Patient-Centered Care
and Conflict-of-Interests
in Athletic Medicine

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Patient-Centered Care

- What is it?
- Where did it come from?
- Why does it matter to us?
Patient-Centered Care Definition

- Institute of Medicine*

Care that is respectful and responsive to individual patient preferences, needs, and values, and ensures that patient values guide all clinical decisions

* An independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public


Patient Protection and Affordable Care Act (ACA)

- Signed into law on March 23, 2010
  - Purposes:
    1. Increased **access** to healthcare
    2. Lowered **cost** of healthcare
    3. Improved **quality** of healthcare
  - Funding for:
    - **Patient-Centered Outcomes Research Institute**
      - Created to promote better-informed health decisions by patients, clinicians, purchasers, and policy makers
Traditional Biomedical Paradigm

- Decision-making tends to be more “disease-focused” & “clinician-centered” than “patient-centered”
  - Focus on the “disease” rather than the “patient” who has the disease
  - The patient’s right to decide what will or will not be done often deemphasized

Dimensions of Patient-Centeredness
Communication Content & Decision-Making Control
Evidence-Based Medicine (1996)

- The conscientious, explicit, and judicious use of current best evidence in making clinical decisions about the care of individual patients
  - Includes thoughtful consideration of patient preferences and values


Evidence-Based vs. Patient-Centered Care

- The individual patient’s needs and preferences are often neglected as relevant factors in decision-making
  - EBM can be more “disease-oriented” than “patient-centered”
    - Psychosocial elements are as important as biomedical factors
  - EBM emphasis on RCTs as highest quality source of evidence
    - Results applied to patients who would have been excluded from study

Differing Inferential Paradigms

**Frequentist Approach**
- Randomized Assignment
- IV: Group membership
- DV: Continuous measure
- Error: Random variation
- Focus: Statistical significance
  - Difference between groups
  - Mean values (central tendency)

**Bayesian Approach**
- Observation of Cohort
- IV: Exposure status
- DV: Binary outcome
- Error: Misclassification
- Focus: Precision of estimate
  - Exposure-Outcome association
  - Relative Risk and Odds Ratio

Patient-Centered Clinical Research

- Clinical epidemiology:
  
  The science of **making predictions** about individual patients by **counting clinical events** in groups of similar patients and using scientific methods to ensure that the predictions are accurate

  Fletcher RH, Fletcher SW. *Clinical Epidemiology – The Essentials*. 2005

- Clinical prediction guide:
  
  A combination of 3-5 prospectively documented patient characteristics that provides a **quantifiable likelihood** for an outcome
New Model for Evidence-Based Clinical Decision Making

**Institute of Medicine**
Health Professions Education: A Bridge to Quality (2003)

- Competencies:
  - Habitual and judicious use of communication, knowledge, technical skills, clinical reasoning, emotions, values, and reflection in daily practice
  1. **Provision of patient-centered care**
  2. Ability to work in interdisciplinary teams
  3. Employ evidence-based practice
  4. Application of quality improvement
  5. Utilization of information technology

What is “Patient-Centered” Care in AT?

- Doing what is best for the patient despite outside pressures


AMA Code of Ethics

- Opinion 3.06 - Sports Medicine

- Physicians should assist athletes to make informed decisions about their participation in amateur and professional contact sports which entail risks of bodily injury.

- The physician's judgment should be governed only by medical considerations.

www.ama-assn.org
FIMS Code of Ethics

The main duties of a physician include:

- Always make the health of the athlete a priority.

- Never impose your authority in a way that impinges on the individual right of the athlete to make his/her own decisions.

www.fims.org

NATA Code of Ethics

- 1.2 …be committed to providing competent care.

- 2.3 …report illegal or unethical practices related to athletic care …

- 4.3 …not participate in any arrangement that exploits the patient.

www.nata.org/
Standard 1: Direction
- The AT renders service / treatment under the direction of a physician.

Standard 6: Program Discontinuation
- The AT, with collaboration of the physician, recommends discontinuation of the athletic training service when the patient has received optimal benefit of the program.

