risk mapping. NY State Bar J. 2012;84(8):48–52.
14. Feliciana v Lacawanna College, 156 A3d 1200 (S Ct Pa. 2017).

15. Searles v Trustees of St Joseph's College, 695 A2d 1206 (S Ct Me. 1997).
16. Williams v Athletico, Ltd, 74 NE3d 1047 (Ill App 2017).
17. Evans v Arizona Cardinals Football Club, LLC, 231 F Supp 3d342 (D N Cal, 2017).
18. Sanchez MW. Bills cornerback leaves and retired in middle of game. New York Post Web site. https://nypost.com/2018/09/16/bills-cornerback-quits-and-retires-in-middle-of-game/. Published September 16, 2018. Accessed September 20, 2019.
19. Wogenrich M. At Penn State, 5 player retirements part of strange year. The Morning Call Web site. https://www.mcall.com/sports/penn-state/mc-spt-penn-state-football-players-retire-20180819-story.html. Published August 20, 2018. Accessed September 20, 2019.
20. Zirin D. Will Maryland College athletes be unionized? A bill being put forward in the Maryland statehouse will give college athletes union protection. The Nation Web site. https://www.thenation.com/article/university-maryland-jordan-mcnair-union-ncaa/. Published February 20, 2019. Accessed September 20, 2019.



Understanding the Sports Medicine Licensure Clarity Act

Experts help bust myths that often come with the law

BY CLAIRE HIGGINS

Passed in 2018, the Sports Medicine Licensure Clarity Act is the first and one of the only federal laws to recognize athletic trainers as health care professionals. Its passing was a milestone in representing athletic trainers and expanding recognition across state lines.

The foundation of the law stops liability insurers from denying coverage because an incident occurred outside of an athletic trainer's primary state, but interpretations of the law beyond that have been varied. By the U.S. government's definition, the Sports Medicine Licensure Clarity Act "extends the liability insurance coverage of a state-licensed medical professional to another state when the professional provides medical services to an athlete, athletic team, or team staff member pursuant to a written agreement."

The definitions of a state-licensed medical professional, covered medical services, where services are administered, what written agreements are and just who counts as an athlete are often where variations creep in.

At first glance, it could be interpreted as a law that allows athletic trainers to practice freely across state lines. It could be interpreted that the Sports Medicine Licensure Clarity Act covers athletic trainers providing care to any

continued on page 08

Q&A, *continued from page 06*

hospital or student health or whatever, and the budget sits there. That's the pure version of the medical model. So, the clinicians are evaluated by a health care administrator or another clinician and not someone in the athletics department. That would be the clear delineation in the medical model.

Radzak: So if there are any performance reviews or annual reviews, they're being done by another medical professional, not somebody within athletics?

Ingersoll: Correct.

Radzak: And what does that change for the day to day for an athletic trainer?

Ingersoll: I think that's going to depend on the institution. But the literature identifies some of the advantages of the medical model. Pay tends to go up when they go in the medical model for the practitioners. They feel most supported by the administration in that model. They work the fewest unnecessary hours. They understand their role and their expectations, their work-life balance is better, and they develop more collegial relationships because they're part of a larger health care system.

Radzak: Does the type of model adopted influence the role of non-health care professionals in the medical decision-making process?

Rapp: One of the lines of thinking we went through was who else might influence decisions that an AT makes from a non-medical, non-patient care perspective. That's one of the reasons why we think the medical model

continued on page 08

Q&A, *continued from page 07*

offers the lowest litigation risk in particular, and that's that the AT isn't thinking about budgets, performance reviews being done by someone who has something else in their mind, like winning a game, beating a rival or getting to a conference championship.

Radzak: Do regulatory bodies, such as the NCAA, have a role in model selection or advocating for specific models in athletic health care?

Ingersoll: A quick answer relative to that is they provide some guidance in terms of that, and they have the appropriate medical care document that is available, and presumably institutions are following that guidance in terms of appropriate medical care. The NCAA's process is such that any violation of those type of things are self-reported by the institution, and so, that's inherent in the model that they have relative to that. So, it's effective to the extent that that model works.

Radzak: How do athletic trainers who are not in an administrative role potentially influence the model adoption at their institution?

Ingersoll: I'll go back to what I had mentioned earlier, that it's important to understand who the final decision-maker is. The relationship that an athletic trainer might have within their institution is going to be different from person to person. Someone who's been there for 30 years may have relationships at all levels within the institution, and it might be much easier to initiate a conversation in that regard. Someone who isn't may have more difficulty. So, I think they need to think strategically about how they would get information to a president or president's cabinet member.

continued on page 09

CLARITY ACT, *continued from page 07*

patient, but there's more to it than that, and it's important for athletic trainers to understand all of the law's caveats.

