The demands of university athletic health care are becoming an increasing challenge for athletic trainers, team physicians, and university officials. With the increase in allowable conditioning and practice sessions, as well as the ever-increasing expectations of health care reaching well beyond the traditional orthopedic or sports-related injury care of student-athletes into more general health care, the athletic arena presents many risk exposures. Risk management, although often overlooked, is the method of identifying risk and decreasing the exposure with a systematic plan of action. Risk management can be classified into three areas of concern as it relates to student-athlete health care: financial, legal, and catastrophic. Often, risk reduction in one of these areas will reduce risk in others. In an effort to minimize risk exposures, an athletic program must address how to determine “standard of care” and “appropriate medical coverage.” The purpose of this article is to highlight the decisions and input needed to formulate an approach to risk management in the athletic setting, which includes clinical-practice guidelines, governing bodies, association position statements, case law, state and federal law, and institutional philosophy and policies.

**Determining Standard of Care**

Managing risk within the confines of a university sports-medicine program involves more than judgments pertaining to athletic trainers—it provides an opportunity to address the components of law most relevant to athletic health care. In many cases the possibility exists for those directly or indirectly involved being named in a trial, if the individual has knowledge of the events and participated or supervised in the establishment of such procedures leading to the event in question. Negligence as expressed by Leverenz and Helms was the cause of litigation in 11 of 13 cases involving athletic trainers.\(^1\) Negligence is “the failure to exercise such care as would be expected by the majority of people under like circumstances.”\(^2\) Searles v. St. Joseph’s specifically relates the “duty to conform to the standard of care required of an ordinary careful (athletic) trainer.” Thus the “careful athletic trainer” under reasonable circumstances would adopt a strategy of accepted practice guidelines and applicable policies and procedures when dealing with a similar risk exposure.

In order to establish negligence one must prove the existence of duty. If no duty exists there can be no negligence. Once an organization hires and obtains the services of an athletic trainer, team physician, or other health-care professional, the organization has established a duty. The duty of the health-care
professional is outlined in the employee contract or job description and indicates that the individual has the obligation to provide care to student-athletes. Institutional duty must be outlined in the department’s policies and procedures, thus identifying the appropriate level of medical services available to student-athletes. Evaluation across institutions establishes the standard of care for which a “careful” university, under reasonable circumstances, would act. In college athletics the duty of the university is established because of “special relationships” with student-athletes. In the case of Pinson v. Tennessee, 1995, the court determined that recruited athletes have established a special relationship in relation to their student-body counterparts as to the university providing appropriate care in the treatment of its athletes. The courts also determined in the case of Kleinknecht v. Gettysburg College, 1993, that the college had a duty to provide prompt emergency medical services because the student-athlete had been actively recruited by the lacrosse program.

The “concept of foreseeability” has implications for whether or not a duty exists. The case of Kleinknecht v. Gettysburg outlined this principle in that “the College owed to the student-athlete . . . the ability to provide prompt treatment in the event he or any other member of the lacrosse team suffered a life-threatening event.” A previous ruling had established that there was a lack of foreseeability in the likelihood of a “cardiac event,” but the possibility of a life-threatening event did exist. The college had reinforced this concept by providing medical services in the in-season training but failed to provide the same services for out-of-season training; therefore the foreseeability of harm was proven and the university was obligated to a duty.

Professional Organizations and Associations

The National Athletic Trainers’ Association (NATA) is the organization most directly involved in determining the standard of care for college student-athletes. To take a holistic approach to risk management, however, one must consider all individuals with risk exposure. Athletic administrators, team physicians, university officials, and others are accountable for the complete and thorough evaluation of liability. Therefore, professional organizations (Table 1) should be considered resources for the development and implementation of an athletic health-care risk-management plan.

The American Academy of Orthopaedic Surgeons, in its Orthopaedic Medical Legal Advisor, suggests that team physicians understand their “duty to the players, do not use medications or numbing agents indiscriminately, fully inform the players of inherent risk and capably reconcile competing interests to achieve a proper balance.” The responsibility for determining standards of care ultimately lies with the team physician, not only in determining the medical care of student-athletes but also in the supervision of staff and policies. The American Orthopaedic Society for Sports Medicine has established Principles for Selecting Team Medical Coverage, with emphasis on the hiring and acquisition of a team physician. This document outlines guidelines to assist in such areas as appropriate credentials and training, hiring and evaluation of staff, disclosures of payment and sponsorships, and bidding and contracting for services, as well as communication procedures. In addition, the team-physician consensus statement that was developed with input.