Code 1: Patient Responsibility – The AT:
1.2 Protects the patient from harm, acts always in the patient’s best interests and is an advocate for the patient’s welfare
1.3 Takes appropriate action to protect patients from ATs, other HCPs or ATS who are incompetent, impaired or engaged in illegal or unethical practice
1.5 Communicates clearly and truthfully with patients and other persons involved in the patient’s program
1.6 Respects and safeguards his or her relationship of trust and confidence with the patient and does not exploit his or her relationship with the patient for personal or financial gain

www.bocatc.org
How “Patient-Centered” is AT?

- Highly responsive to an injured athlete’s desire to return to participation as soon as possible!
  BUT,
- What about the injured athlete who is not anxious to return until normal capabilities are fully restored?
- Are we really as good as we think we are with regard to rapid restoration of functional capabilities?
  OR,
- Are we just really good at helping athletes to adopt compensatory strategies that facilitate rapid return?

Chris Ingersoll, PhD, ATC, FNATA

Unique Patient-Centered Issues in AT

- Risk for catastrophic event?
- Risk for adverse long-term health consequences?
  - Osteoarthritis
  - Diabetes & Cardiovascular disease
  - Cumulative traumatic encephalopathy
- Prevention hyper-emphasized, but underutilized?
- Insufficient AT allocation of time to rehabilitation?

Patient-Centered Care

☐ Does this matter to us?

☐ Are we doing good enough?

☐ Do we have a problem?

How “Patient-Centered” is AT?

☐ Eastern Athletic Trainers’ Association Annual Meeting
   ☐ Timothy Sensor, January 7, 2012 –

- Are we afraid of doing something to upset a coach?
- What are we doing to protect ourselves from burnout?
- Are we fully aware of state laws that define practice?
- Is documentation of athletic injury management adequate?
- Do we communicate sufficiently with supervising physicians?
- Do we need a better means for clinical skill development?

Sensor JT. We have met the enemy, and it is us. Athl Train Sports Health Care. 2012;4:147-150.
Informed Consent

The willing acceptance of a medical intervention by a patient after adequate disclosure of the procedure, risks, and benefits, as well as of alternative courses with their risks and benefits.


How “Patient-Centered” is AT?

- Ethical aspects of clinical decisions:
  - Expert panel derived from NATA Leadership Directory
  - Identified ethical issues in each of 5 practice domains
  - 0-10 ratings for “frequency of occurrence”

1. Failure to inform athlete about realistic prognosis (7.2)

2. Failure to inform athlete or parents about true extent of injury or risk of further injury (6.7)

**“Fiduciary” Legal Obligation**

- **Fiduciary**: A person to whom power is entrusted to the benefit of another (*L. fiduciarius*: hold in trust)
  - Exclusive focus on patient’s health – free of conflict!

- **Professional ethics impose fiduciary obligations that courts convert into legal obligations**
  - Duty to fully disclose all relevant information to patient
  - Duty to resist situational pressures
    - Athletes are particularly vulnerable consumers, poorly equipped to decide whether a medical service is critical, deferrable, or unnecessary

Furrow BR. The problem of the sports doctor: serving two (or is it three or four?) masters. *St Louis Univ Law J.* 2006;50:165-183.

**Factors Influencing Tough Ethical Decisions**

- **Personal**
  - Moral Philosophy
  - Integrity
  - Ambition - Ego
  - Security - Acceptance

- **Professional**
  - NATA Code of Ethics
  - BOC Standards of Practice
  - State Practice Regulations
  - Mentors & Colleagues

- **Organizational**
  - Institution Administration
  - Athletic Director
  - Coaches
  - Team Physician – Med. Dir.

Offensive and Defensive Linemen
Risk for Diabetes & CVD

- NFL linemen: 52% greater risk for CVD mortality
  - Metabolic Syndrome ≥ 3 positive:
    - Waist Circumference: >40"
    - HDL Cholesterol: <40 mg/dL
    - Triglycerides: ≥150 mg/dL
    - Fasting Blood Glucose: ≥100 mg/dL
    - Blood Pressure: ≥130 / ≥85 mmHg

- Division I-FCS linemen (n=21)
  - 52% (11/21) had Metabolic Syndrome
    - U.S. prevalence: 22%
  - 76% (16/21) had low HEI scores (≤ 50)

Davis EB, Fanelli MA. Association of dietary habits with cardiometabolic status and quadriceps strength of college football linemen.

