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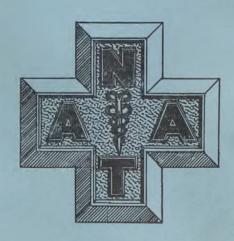
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OF THE

NATIONAL ATHLETIC TRAINERS ASSOCIATION



8th ANNUAL MEETINGS, LINCOLN, NEBRASKA



Let's Go Lincoln!

Lilac City Hosts Eighth Annual NATA Convention, Meetings and Horseplay

Lincoln is located some 55 miles west of the Iowa border and about the same distance north of Kansas. It is 1,167 feet above sea level and has an invigorating climate in the varying seasonal pattern of the temperate zone. Transportation facilities abound, with five railroads serving the city; numerous truck and bus companies plying the fine highways of which Lincoln is the hub; and a veritable beehive of aviation activity at the three airports. Lincoln Air Force Base (a 2-wing, medium bomber SAC unit) is used by scheduled commercial airlines. Private planes use Union Municipal and Arrow airports.

Lincoln started as the tiny village of "Lancaster," founded in 1856 to exploit nearby salt deposits. It flourished after the state capital, the University of Nebraska, and varied business enterprises were located here. It passed the 40,000 mark in 1900, and became metropolitan in the true sense when the separate surrounding communities of Havelock, University Place, College View and Bethany were integrated into the modern City of Lincoln. Emphasis always has been placed on good family living - on civic beauty and cleanliness. Among the countless trees and flowers which beautify its comfortable homes, the lilac is so popular and prolific that Lincoln has been christened "The Lilac City."

PROGRAM

Eighth Annual

N.A.T.A. NATIONAL CLINIC and CONVENTION

Lincoln, Nebraska June 16, 17, 18, 1957 HOTEL CORNHUSKER

SUNDAY EVENING, JUNE 16, 1957

6:00 p.m. Cocktail hour Smorgasbord, visiting, and program for members

Hostesses

and families. Cornhusker Hotel Ballroom Mesdames Paul Schneider & William Orwig,

MONDAY, JUNE 17

8:00 a.m. Registration Welcome - Gov. of Nebraska Victor Anderson 9:00 Greetings from Duke Wyre, Maryland University, National Chairman N.A.T.A. Ankle and Knee Injuries and Repair 9:30 Donald H. O'Donaghue, M. D. Orthopedic Surgeon, Oklahoma City, Oklahoma Fred Webster, M. D. Orthopedic Surgeon, Lincoln, Nebraska 10:30 Break

10:45 Open Forum on Knee and Ankle Injuries Panel Donald H. O'Donaghue, M. D. Fred Webster. M. D. Frank Stone, M. D., Orthopedic Surgeon, Lincoln, Paul Geotowski, M. D., Orthopedic Surgeon, Lincoln, Nebraska 12:00 noon Lunch

2:00 p.m.

Dangers of Nerve and Head Injuries in Athletics Louis J. Gogela, M. D. Neurological Surgeon Lincoln, Nebraska

2:30 Break 2:40 Internal Injuries in Athletics Jon T. Williams, M. D. Lincoln, Nebraska

3:10 Break Open Forum Nerve and Internal Injuries Panel Louis J. Gogela, M. D. Jon T. Williams, M. D. S. I. Fuenning, M. D. Board of Directors' Meeting 7:00

TUESDAY, JUNE 18

9:00 a.m. Physiology of Muscle Donald M. Pace, Ph. D. Department Chairman Professor Physiology University of Nebraska

9:30 Break 9:40 Physiological Use of Hot and Cold Ultra Sound and Light in recovery period of injury. Gordon M. Martin, M. D. Department of Physical Medicine Mayo Clinic, Rochester, Minnesota

10:10 Break 10:30 Open Forum: Muscle Injuries Panel Gordon M. Martin, M. D. Donald Pace, Ph. D. Frank H. Tanner, M. D. Pathologist, Lincoln, Nebraska

12:00 noon Lunch

Trainer, Doctor, and Coach and Player Relations 1:00 p.m. Jerry Bush, Basketball Coach. University of Nebraska

James Hunt, University of Michigan Frank Kavanaugh, Cornell University Conrad Jarvis, Stanford University Steve Wilkowski, Wesleyan University

2:00 Break

2:10 Annual Meeting Guided tour of Nebraska State Capitol Building

THE JOURNAL

of the

NATIONAL ATHLETIC TRAINERS ASSOCIATION

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BOOK REVIEWS

THE EXTREMITIES, Quiring, Daniel P. and others, cloth, 117 pp., Lea and Febiger, Philadelphia, Pennsylvania. \$2.75.

