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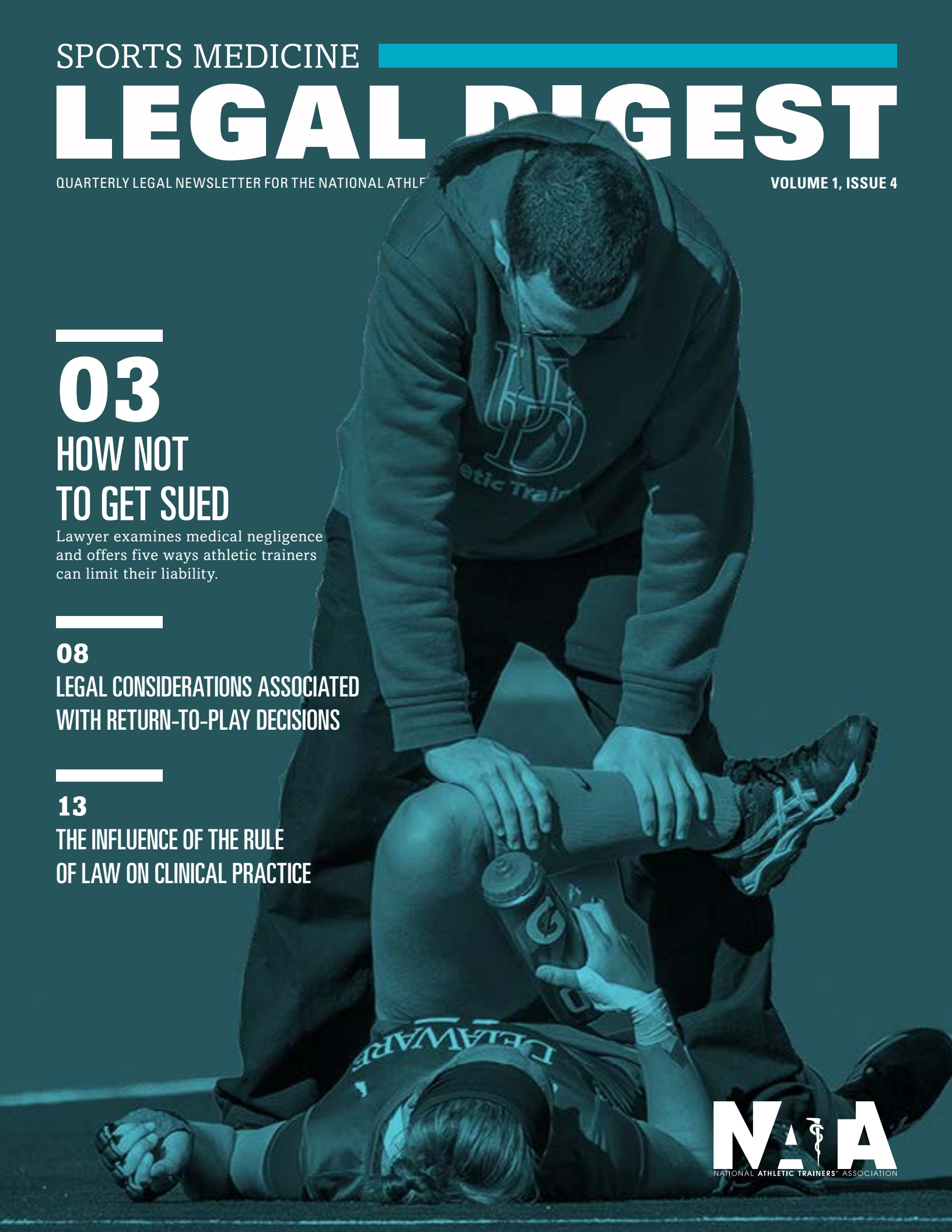

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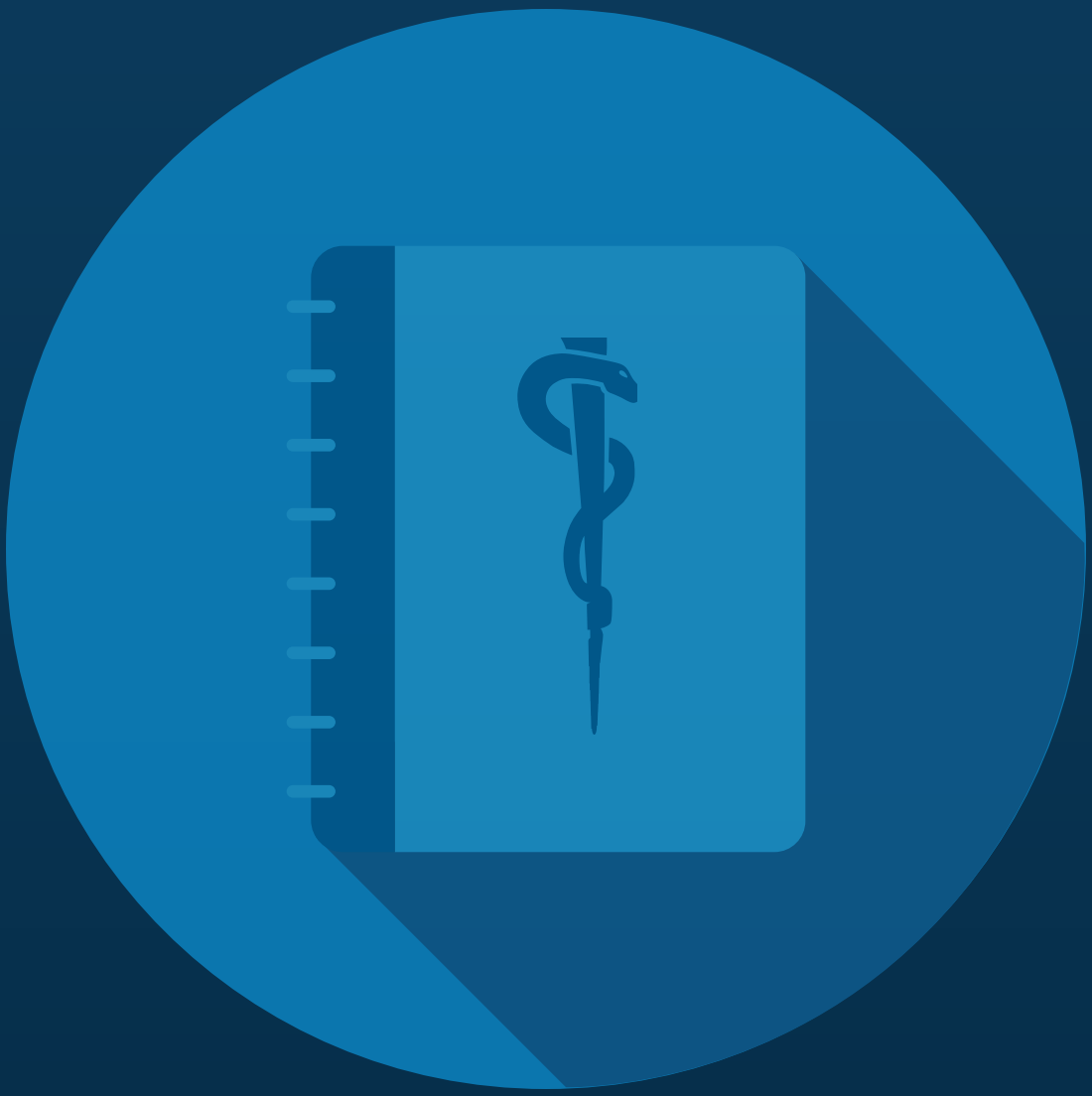
ARE *YOU* LIABLE?



As an athletic trainer, it is your responsibility to protect yourself from potential liability. Understanding the risks involved with patient care is essential for health care providers. The *Athletic Training Liability Toolkit* is a new resource created to help athletic trainers assess their liability.