Power Clean – Spine Compression

- Division 1-FCS football players (n=31)
  - Load limits to avoid excessive L5-S1 compression
    - National Institute for Occupational Safety and Health
    - Univ. of Michigan Static 3-D Static Strength Prediction Program
    - Power clean pull stage L5-S1 compression
      - 100% (31/31) exceeded Lower Limit (3400 N)
      - 77% (24/31) exceeded Maximum Permissible Limit (6400 N)
      - 29% (9/31) exceeded “Adjusted” Upper Limit (9400 N)
        - 67% (6/9) had Oswestry Disability Index ≥ 6
    - Cartilage endplate microfractures are likely to occur
      - Lack of pain receptors may result in cumulative damage without symptoms, other than minor discomfort

Miller LJ, Milburn TM. Static analysis of load on the lumbar spine during an olympic-style lift performed by college football players.
The Junction Boys Syndrome

- High-intensity activity in a “punishing environment”
  - 4 leading causes of non-traumatic death of athletes:
    - Cardiac arrest (cardiomyopathy)
    - Exertional heat stroke
    - Sickle cell trait rhabdomyolysis (exertional sickling)
    - Asthma

- 2000-2011: NCAA Div I-BCS non-traumatic deaths
  - All 16 occurred during FB strength/conditioning activity
  - A “culture” willingly excusing the inexcusable?


Class Action Lawsuit Against NCAA

- Complaint filed September 12, 2011
  - Alleges that the NCAA was negligent in safeguarding student-athletes from the risks of concussions
    - Negligence
    - Fraudulent concealment
    - Unjust enrichment
    - Medical monitoring

- Plaintiffs:
  - Adrian Arrington, Eastern Illinois U. – football
  - Derek Owens, U. of Central Arkansas – football
  - Angela Palacios, Ouachita Baptist U. – soccer
  - Kyle Solomon, U. of Maine – hockey
    - Memory loss, seizures, depression and migraines

http://nflconcussionlitigation.com/?p=1137
NCAA Concussion Lawsuit Commentary

- 2011-12 NCAA Compliance Manual: "An active member institution shall have a concussion management plan for its student-athletes." That plan must include a "process that ensures a student-athlete who exhibits signs, symptoms or behaviors consistent with a concussion shall be removed from athletics activities … and evaluated by a medical staff member" and must "[preclude] a student-athlete diagnosed with a concussion from returning to athletics activity (e.g., competition, practice, conditioning sessions) for at least the remainder of that calendar day."

http://www.slate.com/articles/sports/sports_nut/2012/12/ncaa_concussion_policy_in_college_football_the_risk_of_legal_liability_is.html

NCAA Concussion Lawsuit Commentary

- It's impossible to tell if the schools were breaking the rules, though, because there's no central authority monitoring how they deal with concussions. The NCAA doesn't have a standardized concussion policy—the implementation of these general guidelines is left up to each member school.

http://www.slate.com/articles/sports/sports_nut/2012/12/ncaa_concussion_policy_in_college_football_the_risk_of_legal_liability_is.html
NCAA Concussion Lawsuit Commentary

- At the college level, it’s up to the schools to serve as their football programs' judges and juries. What will it take to get the NCAA to step in? Most likely an on-field tragedy that pushes Congress to demand answers. Until then, there will be no consistent, transparent medical policies in college football, and players like Chandler Whitmer will be at the mercy of the schools that employ them—er, that is, the schools that don't pay them to play revenue-generating sports.

http://www.slate.com/articles/sports/sports_nut/2012/12/ncaa_concussion_policy_in_college_football_the_risk_of_legal_liability_is.html

College Sports Revenue

- NCAA 2012 fiscal year revenue: $860 million
  - Distribution to Division I member institutions: $503 million
  - Conference television contracts:
    - SEC 15-year contract: ~$3 billion
    - Pac 12 12-year contract: ~$3 billion
- Federal Anti-Trust Lawsuit (filed May 2009)
  - Claims of illegal use of athletes’ names, images, & likenesses

http://www.usatoday.com/story/sports/college/2012/10/15/ncaa-assets-pass-500m-including-260m-special-fund/1635297/
NCAA Concussion Lawsuit Commentary

- Despite massive and expensive resistance from NCAA officials and their growing cadre of $500-per-hour, big-firm lawyers, the pressure from these lawsuits and others that are sure to follow might lead to the same kind of settlement discussions and court decisions that transformed the tobacco industry in the late 20th century.


