Working With a Team Physician; 
Best Practices and “Not So Best Practices”

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Purpose of This Talk

• Some confusion and even urban myths about the physician/ATC relationship
• No true “standard of care” exists for defining the nature of the high school level team physician and ATC relationship in Arizona
• There are some regulations you need to be aware of and best practices to help protect athletes and yourself
• Most of this talk is an editorial comment from me and not meant to be a defined “standard of care”, but should be thought provoking
The Inconvenient Truth
(for ATC licensure in AZ)

• A.R.S 32-4101:

“Athletic Training includes the following performed under the direction of a licensed physician…..”
“direction of licensed physician”?

A.R.S 4103:
The board shall adopt rules to prescribe the direction of athletic trainers by a licensed physician, including recommendations, guidelines and instructions as to standard protocols to be followed in the general, day-to-day activities in which athletic trainers engage.

(Most interpret this to mean some kind of regularly reviewed formal prescription of recommendations)
What about other practitioners?

- Confusing because MD, DO, PA, or NP able to sign off PPE
- Some districts allow Doctor’s of Chiropractic Medicine (DCs) or Naturopathic Medical Doctors (NMDs) to sign off PPE
- But your licensure depends solely on prescribed direction from licensed MD or DO
- Your liability depends on this prescribed direction
Involvement of other practitioners

• A.R.S 32-4103:

• “If appropriate, athletic trainers may also seek direction as to the treatment of an athletic injury or athletic illness from any health care provider who is involved in that person’s treatment and who is not licensed pursuant to this chapter but who is licensed pursuant to this title”

• Therefore, you can choose to involve other practitioners, but the care delivered should not conflict with the “prescribed direction” of your MD or DO.
Bottom line:

• Your licensure and liability is based on whatever “prescribed direction” you have from an MD or DO”

• You should probably be confident in the relationship you have with this individual

• Others can deliver services, but these services should fall within the parameters of any protocols or action plans that have been prescribed
Editorial Comment: Practically speaking, what does this mean?

• Best practice – Having a relationship with a primary care sports medicine physician* that can give “prescribed direction” on protocols on a yearly basis. Best to review and co-sign these protocols annually and have discussion regarding necessary updates or revisions.

* Arizona is relatively underserved in this specialty. Especially in Phoenix metro area compared to other large metro areas
Editorial comment

• Not-so-best practice – Having a team orthopedist or chiropractor that you could not pick out of a line-up and who you only talk to when there is a musculoskeletal injury, but who is listed on your school website as the “team physician”.
WHAT DOES PRESCRIBED DIRECTION REALLY LOOK LIKE?

Based on a true story. Best and Not-So-Best Practices......
Best Practice:
Signed document incorporating following elements

1. Clearly outlined “chain of command” that defines the role and name of the team physician. May also list orthopedist or any other practitioners that are regularly involved in team care.

* Recommend discussing and co-signing with administration so that they are aware of the need for this structure and the way your licensure works
Not so best practices

• Having a team physician listed on your website that you have not ever met with in the last 5 years.

• Having a team chiropractor who runs training rooms at the school twice weekly and in their office on Saturdays who advertises that he/she is the team physician and who the coaches send every injury and problem to.
Best Practice:
Signed document incorporating following elements

2. Having a pre-participation exam policy that incorporates the team physician that is in compliance with AIA standards

* Most important to have a protocol for final sign-off and final RTP that can incorporate your team physician for final discretion or as a second opinion. Recommend clarifying this with administration
Not so best practice

- 99% of athletes getting their PPEs done at the local minute clinic or little clinic
- Mass PPEs being done 1 week before the start of football
- Being cleared for soccer 2 weeks after their epidural hematoma without input from treating neurosurgeon (shaved head and staples gave it away....)
- Trusting the urgent care clearance on an athlete that had a documented ventricular septal defect the year before and claimed to be cured after a faith healing intervention
- 600 athletes and 2 docs
- The list goes on.......
3. Having a concussion policy in place
   – There is still no concussion management program that has been shown to improve outcomes
   – I recommend offering, but not requiring baseline impact testing to high risk individuals at time of PPE
Not so best practice

• Sloppy universal baseline testing that nobody can interpret and is not really offered to everyone who needs it

• Not having a physician network that you can send athletes to for second opinions or complicated concussions