NATIONAL ATHLETIC TRAINERS' ASSOCIATION

AVAILABLE TO NATA MEMBERS ONLY. You must be logged in to the NATA website to have access to the Liability Toolkit.

www.nata.org/liability

Shaketha Pierce, ATC, provides care to an athlete at Newman Smith High School in Carrollton, Texas. Photo by Renee Fernandes/NATA

How to Not Get Sued:

A Summary of Medical Negligence and Tips to Avoid Liability

BY EMILY JONES LUDIKER, J.D. RODOLLF & TODD, PLLC

Disclosure: Part of this article will focus on the need for professional liability insurance in order to best protect yourself and your assets in the event of a lawsuit. As part of my law practice, Rodolf & Todd is retained by several malpractice insurance carriers, including Medical Protective Co., National Fire & Marine Insurance Co., CHUBB Insurance Co., Pro Assurance, Physicians Liability Insurance Co., American Physicians Insurance (API), Western Litigation, AWAC and Employer's Reinsurance Corp.

Disclaimer: The material presented herein is for informational purposes only and not for the purpose of providing legal advice. The principles addressed are general in nature as liability will vary in each jurisdiction and state. You should contact your attorney to obtain advice with respect to any particular issue or problem. Any outcomes and/or strategies relating to liability and the results of any cases are dependent on the particular facts of each individual case, among other matters. Results will differ if based on different facts and scenarios. No assurance or guarantee is made that you will be able to fully insulate yourself from liability.

Let's start by defining medical negligence. To really understand negligence, you first need to define ordinary care, which is the care that a reasonably careful health care provider would use under the same or similar circumstances. Negligence happens when a health care provider fails to exercise ordinary care to avoid injury to another's person or property.

To prove negligence, a plaintiff must show the following elements: 1) That the defendant owed a duty to avoid injuring the plaintiff; 2) that this duty was breached by the defendant; and 3) that the plaintiff suffered an injury and damages as a result of the defendant's action.

As athletic trainers, you are required to provide competent care and treatment for your patients, referred to as meeting the "standard of care." If

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Do you have feedback or a content suggestion for the *Sports Medicine Legal Digest* editorial team? Contact us at www.nata.org/contact with your feedback so we can continue to improve this resource.

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HOW TO NOT GET SUED, *continued from page 03*

you were sued for medical negligence, the standard of care would be determined by expert testimony from other athletic trainers or physicians. In order to be negligent, the breach of the standard of care must be the direct cause of injury and damages. It must be proven that the injury wouldn't have happened without the breach in care. If you exacerbate an pre-existing injury, your care will be the direct cause of the additional injury you caused. In many states, health care providers are liable for the entire injury (the original and additional injury) in these instances. When the injury is the result of the combined negligence of two or more people, the conduct of each person is a direct cause of the injury, regardless of the extent to which each person contributes to the injury.

As athletic trainers, you are required to provide competent care and treatment for your patients, referred to as meeting the "standard of care."

Plainly put, not only can you be liable for negligence if your care and treatment caused injury to another person because it was below the standard of care, but you can also be liable if you made an existing injury worse, failed to treat an injury in a timely fashion and/or failed to properly diagnose an injury or condition.

How do we define "damages" in the context of medical negligence? Damages are the monetary value of an injury. Compensatory damages, which can be classified as economic and noneconomic, are those that restore the plaintiff to the position he/she was in before the injury occurred and are recoverable in negligence cases.

Economic damages are quantifiable and are usually uncapped. These damages include medical bills, loss of income, loss of scholarships and loss of household services, to name a few. Noneconomic damages include pain and suffering, emotional distress and loss of a parent or spousal consortium in wrongful death cases. Some states cap the amount of noneconomic damages that can be recovered.

Additional damages can be assessed if your conduct is reckless and disregards the person and property of another. These damages are intended to punish you for your misconduct and are different from compensatory damages because they are awarded above and beyond the actual damages incurred. The burden of proof and availability of punitive damages varies from state to state.

As athletic trainers, it's important to be aware of the laws surrounding informed consent and medical battery. Informed consent involves failing to inform the patient or patient's guardian of risks and complications of certain procedures as well as any alternative treatment options. This usually applies to physicians, but it has been expanded to include additional health care providers in some states. Exemptions exist for life threatening situations, and liability varies by state.

Medical battery is the failure to obtain any consent from the patient or the patient's guardian. This can include when medication is given to a patient without consent, so athletic trainers should be cautious about giving medication to patients – even over the counter medications – without consent of the patient or the patient's guardian. Again, liability for medical battery varies from state to state.

In addition to medical negligence, informed consent and medical battery, another cause of action that could be asserted against a health care provider is negligent or intentional infliction of emotional distress. This represents a higher degree of emotional damages than regular pain and suffering and can result when a patient claims that negligent medical care caused significant mental anguish such as depression, anxiety, etc.

As medical providers, you can't completely eliminate all potential liability; however, the following are ways to limit your liability and reduce your exposure.

1. Understand Your Insurance

The best way to protect yourself is to ensure you are covered by professional liability/malpractice insurance, which will provide you with defense lawyers to combat any claims made against you. If you are not covered by professional insurance, you may be personally liable for all lawyers' fees, defense costs and any money awarded to the plaintiff. This could put your personal assets in jeopardy.

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Q & A

ATTORNEY WHO SPECIALIZES IN TBI CASES OFFERS LIABILITY INSIGHTS

Steven Pachman is a partner in Montgomery McCracken's Litigation Department and a member of the firm's management committee. He concentrates his practice on the defense of traumatic brain injury (TBI) cases and regularly represents individuals and school systems in catastrophic sports injury matters arising out of alleged premature return-to-play decisions and other negligence theories in the sports' context. His past and ongoing representations include a number of high-profile, nationally publicized concussion and other TBI cases against NCAA member colleges, universities, high schools, other academic institutions and various school personnel, including athletic trainers, coaches, physicians and nurse practitioners. These cases involve catastrophically injured football players and other athletes who allegedly sustained prior concussions and second impact syndrome as well as players diagnosed with chronic traumatic encephalopathy (CTE) following a post-mortem autopsy of the brain. Pachman also regularly advises school officials, attorneys, risk managers, coaches, athletic trainers, athletic departments, physicians and other health care professionals on institutional liability issues concerning sport-related concussions, second impact syndrome and other sport-related injuries.

Q: How did you get into the sports law niche?

In 2005, a longstanding university client of my firm requested that I undertake an investigation following a catastrophic brain injury to one of its football players. Two years later, a negligence lawsuit was filed against our client and several of its employees, including its head athletic trainer, and I served as lead defense counsel. Among other allegations, the suit claimed the AT mismanaged the student player's earlier concussion and prematurely returned him to game play. The case ultimately settled and was regarded as a favorable result to my client in both the legal

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HOW TO NOT GET SUED, *continued from page 04*

If you are employed by a school, check with your human resources or legal department to ensure the school's insurance policy covers the care and treatment you provide. Many general insurance policies exclude coverage for medical care and services, so it's important to understand your school's policy.

If you are providing independent contractor services, you will likely need to carry your own professional insurance policy as most policies exclude coverage for individuals who are not employed full time. Also, if you are employed by a school, you will likely need your own policy if you are providing services at an event that is not hosted by your school, as you would be acting as an independent contractor outside the scope of your employment during those instances.

2. Maintain Your Education

As health care evolves, so, too, will the standard of care to which you will be held responsible. The evolving treatment methods for concussions and heat related illnesses are excellent examples of the standard of care changing and evolving. Maintaining your education, attending continuing education seminars and reading current research is integral to ensuring you will provide care and treatment that does not deviate from the standard of care and is defensible if you are sued. In short, your education must stay current and up to date.