As a quick reference in myology and muscle function, The extremities is highly commendable. Bold, well-drawn illustrations graphically present the musculature with their neural and vascular network as concerned with movement of the extremities. Origin, insertion, oction nerve supply and motor point are listed with page reference as per Gray and Cunningham cited for each presentation. The quality of paper is good, and the large print pleasant to read.

Certainly no text for the college student because of its specificity, it is invaluable to the lecturer, Athletic Trainer or Therapist for the same reason. The illustrations lend themselves well to projector screening or as a guide to drawings for classroom teaching.

A maximum of information in a minimum of elapsed time places this book in the "real find" class in its field.

PERIODICAL LITERATURE OF INTEREST

Bass, David E., and Austin Henschel, "Responses of body Fluid Compartments to Heat and Cold," Physiological Review, 36:128-142, Jan. 1957.

Clarke, David H., "The Application of Measurement to Quadriceps Exercise Prescriptions," Jour. Ass'n. Phys. and Mental Rehab., 11:48-50, Mar.-Apr. 1957.

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Friedland, Fritz, "The Present Status of Ultra-sound in Medicine," The Jour. of the A.M.A., 163:No. 10, Mar. 9, 1957.

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Michels, Eugene, "Physical Therapy in the Conservative Management of Back Injuries," Phys. Ther. Review, 37:139-49, March, 1957.

Muller, Erich A., "The Regulation of Muscular Strength." Jour. Ass'n Phys. and Mental Rehab., 11:41-7, Mar.-Apr., 1957.

Norton, Paul L. and Thornton Brown, "The Demobilizing Efficiency of Back Braces. Their Effect on Posture and Motion of The Lumbro-Sacral Spine," Jour. Bone and Joint Surg., 39-A:111-139, Jan., 1957.

Pacheco, Betty A., "Improvement in Jumping Performance Due to Preliminary Exercise," Research Quarterly, 28:55-63, March, 1957.

Rose, Donald L. and others, "Effect of Brief Maximal Exercise on Strength of Quadriceps Femoris," Arch. Phys. ical Med., 38:157-64, March, 1957.

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AN APPROACH TO LOW BACK PROBLEMS WITH RELATIONSHIP TO FOOT IMBALANCE

By JOSEPH DOLLER, D.S.C. — Head Trainer - Chicago Cardinals Football Club; Consultant - Loyola University, Dep't of Athletics; Instructor - Chicago College of Chiropody; Member - National Athletic Trainers' Association; Member - National Association of Chiropodists.

Ever since our early days devoted to the prevention and care of athletic injuries, we have been thwarted on so many occasions to injuries that have been of a questionable history. Of the questionable variety, one that looms foremost is that of the classical low-back pain. So often the athlete will make his appearance in the training room with this complaint which sometimes will include the back of the thigh. More often than not, he will give us vague symptoms as to the type of pain, have limitations of movement, and give us a poor history as to how this injury manifested itself. How often have we asked ourselves, just why and how did this type of injury come about. The athlete relates no direct trauma, no violent or twisting movements, nor any direct clue that could aid us in our direction of treatment. Not that we as Trainers' or those coaches that must carry out their own training work should be looked upon as diagnosticians, but we all feel that coming in contact as we do with so many of these varied types of athletic injuries, gives us a wonderful approach in determining certain types of treatments for these injuries. Over the course of a year's activity, I doubt whether any team can go along without incidence of a low-back problem accompanied by a remote case history. I know that I, for one, have been faced with these problems and have turned to the study of Chiropody to help eleviate some of the problems. Quite naturally, our approach to all athletic injuries is the earliest possible ambulation. At no time thruout this writing shall there be any inference made that the method discussed herein is a sure fire approach to the treatment of all low-back pains. The preliminary workup must first be done in associationship with the team physician. He must rule out any organic disturbances and conclude that the prime disturbance is functional. It is hoped that the true purpose of this writing is to present a procedure with techniques that will be looked upon as another adjunct in the physician-trainer relationship.

