Journal of Athletic Training 2019;54(12):1237–1240
doi: 10.4085/1062-6050-83-19

www.natajournals.org

Sports Medicine Delivery Models: Legal Risks

Geoffrey Christopher Rapp, JD*;
Christopher D. Ingersoll, PhD, AT, ATC, FNATA†

*College of Law and †College of Health and Human Services, The University of Toledo, OH. Dr Ingersoll is now at the University of Central Florida, Orlando.

Educational institutions sponsoring competitive athletics may use an athletics model, academic model, or medical model for delivery of sports medicine to student-athletes. Four types of legal risk are considered for these 3 models: litigation, contract, regulatory, and structural. The athletics model presents the greatest legal risk to institutions, whereas the medical model presents the least legal risk. Institutional administrators should consider these risks when selecting or maintaining a delivery model for sports medicine.

Key Words: university liability, athletic trainer reporting structures, litigation, contract

Three general models for the delivery of sports medicine services in intercollegiate athletics have been described: the athletics model, the academic model, and the medical model.[1–4] These models are primarily distinguished by the reporting structure for sports medicine personnel. In the athletics model, the head athletic trainer (AT) reports to the athletics director. In the academic model, the head AT is part of the academic program and reports to a chairperson or dean. In the medical model, the head AT reports to another medical professional (eg, team physician), and the supervising clinician reports to another clinician or health care administrator and not to the athletic director (or anyone else in the athletic department). In each model, staff ATs report to the head AT. In addition to these 3 broad-brush models, schools can develop hybrid models using portions of several models or using 1 model for financial oversight (ie, who pays the bills) and another for operational and administrative oversight (ie, who directs activities). Still, the straightforward 3-alternatives schema is useful for thinking about the intersection of civil liability concerns and AT models.

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

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

ATHLETIC TRAINERS' ROLES AND RESPONSIBILITIES

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

TYPES OF LEGAL RISKS

Different typologies of legal risk have been developed. Under 1 version, legal risk can be divided into 4 categories. *Litigation risk* captures the chances that an organization will be sued and the expected losses associated with a suit. The full measure of litigation risk includes the costs of defending such suits (eg, legal fees), even if a university is ultimately successful. *Contract risk* involves a risk that an organization's contractual counterparties will breach agreements with the organization. Contract risk can be viewed as including any increased costs associated with negotiating contracts and monitoring counterparty performance. *Regulatory risk* measures the chances that the organization will face additional regulations that impose costs for compliance

or otherwise interfere with the organization's achievement of strategic objectives. *Structural risk* refers to legal threats to the basic model of the organization.[12]

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

LITIGATION RISK UNDER THE 3 MODELS

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

A university itself can be negligent in terms of how it hires, trains, and supervises its employees. In a negligent hiring, training, or supervision case, the university's basic obligation is to act in a way that is consistent with reasonable care. When a custom exists for a particular matter, compliance with custom is evidence that the university has not breached a standard of care, but a defense based on compliance with custom can be rebutted by showing that the university's choices created risks that a reasonable person would have avoided. With respect to the 3 models of sports medicine, no clear custom likely exists. As such, a case asserting that a university's choice of organizational structure was negligent would point to the risks created by a particular choice of structure and its benefits. It is possible that the choice of model creates risks that cannot be justified by the model's benefits. For instance, in an extreme example of the athletics model gone awry, after phone interviews, a university's athletics director hired 2 ATs who lacked certifications or licenses. The people providing references for these 2 ATs viewed them as unprepared for the demands of working as football ATs.[14] Two injured players successfully convinced a court this could constitute negligent hiring on the university's part. Although a "bad hire" is also possible under the medical model, one would hope that those responsible for hiring would at least have a better understanding of the basic qualifications for the AT position. Moreover, credentialing of all health care providers is a common practice in traditional medical settings; this would seem to make it less likely that a university using the medical model would hire an unqualified person.

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

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

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

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

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

CONTRACT RISK

The effect of the sports medicine delivery model on contract risk is arguably less of a concern but potentially

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

REGULATORY RISK

Regulatory risk arises if 1 model increases the chances that new or additional regulations may be imposed on colleges. It is possible, for instance, that a model that produces a higher rate of injuries for players would attract the attention of nongovernmental regulatory actors such as the NCAA or even legislative bodies.

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

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

Regulatory risk might also include violations of applicable regulations, such as federal regulations affecting health care delivery and the privacy of student records. One area of concern might be medical privacy rules, such as those in the Health Insurance Portability and Accountability Act (HIPAA). Because medical providers are typically accustomed to navigating the rules relating to HIPAA and privacy concerns, it seems logical that the medical model would carry the lowest risk of violating student-athlete privacy rights. The Family Educational Rights and Privacy Act (FERPA) regulations on student records are another concern. Although athletics departments are likely growing increasingly savvy about FERPA concerns, the traditional culture of big-time collegiate sports, with its emphasis on transparency and strong relationships with the media, may not be ideally suited for protecting student privacy rights.