3. Emphasize Consent Forms

Consent forms help prevent and defend against negligence claims. They should be detailed, clearly stating what types of care and treatment to which the patient or guardian is consenting. Separate consent forms should be used for medication, even if it is prescribed over the counter. If you are providing medications to athletes, you must have a record of allergies, so make sure your consent forms have a place for allergies to be listed. An athlete who doesn't have a fully completed consent form shouldn't be treated in your office, unless there is an emergency.

4. Know Your Athletes

Ignorance is not a defense to liability. Athletic trainers need to know their athletes and patients, and a good place to start is making sure your athletes are not allowed to participate unless they have a physical on file. Physicals should include prior surgical history, current medications, heart conditions, blood disorders, etc. It's important to identify athletes with special health concerns before they seek out your care. In addition to the information on the physical, you should ask your athletes regularly (not just once a year) if they are taking any new medications, have newly diagnosed conditions or are being monitored by a physician for any reason.

5. Prioritize Documentation

One of the best ways to protect yourself from liability is to keep detailed medical records about the athletes you treat. If you are sued, you will have no evidence to support your care if you do not document when and by whom the patient was seen, what care was provided and what, if any, follow up was recommended. This is particularly important because lawsuits are rarely filed quickly after the care is provided. States often provide one to three years for a lawsuit to be filed, and you may not remember the care you provided if you are sued years later.

Maintaining your education, attending continuing education seminars and reading current research is integral to ensuring you will provide care and treatment that does not deviate from the standard of care.

Editor's note: *The recently published Best Practice Guidelines for Athletic Training Documentation can be found on the NATA website.*

About the Author: Emily Ludiker is a partner at Rodolf & Todd. She concentrates her practice in the areas of medical negligence/malpractice defense, health care law, HIPAA compliance and violations, complex appellate research and writing, and labor and employment. For 11 years, she has been defending health care professionals in medical malpractice actions in state and federal courts throughout the United States. In addition, Ludiker has

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and scientific communities. Many concussion experts refer to the case as a landmark matter since it involved so many important issues of concussion safety that never had been litigated. The case also involved many of the country's leading concussion experts.

After the case settled in 2009, I co-authored a "lessons learned" article with one of the leading concussion experts in the country, Dr. Kevin Guskiewicz. The article appeared in an NATA publication. The publicity from the article led to me to receive a number of inquiries from ATs, physicians and schools on how to minimize risk in the concussion space. I also started receiving invitations to speak before colleges with top sports' programs, Division I sports conferences and athletic training organizations… I have focused my practice on both defending concussion cases and counseling in this area ever since..

Q: How long have you been involved in TBI cases, and how has litigating these kinds of cases changed since you started?

The first case I defended was in 2007. That was a case where the plaintiff was alleged to have suffered second impact syndrome (SIS), a controversial medical phenomenon where the brain sustains a second injury prior to resolution of the first, resulting in catastrophic outcomes. These SIS cases are still being filed today and include the same allegations of negligence they did more than 10 years ago, namely failure to warn, failure to educate, failure to diagnose and premature return to play.

Beyond these SIS cases, a new wave of litigation has surfaced in the CTE context. The allegations of negligence in these cases include the same as in the SIS context, but in these new cases the negligence is alleged to have caused CTE and, in some cases, is said to be the cause of a plaintiff's suicide. The science around CTE is quite young and until researchers reach consensus on the cause of CTE, I expect these cases to remain prevalent. My general strategy for defending these cases has remained the same throughout and begins with a thorough preliminary investigation, including an exhaustive round of witness

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HOW TO NOT GET SUED, *continued from page 05*

defended employment law issues, including wrongful termination lawsuits, alleged violations of the Family Medical Leave Act, the Americans with Disabilities Act, the Age Discrimination in Employment Act and retaliatory discharge claims.

In addition, Ludiker served as the assistant head coach and the head coach of the Pom Program at Union Public Schools in Oklahoma from 2005-17, where she routinely interacted with athletic trainers caring for her athletes.

RELATED RESOURCES

+ Athletic Training Liability Toolkit
+ Risk and Liability
+ Developing an Athletic Medical Review Board
+ How to Reduce your Risk of Liability when Dealing with Psychological Concerns
+ Not Knowing Risk Manager is Risky Business

CASE SUMMARY

HIGH SCHOOL BASKETBALL PLAYER'S MOTHER FILES WRONGFUL DEATH SUIT, CITING INACCESSIBLE AED

BY TYLER WHITE

The mother of a 15-year-old high school basketball player who collapsed and died during an open gym session in April 2017 filed a wrongful death suit in state court in December 2017. The complaint alleges the death of the plaintiff's son was preventable and was proximately caused as a result of general, gross, reckless and negligent behavior by the defendants in delaying emergency medical care consistent with their ministerial duties and established protocols.

Specifically, the plaintiff alleges the school's automatic external defibrillators (AED) weren't readily accessible within the optimal response time and that there was delay in contacting emergency personnel. The plaintiff filed suit on behalf of her son's estate and in her individual capacity. She named the high school's athletic trainers, basketball coaches, athletic director, principal and district superintendent as defendants.

Background and Allegations

The complaint alleges that the player was practicing with the team April 26, 2017, when, at some point, he complained to the assistant coach that he was "light headed, having trouble breathing and that his heart was racing." He then called his mother at approximately 4:19 p.m. asking for a ride home. It is alleged video surveillance shows him playing two-on-two with three of his teammates at 4:24 p.m. and shortly thereafter walking toward the athletic training facility where he complained of the same symptoms to an athletic trainer.

While seeking medical attention in the athletic training facility, he reportedly collapsed around 4:28 p.m. It is alleged the first call to the local EMS was received at 4:33 p.m. and that EMS personnel were on scene 10 minutes later. The plaintiff asserts the EMS report establishes "there was a five-minute delay from the time of collapse to the time 911 was called and estimated eight to 10 minutes had elapsed from the time of collapse until the time of their arrival." It is alleged that, according to the AED event log, the first charge was administered to the player at 4:42 p.m. resulting in a "14-minute delay in the administration of the AED."

The player was taken to the hospital by EMS and was pronounced dead at 5:47 p.m.

Delay in AED Administration and AED Regulations

The plaintiff alleges that if the AED was administered without delay, the device could have prevented her son's death. She contends that, "the AEDs were to be placed in the schools based on an optimal response time

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interviews. This is followed by promptly retaining an appropriate team of experts to provide preliminary opinions on liability-related issues and causation.

Q: Concussions seem to be so prevalent. Why have we not seen more lawsuits?

Although concussions are reported with greater frequency today, awareness has led to better management and treatment of concussions. I attribute this partly to actions by organizations including NATA, NCAA and American Academy of Neurology (AAN). NATA, for example, led by the efforts of AT Steven Broglio and his team of concussion experts, recently updated its Position Statement on the Management of Sport-Related Concussions. NCAA has hosted a number of Safety in College Football Summits, stressing proper concussion diagnosis and management best practices and the importance of independent medical care. AAN has hosted annual conference three straight years dedicated to sports concussion. As part of AAN's efforts, I have been asked to present at this year's conference in July on personal and institutional liability considerations that health care providers face and must balance when making decisions about concussion care. Actions such as these not only are helping to promote the health and safety of the athlete, but perhaps having the additional effect of reducing concussion lawsuits.

Q: You have represented athletic trainers in the past. What were the circumstances?

In the event of a catastrophic outcome in the sports context, an AT's actions leading up to the ultimate injury are nearly always put under a microscope. In the case of a head or brain injury, an AT's prior conduct is especially scrutinized. Most of my representations arise where a player has been diagnosed with an initial concussion (or allegedly should have been), and the player later suffers a more serious injury

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BASKETBALL, *continued from page 06*

of three minutes or less." The ministerial protocols and procedures of the school district, including oversight by a physician licensed in the state as required by a state statute, establish this optimal response time. This timeframe commences the moment a victim is identified as needing emergency care. The plaintiff alleges in her suit that "survival rates decrease by 7 to 10 percent for every minute defibrillation is delayed."