NATA enlisted the experts to bust some of the common myths around the Sports Medicine Licensure Clarity Act and its increased protections for athletic trainers. NATA Director of Government Affairs Amy Callender and Randy Cohen, DPT, ATC, chair of the NATA Liability and Risk Management Assessment Work Group, which created the NATA Liability Toolkit, break it back down to the studs so athletic trainers can be equipped with accurate information about their rights as health care professionals.

MYTH: I'm now covered as an athletic trainer to provide treatment in any state in the U.S.

BUSTED: The Sports Medicine Licensure Clarity Act only extends liability insurance coverage for an insured athletic trainer.

Under this law, medical care provided outside of the athletic trainer's primary state of licensure is treated as occurring in the primary state and can't be denied coverage by liability insurers should a claim be made.

Although it does provide protection of professional liability for athletic trainers to treat injured athletes across state lines, "it does not give you carte blanche to practice in another state," Cohen said. But, if an athletic trainer is practicing in a secondary state as part of the team per a contract or job description, a liability insurer can't exclude them from coverage.

A contract or job description is considered a "written agreement," referenced in the law's language. When a written agreement states that an athletic trainer is authorized to travel with the sports team, they are recognized as part of the team, thus included in liability coverage, Cohen said.

Additionally, for this law to apply, the athletic trainer must be licensed in a primary state, and the secondary state where medical care is provided must also have similar licensure requirements. For the most part, Callender said states that require licensure have substantially similar requirements. Those requirements include, she said, education and continuing education and certifications, for example.

What this law does not do, Callender said, is protect from professional damage if an athletic trainer violates their primary state's practice act while traveling – that is still a condemnable offense. The Sports Medicine Licensure Clarity Act doesn't protect violations of practice acts and doesn't require insurance carriers to cover those cases.

Another key part of applying this law is understanding liability insurance, and if you are covered. Cohen said most athletic trainers should confirm liability coverage with their employer.

He said most athletic trainers don't have personal liability coverage, as physicians are required to have, but athletic trainers may or may not be employed by an organization that provides liability insurance, or insurance that covers athletics.

MYTH: This law covers me, as an athletic trainer, to provide care to all patient populations in another state.

BUSTED: The law only applies to the sports team athletic trainers who are working under written agreement.

As it is written, the Sports Medicine Licensure Clarity Act applies to athletic trainers traveling with traditional sports teams. Traditional sports teams include those at the high school, collegiate, professional, Olympic and Paralympic levels, Callender said.

She clarified that the law doesn't require liability insurers to cover athletic trainers working with performing arts athletes, patients in industrial settings or athletic trainers working as volunteers or hired for per diem work, for example.

When practicing in those settings in another state, Cohen said, athletic trainers should be aware of the secondary state's practice act because athletic trainers should follow that state's practice act to provide care legally.

Who athletic trainers can treat can also vary based on the written agreement. The Sports Medicine Licensure Clarity Act states "athlete, athletic team or team staff member" can be treated by a sports medicine professional. This does not include, for example, a fan attending a sporting event.

Additionally, organizations and institutions could state different language in a written agreement. It is important for athletic trainers to be clearly identified in their written agreement with the sports team to ensure the highest standard of care and to eliminate fear of incurring great professional harm while traveling.

MYTH: I can provide treatment at any location in the state and still be covered by liability insurance.

BUSTED: The law doesn't apply to care provided at a health care facility or while transporting a patient to a health care facility.

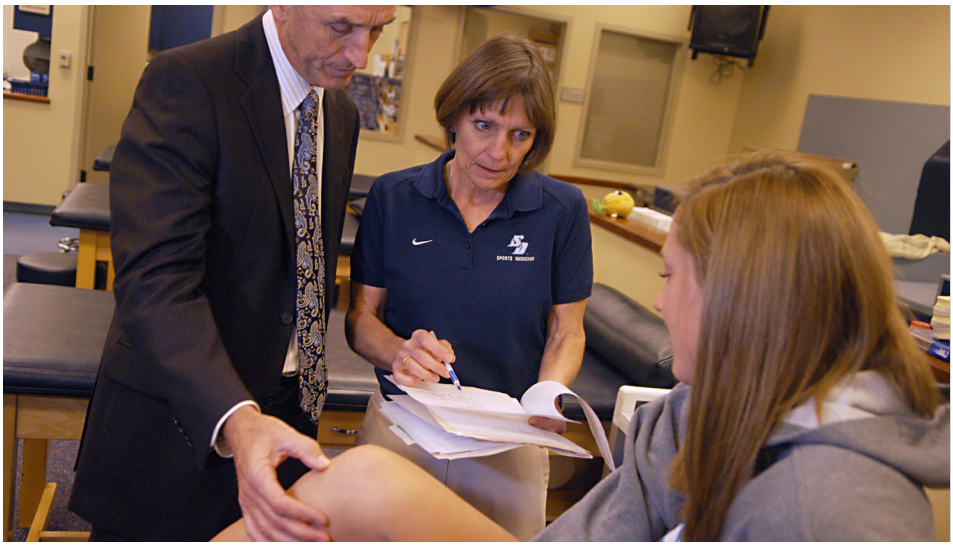
The Sports Medicine Legal Licensure Clarity Act doesn't apply to athletic trainers working in any location in a secondary state, in fact, its parameters are specific.