Before the discussion of treatment of functional lowback pains is begun, let us first get some idea of the structure as it exists. Rather than employing the use of complex technical terminology, it was felt that the simple comparison of the pelvic structure and legs to the man made structure such as a bridge span would fit our purpose. First, let us evaluate the pelvic girdle. This girdle is actually made up of two large bones called the innominate bones which join each other in the front but are attached to each other in the back by means of the sacrum bone. Anatomically speaking, the innominate bone consists of three parts: 1. The illium, 2. The ischium, and 3. The pubis. One of the main check points that we shall employ is the use of the illium bone. The illium is the winged portion of the innominate bone and the part of it that projects on either side of the abdomen and is called the crest of the illium. In football language this crest is called the hip-pointer. The point of the crest shall be this check-point.

For purposes of easy identification, we shall compare the body structure, from the top of the pelvic girdle down to and including the feet, to a rectagular box. The upper border will be an imaginary line drawn across the abdomen, extending from one illiac crest to the other. The sides of the rectangle will be formed by the legs and the bottom will consist of the feet.

SEE DIAGRAM NO. 1

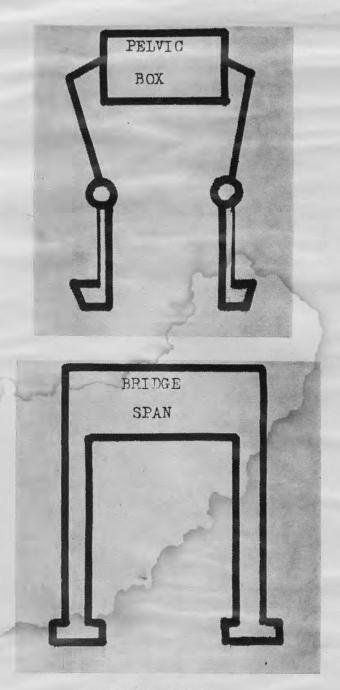


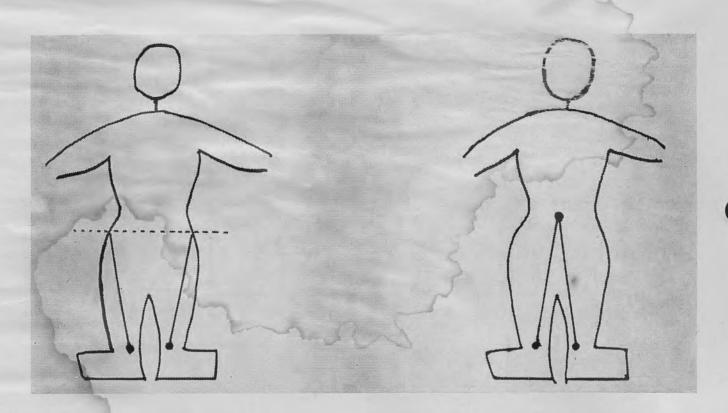
DIAGRAM NO. 1

A gross comparison of the pelvic structure, legs and feet to the structure of a bridge span.

It is this rectangular box that is the barometer in judgment of the competitive days of an athlete. This box is the foundation for the upper structures of the body. It is the boney framework that affords the attachments of the soft structures such as muscle, ligament, fascia, etc. If we can approach and solve problems of the hard structure, the soft structure will usually fall in line. Bear in mind at this point, that although we are stressing the pelvic hard structure, all the structures above and below the pelvic line must be considered as well. With these points made clear, we may now proceed to discuss some of the important points of low-back pains with the principal factors pointing to malalignment, imbalance, and postural incompetencies of the feet. Our approach is going to be from the bottom up.

the smoothness of the bridge span will be effected and the superstructure will soon follow suit. The change in the length of the upright can be attributed directly to a change in the position of the cement piling or foundation. Quite naturally the bridge span will conform its position in accordance to the changes in the pilings with the end result being a bridge that has lost its smooth grace and functional perfection. This of course takes time as it will do in the human body.

