

Medicolegal Considerations of Concussion Policy



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Objectives

1. Discuss the need for concussion policy
2. Describe levels of policy
3. Identify areas where ATs can improve their own concussion policy
4. Apply best practices to ensure appropriate documentation and policy development



Key Components of State Legislation

Education	Informed Consent
Removal from Play	Clearance to Return

Source: Seattle Times Online.
http://seattletimes.nwsource.com/html/localnews/2009881070_lystedsettlement17m.html
Last accessed 12/8/10

Additional State Law Components

1. Education
2. Verification strategies
3. Target population
4. Removal / return protocols
5. Healthcare professional
6. Concussion training
7. Baseline testing
8. Liability waivers

Impact of State Laws

- State laws all require concussion education
- Increased healthcare utilization (Gibson, 2015; Baker, 2017)
 - May improve secondary prevention efforts
- Patients presented to concussion clinics significantly earlier (17.6 vs. 22.8 d) and had quicker recovery (26.5 vs. 40.6 d) post-law v. pre-law (Cuff, 2018)
- Inclusion of state law components into policies are often lacking (Kajankova, 2017; Hackman, 2018; Davies, 2018; Coxe, 2018; Coxe, 2020)
- **Implementation** of laws and policies face barriers (Coxe, 2020; Sullivan, 2020)

Catastrophic Results



Legal Suit

Why Litigation?

- Confusion in the diagnosis
- Grading scales?
- When to return-to-play?
- To play or not to play?

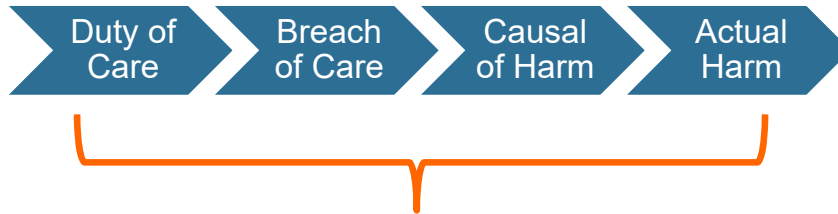
Risk for Litigation

- Assessment (or lack thereof) of the patient
- Documentation of assessment and RTP progression
- Communication with the patient (parent) or physician
- Failure to warn
 - Lack of educating patient (parent)

Negligence

- Malfeasance
 - Intentional conduct that is wrongful or unlawful
- Nonfeasance
 - Failure to act where there was a duty to act
- Misfeasance
 - Conduct that is lawful but inappropriate

Proving Negligence



Need to Prove All Four

Standard of Care

“Legal duty to provide healthcare services consistent with what other health care practitioners of the same training, education, and credentialing would provide under the circumstances.”

Ray, Management Strategies in Athletic Training, 2005

What is the Standard of Care?


Journal of Athletic Training 2014,49(2):909-930
doi:10.4085/1082-4062-49.111
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National Athletic Trainers' Association Position Statement: Management of Sport Concussion

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position statement



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FROM THE AMERICAN ACADEMY OF PEDIATRICS

Guidelines for the Clinician in Rendering Pediatric Care

Clinical Report—Sport-Related Concussion in Children and Adolescents


AMERICAN ACADEMY OF PEDIATRICS
DEDICATED TO THE HEALTH OF ALL CHILDREN[®]

CLINICAL REPORT

Returning to Learning Following a Concussion

AMERICAN ACADEMY OF PEDIATRICS
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Guidelines for the Clinician in Rendering Pediatric Care



Summary of evidence-based guideline update:
Evaluation and management of concussion in sports
Report of the Guideline Development Subcommittee of the American Academy of Neurology

Consensus statement on concussion in sport—the 5th international conference on concussion in sport held in Berlin, October 2016

Concussion Standard of Care

- Ambiguity
 - Diagnosis
 - Recovery
- Numerous guidelines and recommendations

Current Recommendations

International

- Vienna, 2001
- Prague, 2004
- Zurich, 2009
- Zurich, 2013
- Berlin, 2017
- ~~Paris, 2020~~
- Paris, 2021
- Amsterdam, 2023

New version
replaces old version

Professional Organizations

- NATA, 2004
- NAN, 2007
- AAP, 2010
- AMSSM, 2012
- AAP, 2013
- AAN, 2013
- NATA, 2014
- CDC, 2018
- AMSSM, 2019
- NATA bridge, Soon!