The state athletic association also requires coaches, including assistants, of all sports to complete a CPR course that includes the use of AEDs. The plaintiff alleges that the high school had two AEDs on campus; one stationed across from the main office and the other in the athletic training facility near the back corner of the gym. However, she contends that an AED was not present in the athletic training facility on the day of her son's death because it had been removed to the school's baseball field by an athletic trainer.

The Medical Review Panels Act has Since Been Struck Down After Complaint was Filed

The plaintiff also seeks declaratory judgment, and a "proposed complaint" was filed with a state agency against the two named athletic trainers. The essence of this claim is the plaintiff's assertion that state law mandates that "malpractice related claims against a health care provider" shall be reviewed by a medical review panel. The law allows medical review panels to assess and screen "frivolous malpractice claims" before they go to trial. The plaintiff alleges the law is unconstitutional on numerous grounds including it violates equal protection of the law, open court provisions and the right to a trial by jury. Since the suit was filed in December 2017, a state court judge has adjudicated that the state law is unconstitutional on the grounds it impermissibly denies individuals the right to a jury trial.

Legal Issues

The plaintiff must establish that the defendants failed to undertake reasonable measures to ensure that established procedures and protocols were complied with in attending to her son and that such failure was a proximate cause of his death. A news release was issued by the school district that, "the athletic trainer immediately provided emergency care, including CPR and use of the AED (automatic external defibrillator) while 911 was called. When paramedics arrived, they took over his care and transported him to the hospital."

The autopsy of the player revealed that he died from cardiomyopathy of an unknown cause. Cardiomyopathy is an abnormality of the heart muscle, a condition the autopsy report notes may have been inherited by the decedent.

The issues to be litigated in this case are whether the district properly trained and supervised its employees, including the coaches and athletic trainers, to ensure compliance with established procedures and protocols, including the location and use of the AEDs and contact of emergency personnel. The plaintiff is seeking compensatory and punitive damages for the wrongful death of her son as well as for her loss of consortium.

RELATED RESOURCES

+ Sudden Cardiac Arrest Resources
+ NATA Offers Guidelines for Emergency Planning in Athletics
+ High School Automated External Defibrillator Programs as Markers of Emergency Preparedness for Sudden Cardiac Arrest
+ Preventing Sudden Cardiac Death: Automated External Defibrillators in Ohio High Schools
+ Implementing Health and Safety Policy Changes at the High School Level From a Leadership Perspective
+ Guidelines to Prevent Sudden Death in Secondary School Athletics Programs

Q&A, *continued from page 06*

and long-term disability or sometimes death. Often, the theories of liability in these cases, simply put, are that the player never should have been on the field, in the rink, on the court, etc., considering the prior concussion or head injury. I have handled many of these so called "premature return-to-play" cases across the country and have done so in various sports. These can sometimes be tricky cases to defend since there's no magic test to determine whether someone has sustained a concussion or has recovered from one. In addition, the AT is largely reliant on the player to be forthcoming about symptoms after an initial injury.

Q: What does a typical engagement look like when defending ATs and other school employees? Are they hiring you individually, or does the school district hire you?

In almost all cases that I have defended in which I have represented an AT, the AT's school is also named as a defendant. In those cases, either the school's insurance covers the athletic training employee or the school agrees to pay for the defense of the AT. So, it would be the rare case where an AT is retaining me directly. I still advise my athletic training clients to be aware of and understand any applicable insurance policies and ensure the AT is covered personally in the event the AT is named in a lawsuit.

Q: At what point should an AT hire his/her own lawyer?

Although, as noted, the school often picks up the tab for the AT, in the event of a conflict of interest between the school and AT where both are named as defendants (where the defendants' interests appear not to be aligned) the AT may have no choice but to secure separate counsel.

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Murphy Grant, MS, ATC, PES, assistant athletic director for sports medicine at the University of Kansas, evaluates an injured football player.
Photo courtesy of the University of Kansas

Ready or Not? Legal Considerations Associated With Return-to-Play Decisions

BY TIMOTHY NEAL, MS, AT, ATC, CCISM, AND JEFF KONIN, PHD, PT, ATC

Of the many daily decisions athletic trainers make, the decision to return a patient back to participation, particularly during the competitive season, is the most important. Additionally, the input the AT provides to the directing physician regarding the return-to-play (RTP) status of an patient is a vital factor and can influence the final decision made by the physician.

RTP is a general term describing not only one's return to participation in a competitive event, but also a return to practice sessions, conditioning sessions and all other exertional type activities. RTP decisions are not restricted to acute or chronic physical injuries, but also congenital or acquired medical conditions such as diabetes, cardiac abnormalities or exertional heat related illness. Individuals seeking a return to participation following a mental illness or emotional distress-related issue require RTP decision-making criteria.

Both internal and external variables exist in the culture that may attempt to unduly influence RTP decisions, included but not limited to coaches, teammates, patient, parents, other ATs or the AT oneself. Non-medical factors such as the time of one's season (e.g., playoffs), stage of one's career (e.g., last game of senior year) or other competitive issues also play a role in influencing RTP decisions.

As a health care professional, it is well established that the AT has an ethical obligation to safeguard the long-term wellbeing of his/her patient.[1-6] However, there are pressures exerted upon ATs in competitive athletics that may unduly influence RTP decisions, which include threatening the employment of the AT.[7-9] Another potential factor in the RTP equation is contemplating and revisiting a physician's decision to return an athlete back to play prematurely due to pressure or by medical error.[10] Lastly, there are various state laws for interscholastic athletes RTP following concussions. These RTP decisions are challenging and fraught with potential liability if mishandled.

What should the AT consider when involved in RTP decisions, either as an individual or as part of the collective sports medicine team decision? It is always the fiduciary responsibility of the AT to do what is best for the patient. Despite realistic influences to act otherwise, the AT's ethical and legal responsibility includes making difficult decisions not always agreed on by all parties, but that protects the health and safety (short- and long-term) of the patient.

The initial process of RTP decision-making should be established within the AT's standing orders with their directing physician. At a minimum, this would include a line of communication and decision making regarding various medical conditions and injuries that pose a threat to the well-being of their patients.[11] Providing care without standing orders is an ethical, legal and regulatory minefield for the AT, physician and school/organization. As expert witnesses, we have seen these minefields explode under stakeholders without clearly defined standing operating procedures (SOP) or poor adherence to existing procedures. SOP

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should be in compliance with current sports medicine standards of care per evidence-based and best practices. SOPs should be reviewed and agreed upon in writing annually.

Next, the AT should be familiar with existing position statements and available clinical evidence related to conditions that will present themselves and require a RTP decision. Additionally, the AT should be fully aware of all preventable measures, including a thorough and updated emergency action plan, recognition of and the signs and symptoms of potential emergencies, and personnel management required to take action in emergent situations. Resources for these issues are found in NATA position and consensus statements, the NCAA Sports Medicine Handbook and other sports medicine organizations.

When facing an RTP decision, the AT should ask several questions relative to the appropriateness of an athlete either continuing that day in a game, practice or conditioning session with an acute injury or medical condition. The same types of questions should also be contemplated when providing input to a physician when deciding to return an athlete back from a time-loss injury or medical condition or during a preparticipation physical examination.[12]

Some of these questions[13] include:

- Does the injury or medical condition pose an existing emergency response (e.g., anaphylaxis from a bee sting, unresponsive patient following trauma)?
- Is there the potential for this injury or medical condition to turn into a medical emergency?
- Is this an injury or medical condition that needs to be referred to a physician?
- Does the injury or medical condition pose an unacceptable risk for short- or long-term well-being of the patient?
- Does the injury or medical condition place the athlete at increased risk for further injury with continued participation today or in the future?
- Can the athlete safely return after a period of rest/care/taping/bracing, or should they conclude their participation for the day?
- Is the patient a minor child and does this situation require parental involvement?
- Is the patient able to RTP with appropriate interventions that no longer pose any greater risk than normal?
- Are any undue influences placing pressure on your decision to return the patient to participation?