Using the bridge underpinning as the comparative example, it can now easily be seen how the human body can be so easily effected by improper alignment of the feet.



This shows the line of measurement from the crest of the illium to the inside ankle bones.

This shows the line of measurement from the navel to the inside of the ankle bones.

DIAGRAM NO. 2

To further understand the workings of the body, we can compare our God-given structure to one that is manmade, i.e.: a bridge or bridge span. The average bridge will consist of the span, the superstructure, the uprights, and pilings. The supporting media is represented by the uprights and pilings; the span is the moving force giving way to the surrounding elements, and the superstructure acts as a counter-balance for the span. To all of this, we can now compare the pelvic girdle to the span; the upper part of our body to the superstructure; and our legs and feet to the uprights and cement pilings.

Going back to the functional bridge, it is understandable that should the length of any of the uprights be altered,

The low-back syndrome can be, in a number of cases, related directly to the feet. Thru early recognition, these symptoms can be relieved or overcome thru proper foot balance technique and corrective exercises.

Using a hypothetical instance let us start our approach with the ultimate proceedure.

Complaint: Low back pains, pains sometimes in thigh.

Pain is present on standing, walking, or running. Stiffness thru region of low back (lumbar) area on arising in the morning.

Tightness in the muscles of the back.

Additional symptoms could be many and must be considered by the team physician.

Method of approach:

Have the athlete stand before you as completely relaxed as possible, looking straight ahead, with his head level. Examine the level of both the shoulders and the hips. Assuming that the left shoulder is lower than the right shoulder and that the left hip is higher than the right hip. The legs and feet are now examined and careful observation is important. Note if the knees flex and extend easily and if movements of the feet and ankle are normal. Check the position of the feet to see if they are alike or if one is more pronated than the other. Now place the boy against the wall (in a standing position) and measure from the crest of the illium (hip point) down to the inside bone of each ankle. Record your measurements. To further check your accurancy you might measure from the navel down to the same check points on the ankle. To further emphasize the need for accuracy, place the boy in the supine position on a table and repeat the procedure of measuring. These are easy and accepted methods of finding gross shortages in the limbs. Your team physician can use X-ray methods to further substantiate your findings.

SEE DIAGRAM NO. 2

Assuming now that we have found a variance in the shoulder and hip level along with a shortage of the left leg amounting to one-half (1/2") inch. Using the formula:

$$\frac{\text{length of shortage}}{2} = \text{needed elevation}$$

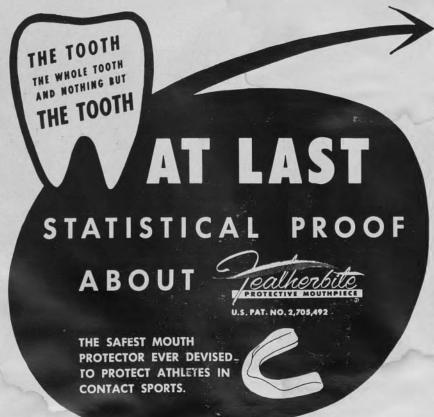
$$\frac{\frac{1}{2}}{2} = \frac{1}{4}$$

Using the one-fourth (1/4") inch as our unit of measure, we take a piece of felt of 1/4" thickness and fashion a connective pad. The pad is to be shaped in accordance to the inside of the athletes' shoe and is to extend from the back of the heel, forward into the shoe, and ending at the same point that the metatarsal bones do. The high point of the pad is at the heel area with the forward end tapered down to a fine edge.

SEE DIAGRAM NO. 3

After the pad has been cut to completion it is then cemented into the shoe. In this case it would go into the left shoe to aid in compensating the leg shortage. Should the situation have presented a shortage on the right side, the pad would of course be placed into the right shoe. To sum it up, we are trying to level off the platform that the body rests upon. It is the feet that the body rests upon and not the earth's surface.

