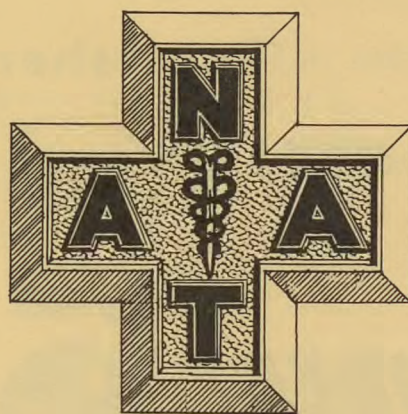


The

FALL 1961

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OF THE
NATIONAL
ATHLETIC TRAINERS
ASSOCIATION



13th ANNUAL MEETING

ALBUQUERQUE, NEW MEXICO, JUNE 11, 12, 13, 1962

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THE JOURNAL OF THE NATIONAL ATHLETIC TRAINERS ASSOCIATION

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EDITORIAL

Everyone who missed the convention in Madison, missed a very fine meeting and social get-together. Walt Bakke and Tom Healion did a very fine job in every respect. The editor would like to urge everyone to try to make next year's convention in Albuquerque.

If our group plans to continue our present advancement we must have a strong representation at all meetings including district clinics.

Received in the mail today a very fine newsletter from the Southwest Trainers Group. Hats off to Jerry Rhea of Ector High School, Odessa, Tex., for a job well done.

In the past few years there has been much talk in regard to hard versus soft padding for the football player. This subject has been kicked around various discussion groups including trainers, physicians, coaches and sporting goods manufacturers. And now in the past few months there is a growing feeling that the face bar is responsible for a great number of head and neck injuries.

The advocates of each type of protective equipment have their strong points. I feel all hard surface pads should be eliminated. This would include padding the outside of the helmet, eliminate the face bar and nylon and steel-tipped cleats. I sincerely believe that many of our football injuries today are caused by hard-surfaced padding. The present day helmet is a true weapon and the face bar gives the boy a false sense of security. The complaint heard from so many coaches is that you cannot hear the so-called leather pop with soft padding. I cannot see that this reason justifies continuing the danger of traumatic injuries, when in fact soft-padding would not change the execution of the present day game.

Another objection of the schools and manufacturers is the cost of transition. This could almost be eliminated by giving everyone five years to make the change. This would be the expected lifetime of almost any piece of equipment now in use. The mouthpiece could replace the face bar if a rule could be made to that effect. For face protection on an injury situation, the old clear plastic mask could be substituted. I would like to urge all trainers and coaches to discuss this subject, make an evaluation, and let me hear your opinion.

I would like to request that everyone try to sell the high school coaches in your area to subscribing for the Journal. Send the subscriptions to Lewis Crowl, Sacramento State College, c/o Athletic Dept., Sacramento, Calif.

EDITOR'S NOTE

In the Spring 1961 issue of the N.A.T.A. Journal we presented an article on "Pre-Game Emotional Tension" written by K. D. Rose, M.D., and S. I. Fuenning, M.D. We inadvertently failed to acknowledge that this article was reprinted from the December 1960 issue of the Nebraska State Medical Journal, Volume 45, Number 12. Pages 575-579.

THE SECRETARY'S REPORT

Twelfth Annual Meeting of National Athletic Trainers Association June 12, 1961

The twelfth annual meeting of the National Athletic Trainers Association was held in the ballroom of the Loraine Hotel, Madison, Wisconsin. The meeting was called to order at 3:45 P.M. by Chairman of the Board, Tow Diehm.

The roll call was dispensed with.

The minutes of the 1960 meeting at Kansas City, Missouri, were approved without being read. The report of the Board of Directors' second meeting was approved without being read.

The treasurer's report was approved as written.

The secretary read the report of the Chairman of the Board of Directors.

Report of the Chairman of the Board of Directors

1. The secretary reported on business transacted through the year.

a. During the past year the Association has made a great deal of progress. We have received recognition from many areas.

b. Last December at the A.M.A.'s Committee on the Medical Aspects of Sports second annual conference on athletic medicine, the Committee gave N.A.T.A. a full measure of tribute for conducting association business as an ethical professional unit.

c. In January, the N.A.T.A. was represented at the Pittsburgh meeting and a report was filed to you at an earlier date. The coaches and directors are cognizant of our attempts to raise standards, professional and educational, as reflected by their eagerness to accept higher qualification in the athletic training position specifications.

d. The March meeting of the A.A.H.P.E.R. in Atlantic City gave N.A.T.A. the opportunity of expression in another area. I was privileged to sit in on the professional preparation conference for men's athletics, administration and athletic training. N.A.T.A. was represented at eight meetings in four days. At the athletic training section meeting the officers were all members of N.A.T.A. and the program presented Ernie Biggs, Ohio State; James Feurig, M.D., Michigan State; and Loyal W. Combs, M.D., Purdue. These men are also members. New officers for next year will be Vernon Barney, Brigham Young, past chairman; William Newell, Purdue University, Chairman; Art Dickinson, Jr., Arizona State University, Secretary—all N.A.T.A. members.

e. Last month in Detroit, Millard Kelley, Detroit Lions, represented N.A.T.A. at the annual meeting of the American College Health Association and also appeared on the program. Samuel Fuenning, M.D., recognized N.A.T.A. as an allied association.

f. In other business of our Association, a new committee was approved for screening articles of worth to submit to the professional journals. They have been given the additional duties as associate editors of the N.A.T.A. Journal to assist the editor with his responsibilities.