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<tr>
<th>Organization</th>
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<td>American College of Sports Medicine</td>
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<td>Collegiate Sports Medicine Foundation</td>
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<td>National Athletic Trainers’ Association</td>
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Table 1. Associations/Organizations for Reference
from various medical societies such as the American College of Sports Medicine (ACSM) and endorsed by many other associations, including the NATA, provides another resource for detailed information on qualifications, administrative duties, medical management, education, and roles and responsibilities of team physicians.7

The NATA Task Force for Appropriate Medical Coverage of Intercollegiate Athletics has established guidelines for medical coverage for athletic events.8 With more teams, more out-of-season practices, and ever-increasing numbers of strength and conditioning sessions, this task force set out to provide institutions with specific guidelines so that athletic trainers can more effectively communicate with administrators in regard to the financial, legal, and health-care needs of student-athletes.8 Athletic trainers and other health-care professionals have special knowledge and abilities, and therefore a duty exists to provide a standard of care consistent with such qualifications. The NATA BOC role-delineation study9 points to athletic training education and the skill sets that a prudent and careful athletic trainer should possess. Of course, athletic trainers obtain additional training outside of their athletic training education programs, and these additional skills and the educational process by which they were obtained should be documented. As a university sports-medicine program determines its risk-management strategy it must consider the individual skill sets of the clinicians, such as a dual-credentialed emergency medical technician. In the event of staff turnover the sports-medicine program might or might not have the same credentials or skills as before and therefore must adjust its policies accordingly.

Many organizations including the NATA have published position statements and guidelines as a means of helping their membership develop institutional policies to best meet the needs of their student-athletes. There has been much debate as to the practicality and legal ramifications of such position statements and how they relate to clinical practice. There is a trend for increasing reference to practice guidelines in the court of law. In 1996, Herbert suggested that attorneys made only moderate use of practice guidelines but suggested the trend was likely to increase.10 In addition, the use of practice guidelines was used to attack physicians more than defend them; however, physicians (clinicians) following published practice guidelines reduce the probability of having claims filed against them.10

Most organizations’ practice guidelines pertain to preparticipation examinations, return-to-play decisions, hazardous-materials-exposure plans, and emergency action plans. Of importance, guidelines are used to treat and care for general populations, not specific individual patients. Therefore health-care professionals’ medical judgment needs to focus on each individual case and not on a regimented standard operational protocol. It is important to document deviations from policy and under what decision-making process the clinician was compelled to act in such a manner. In the absence of a well-researched, -implemented, -documented, and -rehearsed standard operating protocol, the professional organization’s practice guidelines would serve as the standard of care, thus further emphasizing the need for compliance to university sports-medicine policies and procedures.

**Sports-Governing Bodies**

Outside of professional societies, many sports organizations have established minimal standards of care to protect the athletes who compete under their jurisdiction. Organizations such as the United States Olympic Committee, National Association of Intercollegiate Athletics, National Football League, and others are concerned with the health and welfare of their athletes. The National Collegiate Athletic Association (NCAA) was created in 1905 by President Theodore Roosevelt, with a mission to promote the health and welfare of student-athletes, specifically the catastrophic injuries associated with the “flying wedge” in football. Since then the NCAA has expanded on that mission but still maintains a high priority on protecting student-athletes. The NCAA Committee on Competitive Safeguards and Medical Aspects of Sports publishes a sports-medicine handbook11 to provide guidelines to member institutions that are not to supersede medical judgments of health-care professionals. Guidelines are developed to address population-related issues and might not reflect the health-care needs of the group, as well as of individual student-athletes. Governing bodies also establish legislation to provide practical solutions to risk-management concerns. Although many rules are implemented to set minimum standards, many of the regulations address athletes’ health care. Examples such as adjustments in summer conditioning programs, supervision of training sessions, and preparticipation requirements involve safety and risk-management con-
considerations. In the event of prolonged conditioning or training sessions, inadequate supervision or failure to complete the preparticipation examination not only would place the athletic program in noncompliance with NCAA regulations but also could present risk for litigation.

State and Federal Law

In determining the standard of care for institutions, an organization’s administration must consider the state practice acts and boards that have jurisdiction. Regardless of education, national certifications, and professional organizations, clinicians (athletic trainers, team physicians, etc.) are limited by what procedures the state allows a credentialed health-care provider to perform. University athletic-department administrators need to know and understand the duties that can be carried out by particular clinicians working with sports programs. In most states the supervising physician establishes the standard of care he or she feels is appropriate for the circumstances. Subsequently, do university risk managers and legal counsel think that these services should be performed in an athletic environment, or should they be performed in a more controlled setting such as a hospital or physician office? Many times this issue is not considered until an adverse event occurs, at which time officials question the necessity of services being delivered in the athletic environment. The complexity of services being delivered on campus varies greatly among institutions. University staff and officials (see the sidebar) need to evaluate risk and determine the standard of health-care services to be provided for student-athletes.

Summary

The ability of the university sports-medicine staff and athletic-department administration to properly evaluate conformity to established standards of care for student-athletes will better protect them from risk and liability. Risk management is advanced by contributions from a multitude of sources including sports-governing bodies, case law, professional organizations, and state and federal laws.

References


Institutional Risk-Management-Review

Team Considerations

University general counsel
Health-care attorney
University risk management
Team physician
Head athletic trainer
Athletic director
Health-services director
Athletic administrator (responsible for sports medicine)
Strength and conditioning coach
Coaches
Student-athletes
Consultants

4. Kleinknecht v Gettysburg College. 786 F Supp 449 (MD Pa 1992), rec’d and remanded, 989 F 2d 1360 (3rd Cir 1993)
9. National Athletic Trainers’ Association Board of Certification, Inc. Role Delineation Study for the Entry-Level Certified Athletic Trainer. 5th ed. Omaha, Neb: Board of Certification, Inc; 2004

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