In conclusion, we have tried to present a simple approach to the solving of low-back pains of unknown origin where the possibility of organic malfunction has been ruled out. A simple procedure such as presented herein is within the scope of any training room procedure and could well be included in the daily workings of a trainer. In conjunction with the elevation principal the utilization of corrective exercises is self explanatory and should come under the surveilance of the trainer.



Report by
The Security Life and Accident Co.
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Any injury to a young athlete is shocking, but none more so than one involving injury to teeth. A broken tooth, no matter how you repair or replace it, remains a permanently disfiguring injury. A further fact is that a great percentage of all expensive permanent athletic injuries are dental injuries.

Here are the actual facts:

Incidence of dental injuries to athletes (All Sports)

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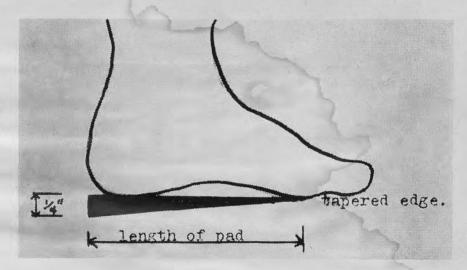
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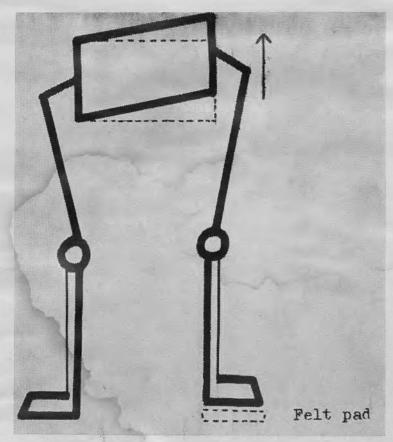
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DIAGRAM NO. 3

The felt pad should maintain this position in the shoe. It will extend from the back part of the heel, forward and ending at the ends of the metatarsals.





A chematic drawing illustrating the effects of the placing of the felt pad. Note that this is not a means of correction but rather a method of eleviating the painful symptoms.

MEXSANA MEDICATED POWDER Best For Routine Conditioning

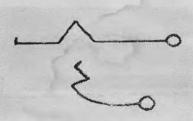
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Hexachlorophene in Mexsana Powder is an effective antiseptic that destroys up to 95% of irritating bacteria on the surface of the skin. By clinging to the skin, Mexsana Powder buffers chafe and skin rub due to socks and shoes... Order Mexsana Powder from your regular drug store... or your sporting goods dealer will order for you.

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Corrective Exercises



No. 1. Hip flexion, bringing the legs up, high on to the chest.



No. 2. Leg elevators, keep knees stiff.



No. 3. Hip bending sideways with the legs in the crossed position.



No. i. Leaning against wall with the arm of the shorter side. Fush away from wall, rotating inside to ou ward direction.



No. 5. Leaning against wall with arm of shorter side. Place opposite hand on hip, forcing pelvis towards the wall.



No. 6. Arch head and back, backwards from a standing position.



No. 7. Arch head and back, backwards from the lunge position.



No. 8. Toe touching while the legs are held in a crossed position. Interchange the legs after each exercise.

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SCIENTIFICALLY DESIGNED TO MEET THE NEEDS OF MODERN TRAINING TECHNIQUES IN PROGRESSIVE RESISTANCE EXERCISE

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It is well known that the knee joint is one of the most commonly injured in athletics. Experience and mediical research have shown that the best way to prenvet knee injuries or to return injured knees to normal function is to strengthen the knee joint muscles, particularly the quadriceps, through the use of heavy progressive resistive exercises. THE N-K UNIT HAS BEEN SPECIFICALLY DE-SIGNED FOR THE MOST EFFECTIVE ADMINISTRATION OF PROGRESSIVE RESISTANCE EXERCISE TO THE IMPORTANT KNEE JOINT MUSCLE GROUP.

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Completely ADJUSTABLE from the smallest child to adult; accomplished by merely sliding the mobile leg rest to the desired position.

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Maximum EFFECTIVENESS because the resistance can be given throughout the COMPLETE RANGE of knee joint motion with maximum resistance during the middle phases of joint range and diminishing resistance at either end, thus to coincide with the muscle force pattern. This is not possible with the usual technique of attaching the weighet directly to the foot.

