Correspondence

(continued from page 2)

of the predicted 70,000 petitions coming to court, there have been fewer than 100, and there have been *no* civil or criminal cases that I am aware of), and clearly expressing an opinion as to the likelihood of such a possibility, is irresponsible both to the physician and to his potential patients.

The response may be that the lawyer has *no* duty to the physician's patients, only to the physician; and that therefore the physician alone must worry about his patient. But surely this is too narrow a view of an attorney's duty, and sees the practice of law as being either amoral or immoral. I submit that, under the circumstances described, lawyers have duties to "innocent third parties," like patients, that might be analogized to the duties physicians have to innocent third parties and the public who might be harmed or infected by their patients. Legalistic thinking, as Professor Hubbard argues, militates against this view: but it is precisely this type of legal game playing that we must abandon if health lawyers are to serve their physician-clients and the general public. GJA

References

1. MEDICOLEGAL NEWS 5(3): 4 (Fall 1979) and 6(2): 3 (Summer 1978) respectively.

Dear Editor:

In his article in the last issue of MEDICOLEGAL NEWS, *Licensing for Athletic Trainers: A Call for Action,* Dr. Redfearn highlights the need for quality control within the profession of Athletic Training — a position which is long overdue. At present, the National Athletic Trainers' Association provides a written, oral, and practical examination prior to awarding certification. This group has joined forces with the American Physical Therapy Association to design model legislation for the purpose of standardizing the licensure procedure for athletic trainers in each state. This action would initiate a control mechanism to assure that the health and well-being of school-age athletes is assigned to a competent allied health professional. However, licensure or certification alone is not sufficient. Continuing education is required in order to guarantee that athletic trainers meet the standards and possess the skills necessary in their profession.

As Dr. Redfearn suggests, the athletic trainer is part of the health care team. No professional wants an incompetent team member, and the time has come for all involved in athletic medicine to start the ball rolling for adequate standards and quality control.

Richard L. Hoover
Educational Coordinator
Center for Sports Medicine
Northwestern University Medical School
Chicago, Illinois

Dear Editor:

In response to Dr. Redfearn's article on the need for licensing action for athletic trainers, this is the same cause the National Athletic Trainers Association (NATA) has been pursuing for a number of years. The resistance of state legislatures to accept such licensing is because many professions want licensing, and a moratorium has been placed on all licensing attempts. We in the athletic training profession are crying out for medical supervision, but as pointed out in the article, only 50 percent of contact sports in high school have physicians present. Furthermore, the great majority of these are not skilled in sports medicine.

I believe a distinction needs to be made between trainers in general and the NATA certified athletic trainer. The certified athletic trainer has gone beyond the qualifications of Redfearn's solution. He is skilled in emergency medical techniques and in preventive and rehabilitative methods. He has passed an exhaustive written, oral, and practical exam. Unfortunately, not all practising trainers are certified. The comments made concerning the unconvincing training and health care techniques sometimes practiced and the empirical and on-the-job knowledge of trainers certainly describes the non-certified athletic trainer.

The magic word of licensing will not in itself make everyone free from negligence. Negligence and misconduct occur everyday with the licensed, but the licensed have the protection of having met a minimum standard for their particular specialty. Everyone in sports medicine today is in danger of greater legal jeopardy because sports medicine has gained a greater profile in society. A physician may tell an athlete never to play again because he may be reinjured, thus protecting himself from a possible suit. However, athletics are very important to a great segment of our society and such advice is not providing optimum care for these people. All prominent people in sports medicine became so by affording the athlete every possible safe opportunity to participate. The athlete assumes a certain amount of risk when he steps on the field. Licensing of physicians, physical therapists, and athletic trainers will not protect the athletes from negligence necessarily, but may protect the practitioner.

As to modality usage in athletics, the only basic difference between physical therapists and certified athletic trainers is that the therapists are licensed. Rehabilitation of athletic injuries is where the certified athletic trainer excels. His expertise far exceeds many therapists in this area.

The *Butkus* case cited, where the athlete was forced to play, and the trainer trafficking in weight control pills are examples foreign to the certified athletic trainer. Most all reasons for suits are alleged negligence or misconduct. The certified athletic trainer is very aware of his limitations and sticks to those despite the pressures of some groups to expand his authority.

The profession wants better control as evidenced by the number of physicians on various committees of the NATA. It is at the direction of the team physician that the certified trainer functions. The lines are drawn as to what is and what is not expected of him by the team physician. Proper diagnostic techniques by the certified athletic trainer are necessary in certain instances before proper first aid is applied, and are often valuable tools in the physician's follow-up.

