

Interassociation Consensus: Independent Medical Care for College Student-Athletes Best Practices

Purpose:

The *Safety in College Football Summit* resulted in interassociation consensus recommendations for three paramount safety issues in collegiate athletics:

1. Independent medical care for collegiate setting;
2. Concussion diagnosis and management; and
3. Football practice contact.

This document addresses independent medical care for college student-athletes for *all* sports.

Background

Diagnosis, management and return-to-play determinations for the college student-athlete are the responsibility of the institution's athletic trainer (working under the supervision of a physician) and the team physician.³ Even though some have cited a potential tension between health and safety in athletics,¹⁻² collegiate athletics endeavor to conduct programs in a manner designed to address the physical well-being of college student-athletes (i.e., to balance health and performance).³⁻⁴ In the interest of the health and welfare of collegiate student-athletes, a student-athlete's healthcare providers must have clear authority for student-athlete care. The foundational approach for independent medical care is to assume an "athlete-centered care" approach, which is similar to the more general "patient-centered care," which refers to the delivery of health care services that are focused only on the individual patient's needs and concerns.⁵ The following 10 guiding principles, listed in the Inter-Association Consensus Statement on Best Practices for Sports Medicine Management for Secondary Schools and Colleges,⁵ are paraphrased below to provide an example of policies that can be adopted that help to assure independent, objective medical care for college student-athletes:

1. The physical and psychosocial welfare of the individual student-athlete should always be the highest priority of the athletic trainer and the team physician.
2. Any program that delivers athletic training services to student-athletes should always have a designated medical director.
3. Sports medicine physicians and athletic trainers should always practice in a manner that integrates the best current research evidence within the preferences and values of each student-athlete.
4. The clinical responsibilities of an athletic trainer should 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 a student-athlete who has an injury or illness should 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 student-athlete's injury management or sports participation status, all aspects of the care process and changes in the student-athlete's disposition should be thoroughly documented.
7. Coaches must not be allowed to impose demands that are inconsistent with guidelines and recommendations established by sports medicine and athletic training professional organizations.
8. An athletic trainer's role delineation and employment status should be determined 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 health care expertise, particularly in the context of hiring, promotion and termination decisions.
10. Member institutions should adopt an administrative structure for delivery of integrated sports medicine and athletic training services to minimize the potential for any conflicts of interest that could adversely affect the health and well-being of student-athletes.

Team physician authority becomes the linchpin for independent medical care of student-athletes. Six preeminent sports physicians associations agree with respect to "... athletics trainers and other members of the athletic care network report to the team physician on medical issues."⁶ Consensus aside, a medical-legal authority is a matter of law in 48 states that require athletic trainers to report to a physician in their medical practice. The NCAA Sports Medicine Handbook's Guideline 1B opens with a charge to athletics and institutional leadership to "create an administrative system where athletics healthcare professionals—team physicians and athletic trainers—are able to make medical decisions with only the best interests of student-athletes at the forefront."⁷ Multiple models exist for collegiate sports medicine. Athletics health care professionals commonly work for the athletics department, student health services, private medical practice, or a combination thereof. Irrespective of model, the answer for the college student-athlete is established medical independence for appointed primary athletics healthcare providers.⁸

Guidelines:

Institutional line of medical authority should be established independently of a coach, and in the sole interest of student-athlete health and welfare. Medical line of authority should be transparent and evident in athletics departments, and organizational structures should establish collaborate interactions with the medical director and primary athletics health care providers (defined as all institutional team physicians and athletic trainers) so that safety, excellence and wellness of student-athletes are evident in all aspects of athletics and are student-athlete centered.

Institutions should, at a minimum, designate a licensed physician (M.D. or D.O.) to serve as medical director, and that medical director should oversee the medical tasks of all primary athletics health care providers. Institutions should consider a board certified physician, if available. The medical director may also serve as team physician. All athletic trainers should be directed and supervised for medical tasks by a team physician and/or the medical director. The medical director and primary athletics health care providers should be empowered with unchallengeable autonomous authority to determine medical management and return-to-play decisions of student-athletes.

References

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***This Consensus Best Practice, Independent Medical Care for College Athletes, has been endorsed by:**

- American Academy of Neurology
- American College of Sports Medicine
- American Association of Neurological Surgeons
- American Medical Society for Sports Medicine
- American Orthopaedic Society for Sports Medicine
- American Osteopathic Academy of Sports Medicine
- Collegiate Athletic Trainers' Society
- Congress of Neurological Surgeons
- NCAA Concussion Task Force
- Sports Neuropsychology Society