Inside Higher Ed

- Ramogi Huma, founder of the National College Players Association:
  - The NCAA is still skirting responsibility and needs to be held accountable.
  - Athletic trainers or physicians on the sidelines are charged with testing the athletes and deciding whether they’re O.K. to go back to playing.
  - But when coaches hold huge power at institutions, and the institutions or even the athletics department are hiring the trainers, conflicts of interest could result in pressure on the trainers to give a go-ahead when they shouldn’t.

http://www.insidehighered.com/news/2013/04/19/culture-ignorance-biases-all-obstacles-preventing-head-trauma#ixzz2Qv8aUTLx
What is the effect of “Burnout” on the delivery of Patient-Centered care in AT?

Job Stress and Burnout

- **Stress**: Too many mental and physical demands
- **Burnout**: Insufficient rewards and recovery opportunity
  - Feeling empty, depressed, and devoid of motivation
- **Key factors**:
  - Role conflict - High time commitment - Low salary
  - Limited career advancement - Poor working conditions
- **High-quality patient-centered care cannot be provided without work-life balance!**
Patient-Centered Care

- Is the status quo acceptable?
- What do we need to do?
- How do we go about it?

Problems with the Prevailing Organizational Culture of College Athletic Programs

- Do college ADs and coaches value athletic trainers?
  - Salaries? Job security? Work-life balance? Part of the team?

- Extent to which coaches are empowered by administrators?
  - 2007 to 2011: 44% increase in football coaches' salaries
  - 42 football coaches making >$2 million per year

- Coaches’ medical knowledge pertaining to health risks?
  - Imposition of unreasonable physical demands
    - The Inter-Association Task Force for Preventing Sudden Death in Collegiate Conditioning Sessions: Best Practices Recommendations

- Who hires the team physician?
  - Who evaluates an athletic trainer's job performance?
A Patient-Centered Model for Delivery of Athletic Training Services

- Athletic trainers solely accountable to sports medicine physicians (subunit of Student Health Services)
  - Performance evaluated from a medical perspective
    - Job security and professional development opportunities
  - Supportive infrastructure for better coordination of care
    - Improved athlete access to various healthcare providers
  - Increased resources – larger clinical staff
    - Increased compensation and more flexible work schedules
  - Collaborative approach to service delivery
    - Improved quality of patient care


Health vs. Sport: Conflict of Interests?

- Informed consent
  - Short-term gain vs. long-term risk

- Financial arrangements
  - Professional earning potential
  - AT bonus based on winning
  - Team physician contract

Team Physician Contracting

- It’s always about the money!
  - Physicians deserve to be compensated for their services
    - Time commitment = Lost clinic revenue generation
  - Hospitals & physician groups paying for exclusivity?
    - Marketing advantage (monetary value)
    - AOSSM Principles of Selecting Team Medical Coverage
      - Selection should be based on qualifications
    - NFL & MLB Commissioners’ position statements
      - Sponsorship dollars should not influence team physician selection
      - Marketing still influences the process for most professional teams
        http://www.slate.com/articles/sports/sports_nut/2013/01/nfl_team_doctors_the_problem_with_pro_football_s_medical_sponsorship_deals.html


Financial Conflict of Interests

- Former Atlanta Falcons team doctor Andrew Bishop told the New York Times in 2004 that he would resign if the team entered a hospital sponsorship deal:

  “It compromises you as a physician. The perception is that if this individual was so eager to do this he’s willing to pay to do it, then he’s going to do whatever management wants to keep the job he paid for.”

How “Patient-Centered” is AT?