CONVENIENT. It is possible to exercise both quadriceps and hamstrings without changing the patient's position. To change legs, simply place the unit in the opposite bracket.

MOTIVATION. Another unique feature is the built-in Range-of-Motion indicator which gives a measurement each time the exercise is performed, thereby giving an accurate day-to-day check on progress. This is not only convenient but an additional motivational factor for the patient. The ROM Indicator is included on every unit.

Note Weights are not furnished with the unit but any conventional disc weight or even sand bagsmay be used.

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Athletic Training Clinic

For High School Coaches and Student Trainers

By Thomas E. Healion Trainer, Northwestern University

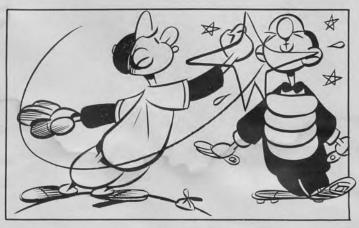
Many Professional, College and High School Athletic Trainers are being called upon to take part in various coaching clinics now being held throughout the United States, and overseas. They are also asked on occasion, to put on their own clinics pertaining to Athletic Training alone. For this reason, I feel a guide or outline is needed, which may enable us to do a more complete job.

The following is one that covers many of the basic practices and ideas of our profession. They are, to us, things we do every day, and usually pass off as "tools of our trade." Yet, there is a great need to relay these "tools" to the people who may, at some time, need them to help an athlete back into action, or prevent him from further injury. We know that in many of the high schools the coach must act as the trainer. We also know that there are many young Student Trainers who are handling this all important job, and must have the knowledge to perform it to the best of their abilities. This is where we can help these people do a better job of maintaining the high standards of our profession. Their actions as coaches and student trainers reflect highly on our ability to teach them, and to pass on our basic know-how and ideas.

- INTRODUCTION Discussion of the need for knowledge in the prevention and treatment of athletic injuries, and its importance in the school situation.
- II. TAPING DISCUSSION AND DEMONSTRATION A — Discussion — Cover topics of how to select the
 - type of tape you want, how much to buy, and what sizes are needed.
 - B Demonstrations Stress the ankle, knee and hand. Also, explain technique of shoulder strapping or bandaging, and the use of ankle wraps.
- III. PROTECTIVE PADDING FOR INJURED AREAS To maintain the highest playing efficiency of injured boys, the injured area should have extra support and padding.

- A Size, shape and material content of the pad is determined by the type and place of injury.
- B The pad must stay in place during the game.
 - a) If the pad slides or moves, it then becomes an obstacle rather than aid to the athlete.
 - b) Natural contours of the body must be taken into consideration.
- IV. 'ON THE FIELD' FIRST-AID Immediate action to head injuries, wind knocked out, groin injuries, sprains, fractures and contusions.
- V. TECHNIQUES IN THE USE OF THERAPEUTIC AGENTS
 - A Explain the types of equipment and how they are used.
 - B Demonstrative how "home-made" equipment can be put into use.
- VI. USES OF THE MANY "TRAINER'S SUPPLIES" ON THE MARKET
 - A First-Aid and follow-up to cuts and abrasions.
 - B Frevention of bacterial growth.
 - C Care and prevention of blisters.
 - D Care of skin from constant taping.
 - E Use of the "Counter Irritant Pack."
- VII. FREVENTIVE AND CORRECTIVE RESISTANCE EXERCISES
 - A Prescribed work to build up the muscles and ligaments surrounding the shoulders, knees, ankles and hip joints.
 - B Prescribed work to restore maximum function to the above.
- VIII. ETHICAL METHODS IN HANDLING ATHLETIC INJURIES —

Discussion on how to explain the injury to the parents, and make them understand that their boy is receiving the best of care. Relation between the coach and teachers can also be discussed here.