The considerations above, along with others deemed necessary by the AT's directing physician, should be emphasized while evaluating an injury or medical condition and making RTP decisions.

Despite realistic influences to act otherwise, the AT's ethical and legal responsibility includes making difficult decisions not always agreed on by all parties, but that protects the health and safety (short- and long-term) of the patient.

ATs should further be aware of any state laws that govern RTP decisions and protocols. Some laws exist specifically for athletes at the secondary school setting, such as The Zackery Lystedt Law[14] in the state of Washington, which is related to documentation of concussions. While many of these laws mainly pertain to concussion management, ATs must strictly follow these laws and document the course of care and decision making per the state law. While, for example, some may argue that state concussion laws are guidelines for consideration, such state laws are enacted by legislatures and signed by governors to protect patients' long-term well-being, particularly minor patients. The AT should follow these laws from an ethical, regulatory and legal responsibility in caring for their patient. Not doing so may raise questions about whether or not the AT is following the expected standard of care.

Often, coaches, administrators, athletes, parents, the media and even some ATs themselves judge the value of an AT by how quickly they return an athlete back to participation following an injury or medical condition. In fact, it is not uncommon for one's annual performance assessment to include how effective and efficient an AT is in returning patients back to participation. This can be viewed as a potential conflict, whereby one's judgment may be skewed when making RTP decisions. In turn, making decisions simply to provide for a quicker RTP can place the patient's long-term well-being at risk, and put the AT, directing physician and school/organization in the crosshairs of litigation in the event of an adverse or tragic outcome. Rather, the AT should be judged by the quality of their care that ensures the long-term well-being of the patient.

Another potential RTP scenario that is fraught with risk is an inexperienced AT making RTP decisions without having them reviewed or instructed by a more experienced AT staff member. There is value in both knowledge and experience, but the lack of experience in that one moment of RTP decision-making may turn out to be an unforgiving one if policies are not followed or the AT feels pressure to return the athlete inappropriately.

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COLUMN

EXAMINING THE LEGAL CONSEQUENCES OF A RESEARCH STUDY THAT SHOWS CFL PLAYERS HIDING CONCUSSION SYMPTOMS

BY JON HESHKA, ASSOCIATE PROFESSOR, THOMPSON RIVERS UNIVERSITY, BRITISH COLUMBIA, CANADA

The legal challenges facing former Canadian Football League (CFL) players in their lawsuits may have gotten even more formidable.

In a study published in the *Clinical Journal of Sport Medicine* in January, it was found that nearly eight in 10 football players who competed in the CFL in 2015 believed they had suffered a concussion and didn't seek medical attention. Eighty-six of the 309 (27.8 percent) respondents who had played in the CFL during the 2015 season believed they had suffered a concussion during that season and 79.1 percent (68 of 86) didn't seek medical attention during a game or practice.

The study was done by the McGill University Health Centre and endorsed by the CFL and the CFL Players' Association. The study involved a questionnaire sent to all nine teams and distributed to players by each team's head athletic trainer/therapist. There were 512 players on the CFL's 2015 opening-day rosters and, due to player turnover, 662 players participated in at least one game over the course of the 2015 season. Of those players, 454 participated in the study.

The most common (48.8 percent) reason cited for "hiding" a concussion was that the player didn't feel the concussion was serious/severe.

The most common (48.8 percent) reason cited for "hiding" a concussion was that the player didn't feel the concussion was serious/severe and felt he could continue playing with little danger to himself. About 41.9 percent said they felt they would be removed from the game by medical staff and didn't wish for that to happen, 39.5 percent were fearful that being diagnosed with a concussion would result in missing future games or practices, 33.7 percent were fearful that being diagnosed with a concussion would affect their standing with their current team or future teams and 20.9 percent were fearful that being diagnosed and labeled with a concussion could affect their financial income at the time or in the future.

These results have the potential to diminish the veracity of the claims of retired CFL players who allege they didn't know about concussions or appreciate their risks.

It doesn't take away, though, from other elements of the claims in various lawsuits wherein retired players allege the CFL knew of the long-term harmful effects of concussions and actively concealed these facts, that the league breached its duty to take all reasonable and prudent steps to protect players' health concerning concussions and failed to warn players of the long-term medical risks associated with repetitive head impacts and the league negligently misrepresented the science respecting concussions in order to induce players to play football.

It does, however, call into question the extent to which the teams and the league are in a position to protect players who don't wish their protection. Without players honestly disclosing signs and symptoms to team medical staff, the team's capacity to diagnose and treat brain injury is compromised.

Whereas current established practices in the NFL (CFL concussion protocols are not as robust) include unaffiliated neurotrauma consultants, injury spotters, team physicians, the blue injury assessment tents and modified versions of the Maddocks questions and Sport Concussion Assessment Tool, the starting point in concussion diagnosis and treatment for CFL players is arguably in the players honestly self-reporting how they're feeling after a hit (suspicious or otherwise) and suspected concussion.

The reasons cited for injured players not reporting that they'd been concussed (fear of being taken out of the game, fear of missing future games, fear of loss of current or future income) are, in a sense, understandable in leagues where non-guaranteed contracts motivate and incentivize players to squeeze everything they can out of their contracts and consequently play hurt. This can only be addressed through collective bargaining between the league and the players' association.

It bears repeating that this study was specific to players competing in the CFL. In 2017, the Court

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Q&A, *continued from page 07*

Q: Are ATs on the firing line any more or any less today, and why?

ATs are one of the easier if not the most obvious targets in a sports injury case. If the allegation is premature return to play following a prior concussion, the AT likely had a key role in the initial concussion assessment and/or diagnosis, taking the player through the return-to-play process and/or the ultimate return-to-play decision. These are prime areas for plaintiffs' lawyers to engage in second-guessing after an injury and attack in a legal complaint.

Q: Is there any risk management advice you would give ATs as they go about their job daily?

My No. 1 tip to my AT clients is that they follow their school's or organization's concussion policy to the letter. Years ago, many schools and organizations didn't have concussion policies and procedures in place. Today, most do, but I sometimes see policy non-compliance, which in the event of a bad outcome provides for an easy allegation of negligence. I also suggest to my AT clients that they stay current on the most recent medical and scientific literature on concussions. This includes ensuring that their organization's concussion policy is up-to-date on at least a yearly basis.I have conducted concussion policy "audits" for many clients to ensure policies are current.

EXAMINING, *continued from page 10*

of Appeal for British Columbia in Bruce v. Cohon et al. 2017 BCCA 186 upheld a judgment of the Supreme Court of British Columbia that dismissed a CFL concussion lawsuit holding that the disputes raised by Bruce arose from the 2014 Collective Agreement and can only be resolved through the grievance and arbitration process. The courts declined to look at the merits of the case. Bruce has filed an application for leave to appeal to the Supreme Court of Canada.

RELATED RESOURCES

+ **Why Professional Football Players Chose Not to Reveal Their Concussion Symptoms During a Practice or Game**

COLUMN

THE RATE AND RISK OF HEAD INJURIES IN MIXED MARTIAL ARTS REMAIN UNKNOWN DUE TO A LACK OF REGULATION AND PROTOCOLS, ACCORDING TO NEW STUDY

BY SHAWN SCHATZLE, ESQ., HAVKINS ROSENFELD RITZERT & VARRIALE, LLP

It was May 25, 2013, in Las Vegas, the mecca of combat sports. T.J. Grant, then a 29-year-old native of Nova Scotia, was riding a four-fight win streak into a lightweight bout with former title contender Gray Maynard at UFC 160. Having competed in Brazilian jiu-jitsu and wrestling as a teenager, Grant began fighting in 2006 and had compiled an impressive record of 20-5 by the time he stepped into the cage in Las Vegas that night. Maynard was a respected veteran who had almost become the UFC's Lightweight Champion on two occasions, only to fall just short in bouts against Frankie Edgar. Otherwise, he was undefeated in every bout he had competed in and was the favorite heading into UFC 160.