- How should RTP decisions be made?
  - Avoidance of re-injury and/or chronic disability

- What are the respective roles and responsibilities of the team physician and the athletic trainer?
  - Ethical – Legal – Administrative Hierarchy

- How influential (intimidating) are coaches?
  - Conflict of interests: team success vs. athlete-patient?


Consensus Statements - Guidelines

- Guidelines are shields to repel pressure to provide medical clearance to participate - they reduce uncertainty about traditional “customary practice”

Furrow BR. The problem of the sports doctor: serving two (or is it three or four?) masters. *St Louis Univ Law J.* 2006;50:165-183.

- The Team Physician and the Return-to-Play Decision: A Consensus Statement – 2012 Update
  - Non-game day RTP decisions
    - AAFP, AAOS, ACSM, AMSSM, AOSSM, AOASM

Relevance to Future AT Education

- Major (and mid-major) university athletic programs
  - Are optimal clinical learning opportunities provided?
    - Coaches’ influences on clinical management decisions?
    - Paranoia about secrecy? AT student access?
  - What is the nature of role modeling that is provided?
    - Loyalty to coach to maintain job security?
    - Willing acceptance of circumstances that prohibit work-life balance?
  - How are AT Graduate Assistants and Interns utilized?
    - Meaningful professional development vs. cheap labor?
    - Selling plasma to get money for living expenses?

NATA Executive Committee for Education

- Future Directions in Athletic Training Education
  - Approved by NATA Board of Directors – June 25, 2012
    - Significant effort should be expended to educate practitioners regarding the fundamentals of evidence-based practice and the use of outcome measures in their practice.
      - Establish an agenda for scholarship that would better inform the practice of athletic training
    - Encourage alignment of professional and post-professional education programs in schools of health professions
      - Emphasizes the correct perception that athletic trainers are primarily healthcare providers

Proposal to develop an inter-association document:

- Outline best practices regarding the selection, role, and supervisory relationships of the sports medicine team

- Secondary Schools Athletic Training Committee
- College and University Athletic Training Committee
- National Collegiate Athletic Association
- National Federation of State High School Associations
- American Medical Society for Sports Medicine
- American Orthopaedic Society for Sports Medicine
- American Academy of Pediatrics

Where do we go from here?

Should we develop position statements and/or accreditation standards?

- Quality of clinical learning experiences within intercollegiate athletics (e.g. professional mentorship)
- Meaningful engagement of team physician(s) in terms of administrative management of AT services
- Proper documentation employed by clinical sites, which supports outcomes research (integrated with academic requirements)
- ATEP within “health sciences” v. “education” academic unit
- Evidence of a “patient-centered” philosophy of care and proper recognition of the need to avoid conflicts-of-interest
Board of Certification

- Facility Accreditation Initiative
  - Essential Facility & Patient Care Principles
    - ADA compliance
    - Emergency Action Plans
    - Safety (OSHA compliance)
    - Clinical documentation (HIPAA compliance)
  - Expansion to included Administrative Structure?
    - Avoidance of conflict-of-interests

Proactive vs. Reactionary Approach?

- Should there be a mechanism for independent oversight of student-athlete health & welfare?
  - Review/approval of standard operating procedures
  - Investigation of complaints
  - Affirmation of freedom from conflicts of interests

- Examples:
  - Institutional Review Board
    - Protection of human subjects participating in research
  - External Review Board for law enforcement agency
    - Public accountability – compliance with established guidelines
10 Principles to Guide Administration of Sports Medicine – AT Services

1. Patient physical & psychosocial welfare must be the highest priority
2. Have a designated medical director
3. Integrate best research evidence with patient preferences/values
4. AT responsibilities must be consistent with MD orders/protocols
5. Decisions that affect health status of the patient made only by a credentialed health professional
6. Thorough documentation (of all aspects of care)
7. Coaches demands must be consistent with sports medicine guidelines
8. AT’s role delineation/employment determined by health professional vs. coach/administrator
9. AT’s qualifications and evaluation reviewed by health professional vs. coach/administrator
10. Administrative structure that minimizes potential for conflict of interests that could adversely affect patient’s well-being


THANK YOU!

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www.utc.edu/gatp