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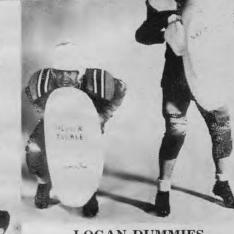


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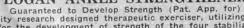
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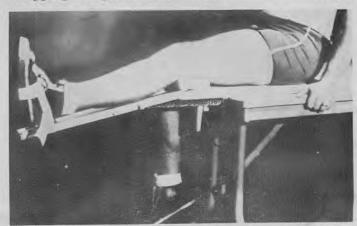




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THE TEAM PHYSICIAN IN ATHLETICS

By John E. Lacey

Head Trainer, Univ. of North Carolina

For the past twenty years, a great transformation has been taking place in the area of athletic training. Gone are the days of the so-called "iodine and liniment man," and in his place has come a group of highly skilled and trained men competent of doing a most important job, who are doing it with deftness and integrity.

Haphazardness is a word of the past, for this new breed is eager to learn. It is keeping abreast of the advancements being made daily in the field through study and research. With the close time schedules which athletic teams of today must meet, it is not only necessary but imperative, that the athletic trainer be a prime concern in any athletic plant.

There is no doubt that the trainer has come a long way, but the role which the team physician has played should not go unnoticed, for the success which trainers enjoy to-day is in direct relation to the important contributions which interested doctors have made in the past.

All athletic teams should have the services of a physician at their disposal, for time and again decisions will have to be made which are beyond the right of the trainer to make. But above that, the team which is fortunate enough to have a physician who is not only interested in athletics, but knows athletes and how to handle them is fortunate indeed.

Possibly one of the biggest things which must be faced by the team doctor is the realization that there is a great difference between injuries and athletic injuries. There is no doubt that boys who participate in a contact sport are less easily injured than those who do not take part in a contact activity. Nor is there doubt that athletes respond to treatment and heal much faster than non-athletes. The reason for this, of course, is still a mystery. Possibly the answer has psychological aspects, the boy's great desire to return to play, etc., playing a great part. At any rate, the evidence is there, and should be taken into consideration by the physicial.

It is of great importance that the doctor get to know his team individually. He should know the character and background of each boy, and this is never easy. No two athletes will be alike, but only by knowing them will the physician be able to determine the extent of injury or make an accurate diagnosis in many cases.

As was just said, no two athletes are alike, either in character or physical makeup. In the latter category we have those on the one hand who at the slightest sign of injury come to the trainer or doctor wanting treatment, when nine out of ten times no treatment is required. These are the chronic complainers and every squad has them. On the other hand, there are boys who never complain of injury, and in many instances are as bad or worse than those who fall in the former group.

All of us can recall cases in which a boy failed to report an injury, simply because he didn't think it serious, only to have something big crop up a couple of days later. It is generally agreed that one of the big jobs to confront the trainer and team physicial is getting to know the boys well enough to distinguish between the complainer and the non-complainer.

Many doctors participated in athletics when they were in school, and this can be a tremendous advantage, especially if he played a contact sport, such as football. Not only does it leave him with a true sense of values for the game, but it gives him a wealth of first-hand information on athletic injuries, and more important, on athletes themselves.

It is essential that the trainer and team physician get along well together, and that each cooperates with the other. Each should feel free to call on the other for help, since a great deal of good has been realized in the past through the exchange of ideas, opinions, and suggestions.

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The consideration of a physician's background is quite important when securing his services. Most colleges, although not all, acquire the services of an orthopedist. The reason is evident, since the most serious injuries in contact sports are usually to the skeletal or related structures. Let it be added, however, that many fine team doctors have specialized in other fields.

Generally, high schools have at their disposal the services of a general practicioner, who in most cases is quite able and willing to handle athletic injuries. It should be realized, however, that the injury experience of most general practicioners is limited, and he should not hesitate to call in a specialist whenever the injury warrants such action.

A good background in injuries is a great asset to any team doctor. Athletic injury studies, which have been made over the past two decades, will be of untold value to anyone working in the area of sports injuries. Such studies are largely responsible for the great advancements which have been made in the past, not only in the prevention, but also the treatment of athletic injuries.

The latest advancements in physical therapy and related fields should be kept abreast of by the team doctor, for in this age of speed we are striving more and more to shorten the recovery period.