The law only requires liability insurers to cover incidents that occur in an arena, stadium or other practice facility.

Care provided at a health care facility or while transporting an injured patient to a health care facility isn't included in coverage under the Sports Medicine Licensure Clarity Act. Under the law, a health care facility is defined as a facility where diagnosis or treatment is provided on an inpatient or outpatient basis.

Read more about the Sports Medicine Licensure Clarity Act at **www.nata.org/blog/beth-sitzler/sports-medicine-licensure-clarity-act-signed-law.**

COLUMN



'If It Wasn't Written Down, It Didn't Happen'

Best practices for athletic training documentation

BY MICHAEL PORTERS, MAT, ATC, AND JAMIE MUSLER, LPD, LAT, ATC
NATA PROFESSIONAL RESPONSIBILITY IN ATHLETIC TRAINING COMMITTEE

Toward the end of the fourth quarter of a varsity football game, one of your wide receivers takes a hit to his unprotected abdomen. You do a quick on-field evaluation and decide to remove him from the field. On the sideline, he complains of abdominal discomfort. You proceed to take his vital signs and note his heart rate is 102 beats per minute, pulse oximetry is 98 percent, respirations are at 22, and his skin is sweaty, normal color and warm. You attempt a manual blood pressure, but are unable to accurately assess it due to the crowd noise. You concentrate your exam on his abdomen and don't question the patient about any referred pain. The patient withdraws himself from the remaining 30 seconds of the game. Once the game ends, you quickly clean up the sidelines, document the night's injuries into your electronic medical recording system and head home because you have early injury check and other events scheduled in the morning. Follow-up vital signs were not taken.

The next day at injury check, one of the football players notifies you that your patient from the previous night was rushed to the hospital later that night with severe abdominal pain due to significant internal hemorrhage. You go into your office, pull up the injury report from the previous night and add that your patient's blood pressure was 120/80 mmHg and the patient denied any referred pain.

continued on page 10

Q&A, *continued from page 08*

Radzak: Are there any specific legal arguments or information that can be used to provide administrative decision-makers with options or more information to influence their choice?

Rapp: I think the most important thing is to understand that athletic trainers are subject to review as medical professionals. So, that requires that their decision-making be more than just ordinarily reasonable and that it meets professional standards. The danger there, then, is anytime someone who isn't from that profession, who doesn't have a medical care background, is influencing those decisions, the decisions may not meet the medical care expectations.

Radzak: Is there legal risk to an individual clinician, but not the organization, that athletic trainers should be aware of if they are participating in a non-medical model?

Rapp: Speaking in very general terms, because I can't give legal advice to your listeners, the fact that an organization might be held responsible doesn't always protect the individual who has engaged in the culpable conduct. So, if an athletic trainer fails to meet the standard of care, that athletic trainer might very well be held liable, in addition to the university facing legal risk. So, the safest approach, I think, is always bear your training and your professional expectations in mind and apply patient care as your first decision-making criteria.

Radzak: Are there any other things that an athletic trainer as an individual can do to decrease their legal risk, specifically within the athletics model?

Rapp: I think it's generally true that it helps to get it in writing.

Documentation in health care is paramount to the continuum of patient care as well as acting as part of a health care provider's defense if subjected to legal action. Documentation serves to protect the patient as well as the provider. Two basic rules apply to documentation: "If it wasn't written down, it didn't happen" and "If it wasn't done, don't write it down." Along with documenting key findings, athletic trainers should be alert to pertinent negatives (the signs and symptoms that might be expected based on the chief complaint, but the patient denies having). Pertinent negatives can help confirm or rule out differential diagnoses, direct future patient care and should be documented.

Ultimately, documentation doesn't just record the relevant signs and symptoms, but should justify and support the athletic trainer's decision-making. It should explain why decisions were made by building a case for those decisions through the documentation of all clinical findings. Recording positive and negative findings that reflect an appropriate clinical progression will support why the athletic trainer did what they did.