Despite the underdog status, Grant stopped Maynard with strikes inside the first round. It was only the second time Maynard had been defeated. Grant was dubbed the top contender to the championship. All of his hard work had finally paid off.

Shortly after his stunning victory in May 2013, Grant was booked against then-champion Benson Henderson in a UFC Lightweight Title bout scheduled to headline UFC 164 in Milwaukee. It wasn't to be, however. He suffered a concussion in training and was pulled from the bout. He was replaced by Anthony Pettis, who defeated Henderson and went on to become a star for the UFC, even appearing on a Wheaties box. As for Grant, the win against Maynard would be the last time he would ever compete in mixed martial arts.

Realizing he needed to find a way to support his family if he was not going to be competing, Grant spent time working in a potash mine in Saskatchewan. Headaches lasted for at least a year after the initial head injury. Even after they subsided, he still experienced short-term memory loss, sometimes forgetting why he went to a particular room in his house.

Grant is certainly not the only mixed martial arts athlete who has suffered a head injury, but a recent medical study indicates that the statistics are largely unknown.

Researchers at St. Michael's Hospital in Toronto recently published an article in the journal *Trauma*, which analyzed 18 studies involving 7,587 patients with head injuries from mixed martial arts competition. Following their review of the studies, the authors of the article concluded that "the rate and potential risk of traumatic brain injury in mixed martial arts remain unknown due to a lack of regulation and protocols surrounding such injuries," according to a press release from the hospital summarizing the article. The authors found that there was "no consistent definition of head injury, concussion or traumatic brain injury or consistent protocol for how [such] injuries are reported and medical clearance [for] return to play." There was no information regarding long-term follow-up of injured fighters available to the authors.

The lack of relevant statistics was noteworthy in light of the possibility of head trauma in the sport. For example, the researchers found that a significant portion of mixed martial arts bouts ended in stoppage due to strikes. More

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COLUMN

FOOTBALL PLAYER WITH ONE KIDNEY SUES; CLAIMS DISCRIMINATION

BY JORDAN AZCUE

After a successful high school career, a football player from the South accepted an opportunity to play football for a prominent Southeastern Conference School.

Playing defensive back for the university didn't work out as planned, so when the assistant football coach at a nearby mid-major school allegedly "reached out to him and invited him to transfer," the young man was ready to make the change.

The transfer process was not without challenges. He had to take online classes and sell his vehicle to make ends meet, while waiting for the opportunity to pursue his dream. But none of those challenges could compare with the one that had confronted him his entire life: the player was born with only one kidney.

While the young man believed he could clear that hurdle, his new school allegedly had other ideas and denied him an athletic scholarship, leading to a recently filed lawsuit that claims the school violated federal anti-discrimination statutes.

The Plaintiff's Lawsuit

The plaintiff alleged in the complaint that the university, the defendant, was informed he had one kidney and he was nevertheless "cleared for all activity without restriction." Without this clearance, the plaintiff said he wouldn't have continued to practice and train for the upcoming season at the university.

"I was cleared to play and was practicing and working out and everything for the whole month of June up until the point I went and told the [head athletic trainer] about the situation," he said. The athletic trainer told the plaintiff he had "to stop practicing." The athletic trainer, allegedly, then took the plaintiff to a "family medicine doctor who acted as the team physician," who affirmed the athletic trainer's decision and pointed to "the liability of his condition," according to the complaint.

The plaintiff didn't give up. Researching the defendant's sports medicine actives and procedures, the plaintiff found two policies that he believed weighed in his favor. First, he could seek a second opinion in matters relating to his health and with a written document from said physician,

continued on page 12

RATE AND RISK, *continued from page 11*

specifically, it was found that contents ended in a "technical knockout" or "knockout" at a rate ranging from 28.3 to 46.2 percent of all matches, with some studies finding that there was a lifetime average of 6.2 technical knockouts or knockouts in an individual career. No information was reported relating to head trauma sustained during training which is notable, especially considering Grant's story.

The researchers at St. Michael's Hospital noted certain regulations generally in place relating to head injuries, although they highlighted deficiencies with such regulations. In Ontario, for example, fighters who sustain a head injury are suspended for a fixed period of 60 days, regardless of ongoing symptoms. Athletes can be cleared early by any physician with a normal CT, MRI or electroencephalogram.

A root issue may be the fact that mixed martial arts is not regulated by any single sanctioning body. Although organizations such as the UFC and Bellator are well-known, they are merely promoters of the sport. Regulation is left up to individual states in the United States and provinces in Canada. Outside of North America, local athletic sanctioning bodies or commissions oversee events, or promoters are left to regulate their own events. This creates a logistical hurdle in setting forth comprehensive protocols for head injuries.

There have been attempts at setting forth uniform protocols by the Association of Boxing Commission (ABC); however, any regulations set forth by ABC aren't binding on individual member athletic commissions. When ABC issued certain changes to the unified rules of mixed martial arts in August 2016, for example, representatives of the New Jersey commission expressly stated their state would not adopt the new rules in full. Nevada has yet to even vote on whether to implement the new rules.

With that said, the individual athletic commissions who objected to certain portions of the new unified rules of mixed martial arts largely did so on the basis of fighter safety. New Jersey specifically objected to a rule change relating to the definition of a grounded fighter on the basis that it could potentially increase head strikes. This indicates that individual commissions may welcome a discussion regarding uniform protocols for dealing with head injuries in mixed martial arts. Perhaps ABC will take up the topic in the near future. Any new protocols issued by ABC regarding head injury regulations would then need to be voted on by each individual member commission.

For its part, the UFC has not been silent on the issue of fighter health. For example, in October 2017, heavyweight contender Mark Hunt was pulled from a bout in Australia due to troubling comments he made in a published article. Hunt complained of sleeping and memory issues, and noted that he was starting to stutter and slur his words. He opined that these issues were "the price of being a fighter." The UFC removed him from his scheduled bout and refused to book him again until he underwent a series of medical tests with specialists in Las Vegas. He apparently passed and was scheduled to compete against Curtis Blaydes Feb. 11 in Australia.

There have been attempts at setting forth uniform protocols by the Association of Boxing Commission (ABC); however, any regulations set forth by ABC aren't binding on individual member athletic commissions.

The UFC has also enacted a comprehensive drug testing program through a partnership with U.S. Anti-Doping Agency, the goal of which is to police and hopefully minimize the use of performance-enhancing drugs in the organization. This program doesn't directly relate to the issue of head injuries, but it is evidence of the promotion's ability to tackle important issues when it elects to do so. $

RELATED RESOURCES

+ **Traumatic brain injuries in mixed martial arts**

Football, *continued from page 11*

he could be cleared to participate in athletic activities. Second, he could sign a waiver that addressed pre-existing conditions, therefore the school wouldn't be liable for further health issues.

On the first point, the plaintiff obtained a second opinion from a kidney specialist and submitted the opinion with hopes that the defendant would reconsider his eligibility. But he was blocked again.

On the second point, the plaintiff's position is solid, according to his attorneys: "It has been black-letter law since the 1980s that barring a student with one kidney from playing football after he offers to sign a waiver of liability is a violation of federal anti-discrimination laws. Grube v. Bethlehem Area School District, 550 F. Supp 418 (E.D. Pa.. 1982) (a football team's doctor advised against a student with one kidney playing football, but an expert cleared him to play and the student offered to sign a waiver of liability. The court granted a preliminary injunction because 'the plaintiff is being deprived of an important right guaranteed by federal legislation.')

"As one court put it, the purpose of federal anti-trust laws is 'to permit handicapped individuals to live life as fully as they are able, without paternalistic authorities deciding that certain activities are too risky for them.' Poole v. South Plainfield Board of Education, 490 F.Supp. 948, 953-954 (D.N.J. 1980)."