Whenever possible the physician should arrange his schedule so that he will be able to attend both practice and game sessions. Trainers for the most part are quite competent, but they are the first to admit that it is essential to have a physician present as much as possible. The trainer has his limits, and more important, he realizes them.

Although experience in injuries and their treatment is desired in a team physician, it should be noted that many of our fine team physicians never had any real injury work until starting in athletics. It may take him a little time to orientate himself into athletics, but through study and first-hand experience "on the field," he will adjust himself to this new program in a comparatively short time.



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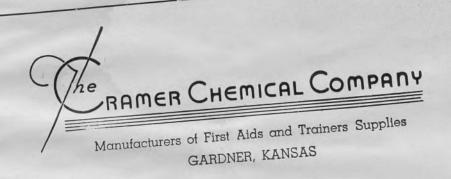
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To the Members of N. A. T. A. :

We feel that a part of our obligation to the training profession is to help acquaint the Athletic Director, and each head coach, with the necessity for greater cooperation with the trainer and his department.

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For many years the trainer has been considered as a necessary evil. The thinking of the coach has been in reverse. He should have made the trainer his first assistant were had him attend all strategy meetings and become a more - had him attend all strategy meetings and become a more efficient working member of the staff.

Check your most successful teams. You will always find the trainer carrying a part of the departmental load as well as treating the injuries.

Cordially yours,

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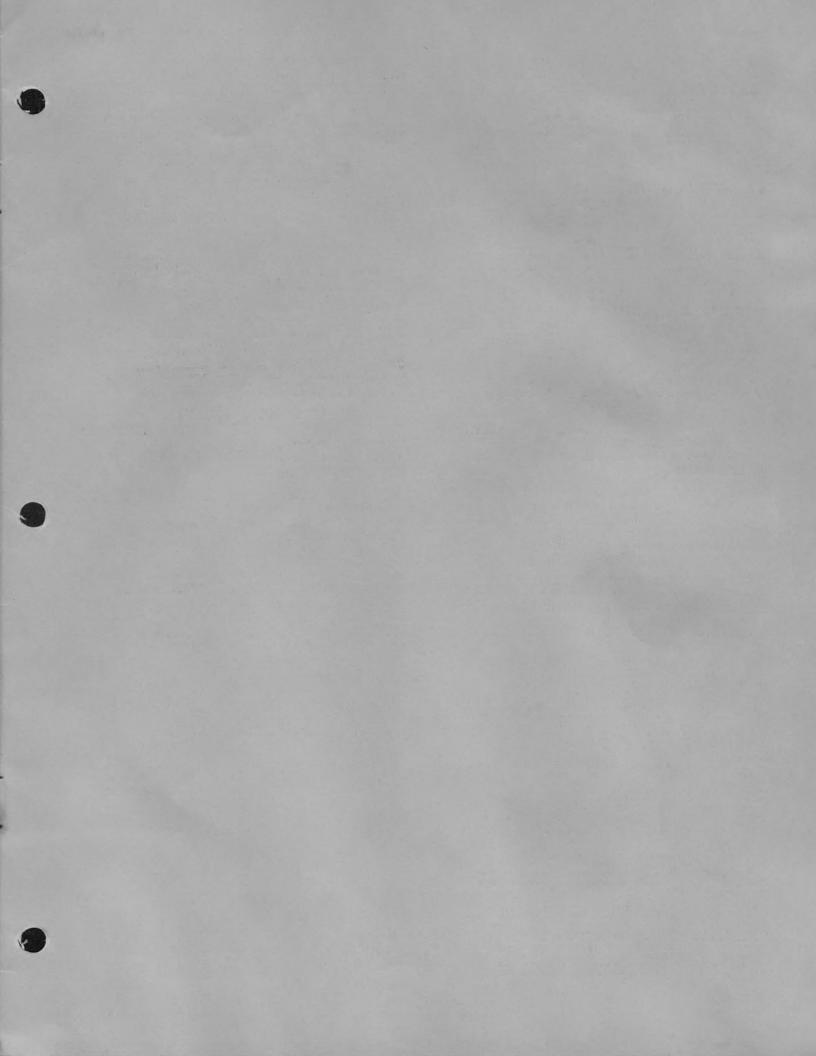
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