• Having the team chiropractor use the “tuning fork test” on the sideline to determine RTP in concussion
4. Identifying athletes that might have sickle cell trait (not just disease)
   - 20-40 fold increase in all cause exercise related death (military), mainly due to exertional heat stroke
   - Consider screening in atypical cramping patterns, esp. in high risk ethnic groups
   - Id’ing those that check “yes” on the PPE form for this
Not so best practice

• Having a PPE form that says “yes” to sickle cell trait and then not formally addressing it, or trusting that it was addressed by the NP working at the little clinic

• Treating an athlete for exertional muscle cramping when they are really having a sickling crisis
5. Identifying athletes with asthma and notating their emergency action plan or risk for status asthmaticus

– Having your team physician participate in the free epi-pens for school initiative

– Monitoring your asthmatic athletes to make sure they are under adequate control

– Knowing that it’s predictable who might die from an asthma attack
Best Practice

6. Having a position statement in place (that administration agrees with) that comments on screening for causes of sudden cardiac death

   – I am currently NOT aware of any program offered locally that passes the test for sound public health policy at the high school level. Including the PPE.

   – AMSSM position statement does NOT currently endorse screening EKG in high school unless there is proper infrastructure in place.

   – Paying close attention to the history portion of PPE and not dismissing possible real symptoms.
Not so best practices

- Understaffing for mass PPEs held in noisy gyms
- Overscreening and profiteering on the PPE
- Believing an athlete or family that their child probably passed out in practice because they were not drinking enough fluids and not doing further work-up
7. Knowing emergency response times to your athletic venues and considering AED on-site if call to response time is greater than 4 minutes
Not so best practice

• Having your AED locked in the nurses office on Friday night when you need it on the field
Best Practice

8. Outlining an attainable heat illness protocol

• Factors to consider:
  – Synthetic turf
  – Climate change w/ warmer temps in August?
  – Concrete “heat island” effects not allowing evening temps to drop as much. Increased humidity on field in AM?
Not so best practice

• District administrator calling me in a panic on a 117 degree day in August wanting to know what precautions the district should be taking

• Considering practice modifications if temperature is above 130 degrees
Best Practice

9. Having an up to date cervical spine injury policy in place. Should be in combination with policy as it relates to situations where possible head injury has also occurred
Not so best practice

• Not recognizing possible c-spine injury in conjunction with head injury
• Allowing EMS crews to dictate c-spine policy
• Allowing on-field neck adjustments from team chiropractor after possible neck injury (from the same guy that uses tuning forks to clear concussions)
Best Practice

10. Have a clear policy in place regarding infectious dermatology and identify network of physicians who adequately understand these conditions in athletes and are well-versed in treatment recommendations. COMMUNICATE THIS WITH SCHOOLS AND COACHES B4 THERE IS A PROBLEM.

• Understand this can be a common area of clinical weakness for many health practitioners and that you may be the most important public health link in preventing an outbreak of communicable disease.
Not so best practice

• Sending numerous wrestlers to urgent care to be treated for impetigo when they really have herpes gladiatorum on their face
• Trusting any wrestler or opposing team wrestling coach about a suspicious lesion
• Not having security available to escort your team physician out from skin checks
Best Practice

11. The LEAST important (from a liability perspective) – Statement regarding other routine orthopedic injuries and chain of command between team physician, orthopedic surgeons, or other practitioners (PTx, chiro, urgent care, ER, etc....)
Not so best practice

• Allowing the team chiro to have final judge, jury, and verdict on orthopedic clearance issues without any input from you. Especially when his daughter is dating the offensive lineman that is a recurrent shoulder dislocator. (yes, same guy that uses a tuning fork to clear concussions)
12. “Other”:

- Have regular open lines of communication
- Allowing a degree of flexibility/autonomy on the patient’s/family’s part
- Recognition of potential conflicts of interests (even in the forms of grants and “goodwill efforts”, etc.)
- Working with school and district administrators to form reasonable policies
Not so best practice

• “Other”
  – Forming unreasonable policies that no one can follow, just for the sake of having policy
  – Not having any “prescribed direction” and going naked
  – Having a false sense of security that you are doing things well just b/c you haven’t had a bad outcome yet
Summary

• Have a plan
• Take ownership of your licensure, professional responsibilities, and professional liabilities
• Be proactive in working with administrators to highlight the need for a stable ATC/Team Physician relationship
• Clarify rules and regulations that are already in place
• Feel free to copy this talk to take to administration to begin the discussion
References

• AMSSM Team Physician Consensus Statement: 2013 Update
• CORE Institute Team Physician/ATC Protocols 2016
• Codes.findlaw.com
• Law.justia.com