The plaintiff also claimed in the lawsuit that one of the defendant's coaches relayed false information to a current player at another school, informing the player that the plaintiff couldn't play football because he didn't pass a physical at the university. The plaintiff alleged that the coach wasn't only committing defamation by lying about him not passing the physical, but that it was a violation of HIPAA and FERPA when he disclosed his medical information. $

Kathy Dieringer, EdD, ATC, LAT, works with a patient at her clinic, D&D Sports Medicine.
Photo by Renee Fernandes/NATA

The Influence of the Rule of Law on Clinical Practice

BY JAMIE MUSLER, LPD, ATC

Have you ever asked yourself, how broad is an athletic trainer's scope of care? Can we suture to close a wound? Can we administer an IV? Can we assist with surgical procedures or cast a fractured bone? Determining practice boundaries and a standard of care is a complex confluence of state and federal statutory laws, government regulations, professional association standards, educational requirements and state and federal case law (Diagram 1 on next page).

The lack of clearly defined practice standards makes it difficult, if not impossible, for the practicing athletic trainer to understand the legal boundaries to his/her practice. The lack of clear professional boundaries is not necessarily a bad thing. It is this ambiguity that allows for innovation, experimentation and growth in a profession. The challenge for any clinician is to provide the highest quality patient care while remaining within the acceptable standard. In some cases, it ultimately may be legal action in the form of litigation that provides the needed clarity, but at that point it may be too late for the athletic trainer involved.

Judicial review serves as ultimate authority for public and private disputes relative to the rule of law. Judicial process and the resulting case law are not part of the traditional statutory law we typically think of in relation to our state practice acts and other regulations. Case law is the result of a judicial review of the facts with consideration of pertinent prior cases and applicable state or federal statutes.

When the judiciary considers malpractice or medical liability cases, the judge may look beyond prior case law to determine what a reasonably prudent professional should do under similar circumstances. In establishing a "standard of care," the judge could consider the opinion of professional organizations, experts in the field, established guidelines and the opinions of other private or public agencies.

Once established, it is the standard of care, along with prior case law, that the judiciary uses to resolve the case before them. The result is new case law that may impact the practicing professional.

The athletic trainer is not required to be knowledgeable in all foreseeable injuries or all aspects of care, but must address the required emergency care for the injury or illness outcome.

While the incidence of athletic trainers being sued is comparatively low in relation to other health care providers, it is becoming more common. Each new ruling adds to the case law and precedent that will be used to adjudicate future cases. Unfortunately, there are no easily accessible means for an athletic trainer to review and evaluate case law.

Case Law Review

In an effort to identify relevant case law, a systematic reviewed was performed within the LexisNexis and Westlaw databases to identify athletic training-related cases. Identified cases were reviewed to determine the context of the term athletic trainer in the record, role of the athletic trainer in the case, issue in dispute, court's decision and legal foundation for the decision.

Relevant cases were reviewed and categorized in accordance with their potential influence on the athletic trainer's practice. For each case, the legal reasoning was identified and cases with similar legal reasoning and common principles of legal rule were grouped together for analysis.

A total of 218 cases were identified and analyzed. Of those, 68 were reviewed by U.S. District Courts, 30 were reviewed by U.S. Courts

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of Appeals and 89 came before State Supreme or Appeals Courts (Table 1).

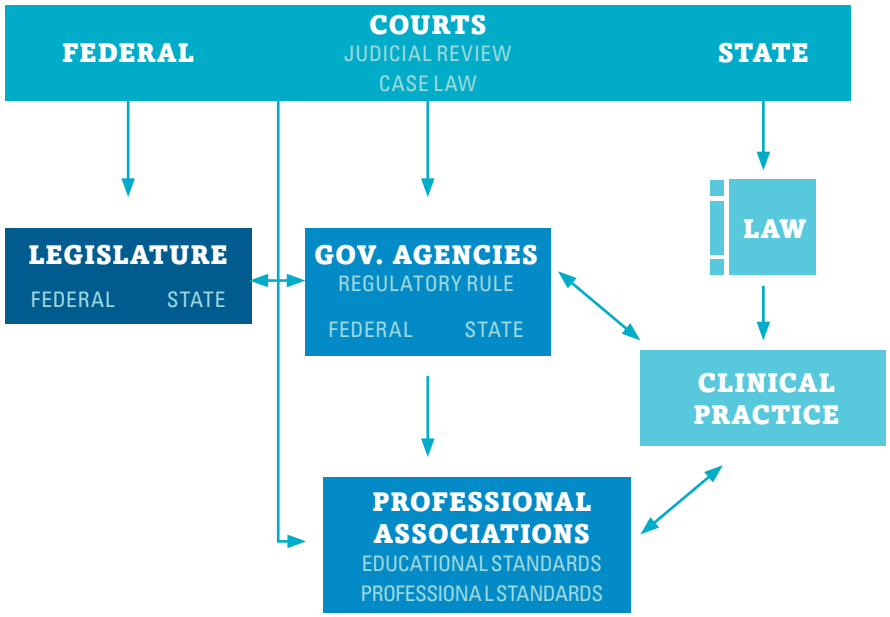
In 109 cases, it was determined that the issue in dispute had nothing to do with an athletic trainer or the practice of athletic training. These cases were coded "NR." Of the 109, 53 cases indirectly referenced athletic trainer when citing precedent or other cases, but the occurrence of the term "athletic trainer" was determined to be incidental and without impact on the case. Of the 109 cases, 32 made reference to statutes containing the term "athletic trainer," but an athletic trainer had no relevance to the case. Also, 15 cases referenced the testimony of an athletic trainer, six of which identify the athletic trainer as an expert witness, however, the issue in dispute was not related to the practice of athletic training. Nine cases involved issues of employment, personal bankruptcy and unlicensed practice and contained incidental references to "athletic trainer" (Table 2).

In 79 cases, the athletic trainer or the practice of athletic training was at issue in the legal dispute. Eleven contained legal reasoning and addressed a duty to care; 34 contained legal reasoning and addressed a standard of care; and three cases contained legal reasoning that identified issues of public policy. Finally, 31 cases had no conclusive legal reasoning (Table 3).

Establishing Expectations

As one might imagine, there is not a specific standard of care that is utilized by the courts; however, the courts have established expectorations for the care provided by an athletic trainer. These expectations serve as the minimum standard for which the athletic trainer was judged in the reviewed cases.

DIAGRAM 1. **THE INFLUENCE OF THE RULE OF LAW ON CLINICAL PRACTICE**



There are also very fewer incidences of the court limiting the athletic trainer's actions resulting in practice boundaries.

The majority of cases were reviewed based on the legal principles of negligence, with the courts committing a significant amount of effort to the principles of duty, breach of duty, cause in fact, proximate cause and harm.

The courts' legal reasoning have been synthesized into recommended standards intended to provide a foundation to build a comprehensive system of patient care that reduces the risk of an adverse judicial outcome.

The standards are divided into two groups, institutional standards and standards for the athletic trainer. The two groups of standards were the result of the case analysis and the legal reasoning applied by the courts. While there is overlap between the two groups, the courts made a clear distinction between institutions and professionals in their reasoning.

Institutional Standards

Standard No. 1: The institution must have a system in place to provide prompt treatment, including lifesaving procedures for all foreseeable injuries and illnesses, including permanent disability and life-threatening situations during all athletic activity (Kleinknecht 1993b).

Standard clarification: Foreseeable injury and illness includes all medical conditions commonly part of an athletic trainer's education, or accessible in the literature on sports medicine. Athletic activities include all organized and supervise practices and games regardless of whether they are in or out of season.

Standard No. 2: The institution must have a system in place to provide ongoing care beyond prompt initial treatment that assures access to the emergency medical system (EMS) in a manner that meets or exceeds the average EMS response time for the local community (Kleinknecht 1993b).