Statement Similarities

- Clinical diagnosis
- Lack of utility of imaging
- Multifactorial assessment
- No same day return
- Serial monitoring
- Graduated RTP progression

Broglio, 2014; McCrory, 2017;

Statement Differences

- Rest vs. Activity
 - Older statements recommend longer rest period
 - Rest until asymptomatic (NO!!)
- Treatment
 - More recent statements take active approach
- Specifics of graduated RTP protocol
- Neurocognitive Testing
 - 2014 NATA statement is the only one that recommends baseline testing of high-risk athletes

Broglia, 2014; McCrory, 2017;

International Statement Neurocognitive Recommendations



Vienna (2001)

- **Cornerstone** of concussion evaluation
- Contributes **significantly** to understanding the injury and management of the individual



Prague (2004)

- Cornerstone of evaluation in **complex** concussion
- **Aid** to clinical decision making
- Not done while athlete is symptomatic



Zurich (2008, 2012)

- **Not the sole basis** for decision making
- Neuropsychologist is best to interpret
- Most cases not done until athlete is asymptomatic



Berlin (2016)

- Aid to clinical decision-making
- Computerized tests not substitutes for full NP evaluation
- Baseline and post-injury testing not required

Statement Differences: Neurocognitive Baseline Testing

AMSSM	AAN	NATA (2014)	Berlin
<ul style="list-style-type: none"> • Baseline testing may be useful in some cases but is not necessary, required, or an accepted standard of care 	<ul style="list-style-type: none"> • Memory, RT, processing speed may be used to identify presence of concussion • Insufficient evidence for use in preadolescent 	<ul style="list-style-type: none"> • Athletes at <u>high risk</u> of concussion should undergo baseline testing • New baseline completed <u>annually</u> for adolescents • Baseline should be <u>multifactorial</u> and include neurocognitive testing 	<ul style="list-style-type: none"> • Aid to clinical decision-making • Brief computerized tests not substitutes for full NP evaluation • Baseline and post-injury testing not required for all athletes

Harmon, 2019; Giza 2013; Broglio, 2014; McCrory, 2017

Amsterdam, 2023

Neurocognitive test batteries, where accessible, may add value to assessing SRC and its sequelae. Computer-based test batteries, especially in comparison of reaction times against patient baseline and community norms, may be useful. The results of these tests should be interpreted in the context of broader clinical findings and are not to be used in isolation to inform management or diagnostic decisions.²⁵

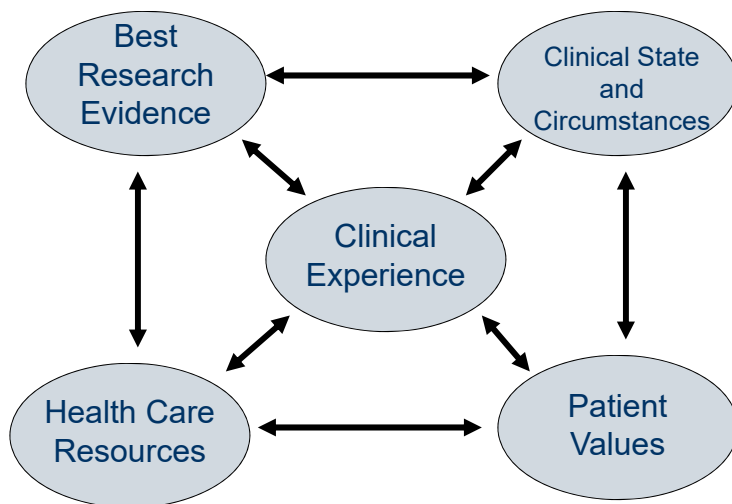
The recent position statement of the Concussion in Para Sport Group summarised expert opinion regarding concussion prevention, assessment and management in para sport participants.⁹⁶ Most significantly, (1) individuals may benefit from baseline testing given the variable nature of their disability and the potential for atypical presenting signs/symptoms of concussion, (2) individuals with a history of central nervous system injury (eg, cerebral palsy, stroke) may require an extended period of initial rest, (3) testing for symptoms of concussion through recovery may require modification such as the use of arm ergometry as opposed to a treadmill/stationary bike and (4) RTS protocols must be tailored and include the use of the individual's personal adaptive equipment and, for applicable participants with visual impairment, partnership with their guide.

Paediatric athletes are less likely to have trained medical personnel available on the sideline, and it is strongly recommended that the CRT6 be used by all adults supervising child and adolescent sport. The Child SCAT6 (8–12 years) and SCAT6 (adolescents) should be used by HCPs; however, baseline testing is of limited use in younger athletes because of neurocognitive development. Evaluation with the Child SCAT6/SCOAT6 provides a framework for multiple domain assessments and informs the clinician on implementing appropriate exercise, RTL and RTS, and rehabilitation. Such a multifaceted clinical evaluation is recommended to guide both management and the possible need for referral to practitioners from multiple disciplines experienced in paediatric SRC.

Statement Use in Clinical Practice

- Focus of the statement
 - Which providers?
 - Patient population (eg. AAP)
- Feasibility to implement in your setting
 - Medical direction
 - Equipment, supplies
 - Personnel

Statement Use in Clinical Practice



Haynes et al. 2002

NATA 2014 Legal Aspect Recommendations

- AT should be aware of all governing bodies and their policies and procedures
- AT should document athlete's (and where appropriate, parent's) understanding of concussive S&S and his/her responsibility to report concussion
 - Informed consent (80% of state laws)

NATA 2014 Legal Aspect Recommendations

- AT should communicate status of concussed patient to managing physician on regular basis
- AT should ensure proper documentation of the evaluation, management, treatment, RTP progression, and physician communication