STRUCTURAL RISK

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

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

Table. Summary of Legal Risk Levels in Sports Medicine Models

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

CONCLUSIONS

The athletics model presents the highest litigation and regulatory risks to the sponsoring institution. Contract risk is moderate in the athletics model but still higher than in the academic or medical model. The academic model presents moderate litigation and regulatory risks. The medical model offers the lowest litigation, contract, and regulatory risks of all models. Structural risk is low in all 3 models.

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

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

REFERENCES

1. Eason CM, Mazerolle SM, Goodman A. Organizational infrastructure in the collegiate athletic training setting, part III: benefits of and barriers in the medical and academic models. *J Athl Train*. 2017;52(1):35–44.
2. Goodman A, Mazerolle SM, Eason CM. Organizational infrastructure in the collegiate athletic training setting, part II: benefits of and barriers in the athletics model. *J Athl Train*. 2017;52(1):23–34.
3. Mazerolle SM, Eason CM, Goodman A. Organizational infrastructure in the collegiate athletic training setting, part I: quality-of-life comparisons and commonalities among the models. *J Athl Train*. 2017;52(1):12–22.
4. Laursen RM. A patient-centered model for delivery of athletic training services. *Athl Ther Today*. 2010;15(3):1–3.
5. Shepherd A. In the right place. Training Conditioning Web site. http://training-conditioning.com/2009/08/31/in_the_right_place/index.php. Published January 29, 2015. Accessed September 20, 2019.
6. Wolverton B. Coach makes the call. The Chronical of Higher Education Web site. https://www.chronicle.com/article/Trainers-Butt-Heads-With/141333. Published September 2, 2013. Accessed September 20, 2019.
7. Bradley B. Almost half of college trainers feel compromised by coaches. NFL Web site. http://www.nfl.comhttp://www.nflevolution.com/article/almosthalfofcollegetrainersfeelcompromisedbycoaches?ref=0ap1000000237767. Published 2013. Accessed August 22, 2019.
8. Brice J. Are coaches endangering players by taking more control of staff? National Football Post Web site. http://gridironnow.com/are-

coaches-endangering-student-athletes-by-taking-more-control-of-training-staffs/2/. Published 2018. Accessed August 22, 2019.
9. Sport Science Institute. Athletic health care administration best practices. National Collegiate Athletic Association Web site. http://www.ncaa.org/sport-science-institute/athletics-health-care-administration-best-practices-0. Accessed August 22, 2019.
10. Henderson J. *The 2015 Athletic Trainer Practice Analysis Study*. 7th ed. Omaha, NE: Board of Certification; 2015.
11. National Athletic Trainers' Association. *Athletic Training Education Competencies*. 5th ed. Dallas, TX: National Athletic Trainers' Association; 2011.
12. Little M. How to measure and manage legal risk. Berkman Solutions Web site. https://www.berkmansolutions.com/risk/how-to-measure-and-manage-legal-risk. Accessed August 22, 2019.
13. Stevens J. It's a risky business. The importance of legal risk mapping. *NY State Bar J*. 2012;84(8):48–52.
14. *Feliciana v Lacawanna College*, 156 A3d 1200 (S Ct Pa. 2017).
15. *Searles v Trustees of St Joseph's College*, 695 A2d 1206 (S Ct Me. 1997).
16. *Williams v Athletico, Ltd,* 74 NE3d 1047 (Ill App 2017).
17. *Evans v Arizona Cardinals Football Club, LLC,* 231 F Supp 3d342 (D N Cal, 2017).
18. Sanchez MW. Bills cornerback leaves and retired in middle of game. New York Post Web site. https://nypost.com/2018/09/16/bills-cornerback-quits-and-retires-in-middle-of-game/. Published September 16, 2018. Accessed September 20, 2019.
19. Wogenrich M. At Penn State, 5 player retirements part of strange year. The Morning Call Web site. https://www.mcall.com/sports/penn-state/mc-spt-penn-state-football-players-retire-20180819-story.html. Published August 20, 2018. Accessed September 20, 2019.
20. Zirin D. Will Maryland College athletes be unionized? A bill being put forward in the Maryland statehouse will give college athletes union protection. The Nation Web site. https://www.thenation.com/article/university-maryland-jordan-mcnair-union-ncaa/. Published February 20, 2019. Accessed September 20, 2019.

Address correspondence to Christopher D. Ingersoll, PhD, AT, ATC, FNATA, College of Health Professions and Sciences, University of Central Florida, 12805 Pegasus Drive, Suite 365, Orlando, FL 32816-2200. Address e-mail to christopher.ingersoll@ucf.edu.