The case study above is an example of falsification of medical records. When an athletic trainer commits an act of omission or falsifies a record in an act of commission, they shouldn't attempt to cover it up. The athletic trainer should document exactly what did and did not happen along with any actions taken to correct the error. False information can lead to disciplinary action and, potentially, criminal charges. Falsification of medical records can affect the credibility of the health care provider and may subject the individual to aggressive cross-examination by attorneys. An improper alteration of a medical record may prevent the health care provider from defending their case. When a medical record is proven to be intentionally falsified, the health care provider's professional liability insurance policy is at risk of cancellation or non-renewal. Unfortunately, there is no substitute for sound clinical practice, appropriate documentation of all patient assessments and clear justification of clinical decisions.

Medical records that are erroneous, illegible or incomplete – such as lacking dates and times – can be used by a plaintiff to question the quality of care given to the patient. When an error occurs, it shouldn't be erased or covered up. If written, a single line should be drawn through the error, the health care provider should initial it, and the correct information should be written next to it. The date of the correction should also be written.

If a record is electronic, the record should be amended with the date and time of the correction. If an electronic record can't be edited, a printed copy of that record can be corrected and attached to the electronic record. Altering a medical record may imply tampering with evidence. If forensic experts discover evidence of tampering, it may be used to show that the health care provider knew they did something wrong and tried to cover it up.

Tips for Documentation

- Document the entire patient encounter including conversations had with coaches, parents, etc. Remember: "If it wasn't written down, it didn't happen."
- Document all positive findings along with any pertinent negatives.
- Don't falsify the medical records. Deliberate lying and other unethical behavior can discredit the health care provider. Remember: "If it wasn't done, don't write it down."
- Identify errors and correct them appropriately. Don't remove or cover them up.
- Write legibly.
- Provide a comprehensive narrative that includes support for the clinical decisions.
- Use only standard abbreviations and those approved by your organization.
- Learn more by reading the NATA Best Practice Guidelines for Athletic Training Documentation, available at **www.nata.org/practice-patient-care/risk-liability#documentation**. §

References

1. Konin JG, Frederick M (Eds.). Documentation of Athletic Training. 3rd ed. Thorofare, NJL Slack Inc. Publishers; 2018.
2. Locke TD. Medical records issues: content, maintenance and retention. HollandHart.com. https://www.hollandhart.com/pdf/DHCP_medical_records_webinar.pdf. Published September 22, 2016.
3. Mistovich JJ & Karren K.J. Prehospital emergency care. 11th ed. Hoboken, NJ: Pearson Education, Inc; 2018.
4. BEST PRACTICE GUIDELINES FOR ATHLETIC TRAINING DOCUMENTATION. https://www.nata.org/sites/default/files/best-practice-guidelines-for-athletic-training-documentation.pdf.
5. Thompson J. What are the consequences of falsifying medical records? Legalbeagle.com. https://legalbeagle.com/8396562-consequences-falsifying-medical-records.html. Published December 9, 2018.

CASE SUMMARY

COACH'S DECISION TO ALLOW INJURED PLAYER BACK IN GAME DESPITE EMT'S RECOMMENDATIONS LEADS TO SUSPENSION

In an American Youth Football game, an emergency medical technician (EMT) recommended that a 10-year-old injured player stay on the sideline after an injury and not be put back in the game. Despite this recommendation by a medical professional, the coach of the team decided to allow the injured player to re-enter the game.

Whether or not the EMT actually told the coach that the player could not re-enter the game is in dispute. The coach claimed that he was not told by the EMT that the player could not return to the game. The coach said that during the fourth quarter of the game, he approached the player after he went down on the field with an injury and asked him what was hurt. He said the player told him his head hurt and that someone had stepped on his leg.

The coach said the EMT, who was contracted to be at the game, got the player to his feet and walked with him to the bench for evaluation, while he, in turn, went back to coaching. Near the end of the game, according to the coach, the player approached him with his helmet on and mouth piece in place and said he was ready to go back into the game. The coach said the player told him he had been cleared to go back into the game and that he felt good.

Shortly after he was back in the game, the coach said a referee told him that the boy had been removed from the game by the EMT. According to the coach, he approached the EMT, who apologized that he forgot to inform him of his decision to remove the player from the game.

However, investigators looking into the incident determined that the head coach should have

checked with the EMT before deciding to return the player to the field. In addition, according to the investigation of the incident, after the player was evaluated by the EMT, both the player and his mother were told that the player could not return to the game, and the boy's helmet was given to another player.