The problem lies in the fact that all trainers do not have the skills of the certified athletic trainer. Even those that do as Redfearn stresses, do not have the protection of licensure. Inclusion within the state board of medicine in many instances would be more desirable than legislation.

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MEDICOLEGAL NEWS welcomes correspondence from its readers concerning the articles and other comments published. Letters should be sent to the Editor-in-Chief, MEDICOLEGAL NEWS, 520 Commonwealth Avenue, Boston, MA 02215.

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Correspondence
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It is hoped that the status quo of licensure can be eliminated and progress made to recognize the qualified athletic trainer as the professional he is.

Sincerely,

Joe Gieck, Ed.D., ATR, RPT
Curriculum Director
Head Athletic Trainer
Division of Sports Medicine
and Athletic Training
University of Virginia

Dear Editor:

In response to the letter from Frances Kolbmann, ART, concerning the retention of the medical records of a closed hospital, there is a Washington state statute relating to disposition of records for hospitals that close. It is part of a record retention act and covers hospitals and nursing homes. Specifically, it reads:

> If a hospital ceases operations, it shall make immediate arrangements, as approved by the department (Department of Social and Health Services, a state governmental agency, similar to other state health departments) for preservation of its records.

The implementing Administrative Code states:

> If a hospital ceases operation, it shall make immediate arrangements for preservation of its medical records and other records of or reports on patient care data in accordance with applicable state statutes and regulations. The plan for such arrangements shall have been approved by the Department (Department of Social & Health Services) prior to the cessation of operation.

Since specific retention periods are defined for medical records, there is no question as to the requirement to preserve for at least that length of time. We have had no hospital close since the legislation was passed, but it was written in because one had closed prior to that time, with problems arising due to lack of a statute. The same wording was used to include nursing homes in that bill, the greatest problems having arisen at that level.

The suggestion that a newspaper announcement be placed to notify patients of the upcoming destruction of their records, with adequate lead time to permit recovery, seems a most viable one, certainly the least expensive. This might be followed by a request for preservation in the state archives of the remaining records, with a specified time for destruction. Putting this up to the state's health department might be a step in solving the problem once and for all, if some decision, such as placement in state archives, could at least be part of the hospital licensing laws of the state.

Mrs. Lynn Regudon, RRA
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Shoreline Community College
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b) limited bibliographic research assistance by telephone request
c) access to photocopy service
d) circulation of duplicate copies of books
e) librarian members will also be permitted to duplicate the entire card catalogue of the Library for reference by their own users.

The following fee structure has been established for 1980:

• librarians	$ 150
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For more information on the Library, its collection, and services, please contact Edward Doudera, Esq., Executive Director, American Society of Law & Medicine, 520 Commonwealth Avenue, Boston, MA 02215, (617) 262-4990.

Conference Advisory Committee

As the conference program of the Society expands, it is essential that the involvement of Society members in the planning process increase. Accordingly, a Program Planning Advisory Committee has been authorized by the Executive Committee of the Society. This Committee will serve as a resource to evaluate suggested conference topics and the substantive content of proposed programs. It will also nominate faculty participants and otherwise contribute to the Society's series of educational programs.

All members of the Society are eligible for appointment to this Committee. Interested persons should write Elliot L. Sagall, M.D., in care of the Society, mentioning their primary areas of expertise.

Annual Membership Meeting Proposed

On a related topic, it has been suggested that the Society plan and sponsor an annual meeting of the membership. Because of the diverse interests of the Society's membership, such a meeting would necessarily combine plenary and a variety of concurrent sessions on a wide range of medicolegal issues. Hawaii has been proposed as the site for the meeting and space has been tentatively reserved for early December 1981. All members are asked to communicate their interest in attending or participating in such a meeting and the issues they would like covered to Edward Doudera, Esq., Executive Director of the Society.

Stress, Strain, Heart Disease and the Law

The *Proceedings of the Conference on Stress, Strain, Heart Disease and the Law* are still available. The 217-page paperback book resulted from the January 1978 conference which was sponsored by the American Society of Law & Medicine, the American Heart Association, the President's Committee on Employment of the Handicapped, and the Massachusetts Affiliate of the American Heart Association.

Included are such topics as: Medical and Legal Assessments of Causality in Heart Disorders; The Role of Coronary Risk Factors; Physical Activity and Heart Disease; Physical Activity and Sudden Death; The Long Term Effects of Physical Activity and Heart Disease; Exercise Testing and the Assessment of Cardiovascular Disability; and the Relationship Between Emotional Stress and Illness Onset.

To order your copy, send your name, mailing address, and a check for $2.50 (to cover postage and handling) to: American Society of Law & Medicine, 520 Commonwealth Avenue, Boston, MA 02215.

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