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Objectives

• Discuss the why, how and what regarding this issue and the consensus statement
• Explain the components of the statement
• What did it accomplish?
• What are the controversies?
• Where do we go from here?
Why? (stated)

• As the concerns grow over musculoskeletal injuries, as well as life threatening conditions and traumatic brain injuries such as concussions, more secondary schools and colleges are being forced to evaluate the medical services that they are providing their athletes.
Why? (unstated)

• Many schools have no appointed team physician(s)- this may soon be mandated by NCAA
• Licensure for ATC requires supervision by MD/DO
• Reported episodes of ATC working “around” physicians affiliated with teams
• Concern regarding “inherent” conflict of interest when ATC and/or team doc employed by athletic department
How?

• First stirrings in Atlanta- AMSSM 2012
• Issue taken to NATA board a few months later
• Drezner appointee to NATA “task force” as AMSSM designate Summer 2012
• Endorsement process completed and final statement for NATA website in Summer 2013
• Picked up by J Ath Training soon after, and with edits was published Jan 2014
What?

• (1) who defines the job description of the athletic trainer and team physician, and what components are included;
• (2) supervisory relationships and the chain of command within the sports medicine team members;
• (3) decision-making authority relating to approval for participation of student-athletes, as well as injury management and return to sport participation status following injury/illness;
• (4) administrative authority for the selection, renewal, and dismissal of related medical personnel; and
• (5) performance appraisal tools for the sports medicine team.
Patient(athlete)-centered Medicine

• NATA BOC, Code of Ethics and state medical regulations combined for 10 guiding principles when assessing current policies
• Strong ethical approach to overcome any suggestion of conflict of interest
• Efforts to minimize any heavy handed influence from coaching (or anyone else who is non-medical) regarding RTP decisions
Job Description of the Athletic Trainer and Team Physician

- Using TPC statements and other sources, paper suggests job descriptions
- Strong language requiring ATC to follow direction of team physician or medical director
- Primarily created by medical personnel (and not from other sources)
- Careful delineation of “roles’ taken by ATC to insure that non-medical does not overshadow foremost responsibility for medical care


**Supervision of Athletic Trainer**

- The athletic trainer should be directed and supervised in regard to administrative tasks, by the athletic director;
- in regard to medical competence, by the team physician;
- and in regard to academic competence, by the academic department chair or dean.
- A coach should *never* be the direct supervisor of an athletic trainer due to conflict of interest issues.
Authority

“Owing an obligation to athlete welfare, the institution must establish a clear line of unchallengeable authority to the team physician and athletic trainer.”

“Line of authority affords sports medicine providers freedom from personal and professional bias in their ethical and medicolegal obligation to the athlete’s health.”

- Furrow BR. The problem of the sports doctor: Serving two (or is it three or four?) masters. *Saint Louis University Law Journal*. 2006;50.1:165-183.

Authority

“The institution must affirm, in policy and protocol, that sports medicine providers are empowered to make best-interest decisions regarding the athlete at all times and in all settings, and those decisions are authoritative and not to be ignored.”
Specifically, at the HS level...

It is **ESSENTIAL** that:

- Athletic trainers work under the direction of an actively-involved team physician based on their state practice act and professional standards.
- Athletic trainers have policies and procedures which are written in conjunction with the team physician and supported by the school administration.
- Athletic trainers communicate return to play concerns with the team physician, with whom the final return to play authority rests.
- All athletes undergo a comprehensive pre-participation physical examination, and that no athlete is allowed to practice or compete until providing documentation of the examination.
- All schools with athletic programs have Emergency Action Plans that are written, posted, and practiced by all who have responsibility for the acute management of athlete’s injuries/illnesses.
- All schools have an appointed or designated team physician.
- All schools with athletic programs provide an appropriate number of sports medicine providers, specifically and most appropriately athletic trainers, based on the number of athletic teams and athletes.
Selection, Renewal and Dismissal of Athletic Trainer

• Resources provided for evaluation of sports medicine team
• Regular evaluations and feedback on performance from those in position to judge appropriately
• Recommendation to appoint team physician (or his designate) to senior administrator role within athletics
• The coach’s voice should not be the only one heard in the review process but could serve as a start of communication and dialogue
10 Guiding Principles

1. The physical and psychosocial welfare of the individual athlete must always be the highest priority of the athletic trainer and the team physician.

2. Any program that delivers athletic training services, including "outreach" services provided to secondary schools or other athletic organizations, must always have a designated medical director.

3. Sports medicine physicians and athletic trainers must always practice in a manner that integrates the best current research evidence within the preferences and values of each athlete.
10 Guiding Principles

4. The clinical responsibilities of an athletic trainer must always be performed in a manner that is consistent with the written or verbal instructions of a physician or standing orders and clinical management protocols that have been approved by a program's designated medical director.

5. Decisions that affect the current or future health status of an athlete who has an injury or illness must only be made by a properly credentialed health professional (e.g., a physician or an athletic trainer who has a physician's authorization to make the decision).

6. In every case that a physician has granted an athletic trainer the discretion to make decisions relating to an individual athlete's injury management or sports participation status, all aspects of the care process and changes in the athlete's disposition must be thoroughly documented.
10 Guiding Principles

7. To minimize the potential for occurrence of a catastrophic event or development of a disabling condition, coaches must not be allowed to impose demands that are inconsistent with guidelines and recommendations established by sports medicine-athletic training professional organizations.

8. An inherent conflict of interest exists when an athletic trainer's role delineation and employment status are primarily determined by coaches or athletic program administrators, which should be avoided through a formal administrative role for a physician who provides medical direction.

9. An athletic trainer's professional qualifications and performance evaluations must not be primarily judged by administrative personnel who lack healthcare expertise, particularly in the context of hiring, promotion, and termination decisions.

10. Universities, colleges, and secondary schools should adopt an administrative structure for delivery of integrated sports medicine and athletic training services to minimize the potential for any conflict of interests that could adversely affect the health and well-being of athletes.
What Did It Accomplish?

• Created a document as a starting point
• Stimulated conversations
• Multiple conferences and meetings
• Policy changes
Meetings

• Chattanooga, TN- Journal of Athletic Training
• Atlanta, GA- NCAA
• Athens, GA- NATA
Journal Articles and Editorials

• Journal of Athletic Training 2014;49(4):5-6
• Journal of Athletic Training 2014;49(1):5–6
Policy Changes

- NCAA- July 2014 “Independent Medical Care Guidelines”
- Educators United- liability coverage requiring completion of “risk checklist” to include prohibition of coaches as primary supervisor of ATC or team physician
What Are The Controversies?

• Resistance to change from athletic departments/coaches who will lose some degree of control
• Fear of non-quality, “out of touch” physicians making RTP decisions (as was prevalent in previous times)
• Not all institutions can support “best” model
• General fear of change even from medical professionals
• Accountability and transparency is hard work
• Allowing insurance companies to dictate policy
Where Do We Go From Here?

• Take a more aggressive approach to determining the “model” that best serves the athlete and minimizes conflict of interest

• Specify in the insurance checklists that no athletic department personnel (not just coaches) should have supervisory roll in athletic medicine affairs

• Review policy and implement needed changes to reflect “10 Guiding Principles”