The coach's decision to put the injured player back in the game, against the advice of the EMT, proved costly for the coach and also the local association in charge of administering football games. The coach was suspended for four games for re-entering an injured player ruled out by the EMT. In addition, the association was placed on probation for the remainder of the season as a result of the incident.

It is unclear whether the mother, in fact, was told that her son could not return to the game. According to an attorney in the case, the mother said there was only one minute and 23 seconds left in the game so she thought that's why her son was sitting out and not that he was not cleared to come back into the game.

The EMT did not approach any of the coaches or her, the mother said, to say her son was no longer allowed to return to the game because he was hurt. She said she subsequently took her son to a doctor, as required by American Youth Football when a concussion is suspected.

After another investigation into the incident, a state youth football official said the town did not have a protocol in place to ensure EMT-coach communications about injured players. The official stated that the next time a similar violation occurred, the penalty could range from an additional four games suspension for an official associated with the program up to, and including, a permanent ban of the league itself.

CASE SUMMARY

LACK OF DULY LICENSED ATHLETIC TRAINERS AT FOOTBALL PRACTICE LEADS TO POTENTIAL NEGLIGENCE LIABILITY FOR JUNIOR COLLEGE

Two junior college football players were injured during a contact football practice. The two football players sued the junior college, the football coach and the athletic trainers, who, at the time of the incident, had not yet been licensed as athletic trainers, for negligence.

The trial court sided with the defendants on the basis that the players had signed waivers that precluded any liability on their part. The players appealed, arguing that, to prevent liability, they needed to sign a consent for treatment by a licensed athletic trainer and that the school had failed to provide such a licensed athletic trainer for the football team.

After filing appeals with trial and appellate courts, the state Supreme Court concluded that the defendants had a duty to provide duly licensed athletic trainers for the purpose of rendering treatment to its student athletes participating in athletic events, including the football practice, and that there was a genuine issue of material fact regarding whether defendants breached this duty.

Moreover, the court stated, although the waiver bars recovery for appellees' damages arising from ordinary negligence, the waiver does not bar recovery for damages arising from gross negligence or recklessness, and there remain factual questions regarding whether appellants' conduct constituted gross negligence or recklessness. Accordingly, the court remanded the case to the trial court to make that determination on negligence.

Initially, the trial court found the waiver immunized the school, coach and athletic trainers from liability because it addressed the "risks and hazards" ordinarily inherent in the sport of football. Finding the negligence claims barred, the court ruled the claim for punitive damages also failed, that there was no genuine issue of material fact and that the defendants were entitled to judgment as a matter of law on the basis of the waiver.

The students then filed an appeal, and the appellate court reversed the judgment of the lower court. Although the court agreed with the trial court's holding the waiver was valid, it disagreed that the waiver barred all of the students' claims as a matter of law.

The panel ruled that the waiver was "not sufficiently particular and without ambiguity" to relieve the defendants of liability. The court also held the trial court erred in failing to address the students' allegations underlying their claim for punitive damages.

The court's most important reason for reversing the trial court's ruling was that there were genuine issues of material fact as to "whether the college's failure to have qualified medical personnel at the practice constituted gross negligence or recklessness and whether that failure caused the injuries or increased their risk of harm."

The court determined that the college had a "duty of care to its intercollegiate student athletes . . . to have qualified medical personnel available at the football tryout … and to provide adequate treatment in the event that an intercollegiate student athlete suffered a medical emergency."

The defendants then appealed this decision to the state Supreme Court, which ruled that the college was required to have qualified medical personnel present at intercollegiate athletic events to satisfy a duty of care to the college's student athletes.

The court specifically noted that the defendants failed to comply with existing common law and statutory duties to have qualified medical personnel available at intercollegiate athletic events, referring to provisions that set forth the qualifications for an athletic trainer and the manner in which they must perform their duties.

The court further pointed out that the regulations establish restrictions and protocols for licensed athletic trainers and that the rules prohibit the use of the title "athletic trainer" by any person without a board-issued license.

An athletic trainer who meets the requirements of this section shall be licensed, may use the title athletic trainer and may perform athletic training services. A person who is not licensed under this section may not use the designation of licensed athletic trainer, athletic trainer or any of the listed abbreviations for that title, including LAT or ATC, or any similar designation, the court noted.

Finally, the court noted, the college demonstrated its awareness that the two athletic trainers did not have the qualifications of athletic trainers by renaming them "first responders." However, the college did not alter their job descriptions, which encompassed the duties of athletic trainers and that the two first responders were the only individuals present at the football tryout to provide treatment to injured student athletes and that the coaching staff propagated the misrepresentation of the "first responders" as "athletic trainers."