Standard No. 3: The institution must have a system in place to provide ongoing care beyond prompt initial treatment that assures access to a physician for follow-up care that meets or exceeds the referral time that is appropriate for the injury or illness (Stineman 1981), (Jarreau 1992), (Livingston 2006).

Standard clarification: Not all injuries are life-threatening and require immediate referral. Access to a physician must be assured and coordinated by the institution. Referral times must be consistent with the commonly acceptable procedures for the injury or illness to assure effective care.

Standard No. 4: The institution must have a system in place to inform a coach or other responsible supervisors of an injury or illness that could cause additional harm to a participant because of ongoing participation (Jarreau 1992).

Standard clarification: The coach or others responsible for supervising athletic activity

TABLE 2. **UNIQUE CASES CONTAINING THE TERM ATHLETIC TRAINER (N=188)**

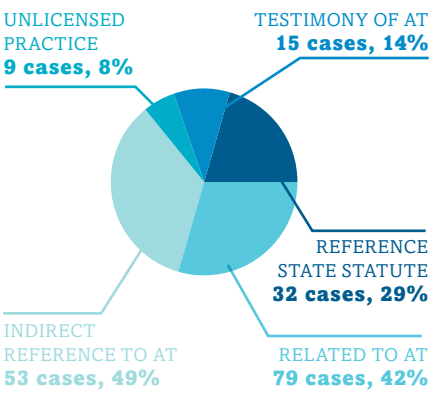


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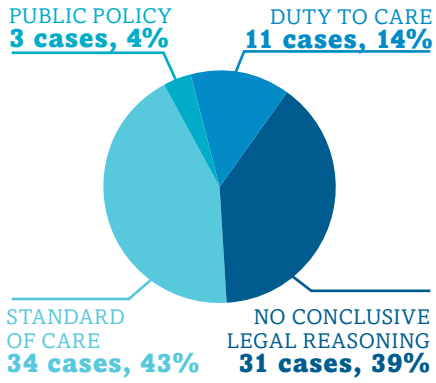
TABLE 3. **CATEGORIES OF LEGAL REASONING IMPLICATION (N=79)**



must protect the well-being of the participants. Therefore they must be aware of all the participant's injuries and risk of additional harm in order to make an informed decision about the appropriateness of their participation in the activity.

Standard No. 5: The institution must provide equal access to medical care for all classes of athletes participating in school sponsored or supervised athletic activities (Haffer 1987a).
Standard clarification: An equal number of health care personnel must be available to all athletes. Access to care, defined by patient weight times, must be equal for all athletes. Access to health care facilities and health care equipment, must be equal for all classes of patients. Access to follow-up care, including physicians, other health care providers and facilities must be equal for all classes of patients. Patient class is defined by scholarship versus nun scholarship athletes, as well as revenue and non-revenue producing sport participants.

Standard No. 6: The institution must have a physician on staff or provide a physician to serve as supervisor for all athletic trainers that are employed by the organization and responsible for patient care (Georgia Physical Therapy 1995a).
Standard Clarification: The organization employing the athletic trainer providing services onsite or in an outreach position is responsible for providing a physician to serve as supervisor for all athletic trainers responsible for patient care.

Athletic Training Standards

Standard No. 1: The athletic trainer should exercise reasonable care to protect the health and safety of all student athletes under their care (Searles 1997), (Hemphil 1982).
Standard Clarification: A student athlete is considered under the athletic trainers care if they are a member of a sponsored athletic team at the institution that employs the athletic trainer. The athletic trainer should protect the athletes from known harm of foreseeable injuries. The athletic trainer should protect athletes from foreseeable harm of current injuries. The athletic trainer should protect athletes from foreseeable harm of participating with an injury.

Standard No. 2: The athletic trainer should be adequately prepared to provide care for all injury and illness outcomes commonly part of an athletic trainers education or that are accessible in the literature on sports medicine even if the case is rare (Kleinknecht 1993b), (Livingston 2006).
Standard Clarification: The athletic trainer is not required to be knowledgeable in all foreseeable injuries or all aspects of care, but must address the required emergency care for the injury or illness outcome. The athletic trainer must be prepared for and have procedures in place for all adverse outcomes that could occur in sport including paralysis and cardiac events regardless of the underlining cause.

Standard No. 3: The athletic trainer must use reasonable and currently acceptable evaluation techniques (Searles 1997), (Lennon 1993c).
Standard Clarification: Reasonable and currently acceptable techniques are those procedures that are commonly taught as part of an athletic trainer's education or are accessible in the literature on athletic training and sports medicine.

The athletic trainer must protect the well-being of his/her patients. The action of the athletic trainer must not increase the risk over and above the risks inherent in the participation of the activity.

The evaluation should determine if an athlete is faking or hiding an injury. The evaluation should determine the source or mechanism of an injury; the evaluation should determine the extent of an injury. The evaluation should determine when an athlete should be referred to a physician. The evaluation should determine the appropriate course of treatment for an injury. The evaluation should determine if an injury is adequately responding to treatment. The evaluation should determine when an athlete should be restricted from athletic participation. The evaluation should determine when a patient should return to athletic participation.

Standard No. 4: The athletic trainer should assure timely and immediate referral to a physician for medical care when needed to assure a positive patient outcome (Stineman 1981), (Jarreau 1992), (Livingston 2006).
Standard Clarification: Timely and immediate referral is based on the commonly acceptable procedures for a given injury or illness to assure effective care.

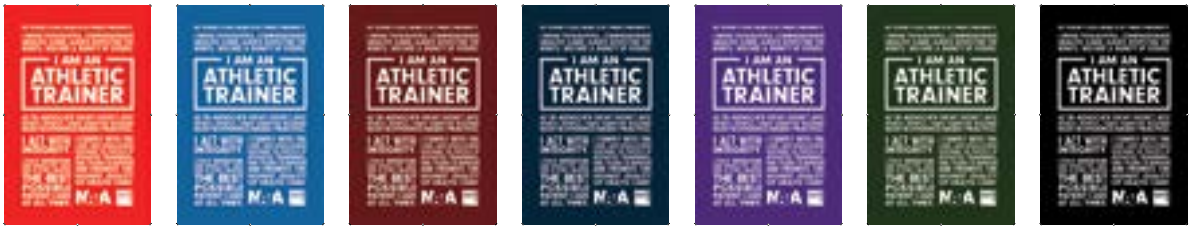
Standard No. 5: The athletic trainer should restrict patient participation when the participation has a reasonable chance of producing an adverse affect on the patient's injury (Jarreau 1992).
Standard Clarification: The athletic trainer must protect the well-being of his/her patients. The action of the athletic trainer must not increase the risk over and above the risks inherent in the participation of the activity.

Standard No. 6: The athletic trainer must inform and educate the patient on the seriousness of his injury, and the harm that may be caused by the continued participation in athletic activities (Jarreau 1992; 1997).

Standard No. 7: The athletic trainer should inform a coach or others responsible for supervising athletic activity of an injury or illness that could cause additional harm to a participant because of ongoing participation (Jarreau 1992), (Searles 1997).

Standard No. 8: The athletic trainer should comply with written and/or verbal instructions of supervising, consulting or treating physicians for all patients under his or her care (Pinson 1995b).
Standard Clarification: Written or verbal instructions from a physician supersedes standing orders and the discretionary reasoning of the athletic trainer.

Standard No. 9: The athletic trainer should not store or distribute prescription medication (Wallace 1998a).
Standard Clarification: A supervising physician cannot authorize an athletic trainer to dispense medication on his or her behalf.



GETTING THE ATHLETIC TRAINING

MANIFESTO

NATA members have exclusive access to the new Athletic Training Manifesto, a public declaration of the high standards described in the NATA Code of Ethics. Display the poster in your facility or download the wallpaper for your phone and computer.

www.nata.org/athletic-training-manifesto

Note: You must be logged in as an NATA member to view the manifesto resources.