THE SECRETARY'S REPORT (Continued)

g. Bill Dayton, Yale University, was elected unanimously to succeed Professor Pennock on the Nominating Committee to the Helms Hall of Fame.

h. Approval was given to a proposed course of action as proper procedure when a member becomes deceased. This is now in effect. District directors should appoint a memorial resolution committee to write an appropriate memorial for any member who has died during the past year to be presented for approval at the national business meeting.

It was moved and seconded that the report be approved.

2. The Chairman of the Committee on Committees gave a combined report of all of the Standing Committees.

a. Membership—It was decided that we should not include members of the dental profession in our advisory membership. It was moved, seconded and approved.

b. Ethics Committee—It was reported that there were no infractions through the year. It was decided that N.A.T.A. should make an endorsement of the Athletes Bill of Rights. The endorsement will be in the form of a letter directed by the secretary to Dr. Allan Ryan, Chairman of the A.M.A.'s Committee on the Medical Aspects of Sports. It was moved and seconded that the report be approved.

c. 25 Year Award—No report given.

d. Honorary Memberships and Awards—The committee elected to membership Charles Yocum of the Becton-Dickinson Co., Rutherford, New Jersey. Last year's exhibits manager and program chairman were awarded the N.A.T.A.'s medal. It was moved and seconded that this report be approved.

e. Injury Report—It was reported that the N.C.A.A. Sports Injury Report has been published and is available to the N.A.T.A. membership. It was moved and seconded that this report be approved.

It was moved and seconded that the report of the Chairman of the Committee on Committees report be approved.

3. The Special Committees and representatives were heard.

a. The Nominating Committee for the Helms Hall Board reported by a letter directed to the Chairman of the Committee from Bill Schroeder stating that the Helms Hall Board would take action on N.A.T.A.'s nomination this June. It was moved and seconded that this report be approved.

b. Duke Wyre, N.A.T.A.'s representative to the United States Olympic Association, gave a report on the last Olympiad and remarked about some of the recommendations that would be made to the next meeting of the U.S.O.A. It was moved and seconded that this report be approved.

c. Future affiliations were discussed and it was reported by the secretary that exploratory letters had been directed to officers of the N.J.C.A.A. and the N.A.I.A. It was moved and seconded that this report be approved.

d. The Board of Directors have made a decision to go to Lexington, Kentucky in 1963. Miami Beach will serve as an alternate site.

4. Other new business heard by the Board was approved as recommended.

a. Selection of new Chairman of Board of Directors.

b. It has been suggested by Rosie Collins of District No. 7 that the national secretary check on the cost and if within reason make available the N.A.T.A. pin with a chip diamond in the center of it to the twenty-five year members at the member's own expense. *Recommendation:* This should be turned over to the Twenty-five Year Award Committee for consideration and appropriate action.

c. It has been suggested that the Board of Directors (1) encourage the stronger enforcement of rules by officials regarding illegal equipment such as taping of hands, and various other pads, etc.; (2) go on record as recommending all football helmets be covered with absorblo or be made of softer materials; and (3) endorsement of the recommendation on athletic activity in hot weather. *Recommendation:* This should be turned over to the Sports Injuries Committee for consideration and appropriate action.

d. It has been suggested by Walt DeLand that we set up a "nutritional research committee" to make a study on "Nutrition and Its Relationship to Athletic Injury, Conditioning and Health." *Recommendation:* Since A.A.H.P.E.R. has established the Committee on the Health Aspects of Injuries and Sports and they have been given the assignment as a first project for the synthesizing of all available materials in a readable manner, N.A.T.A. should wait until this is a published fact to eliminate a duplication of efforts.

e. The Executive Secretary will become salaried.

f. It was decided that at next year's national meeting a registration fee would be required of all attending the program other than exhibitors and guests. That this would be independent of any dues. The fee was established at \$4.00.

g. The national program this year has been taped and the secretary will see that it is typed and the program chairman will send each lecture to the clinic speaker involved for editing. When returned it will be published as a service to the membership. The approximate date of publishing will be January 1.

h. N.A.T.A. has been approached with the possibility of joint meetings being established with two associations: (1) The A.M.A.'s Committee on Medical Aspects of Sports, and (2) The American College Health Association. It was decided that the secretary explore the possibility of their changing their meeting dates to coincide with that of ours.

i. These men were appointed for three year terms to the following committees:

Membership Committee

Tom Sheehan, Rensselaer Polytechnic Institute
Fred Wappel, Missouri
Bob Hand, San Diego

Code of Ethics

Dean Kesmith, Kansas
Jim Hunt, Michigan

Injury Committee

Jim Stultz, Colorado State
Dick Wargo, Connecticut

THE SECRETARY'S REPORT (Continued)

Constitution and Bylaws
Jules Reichel, Syracuse

Twenty-five Year Awards
Henry Schmidt, Santa Clara

Honorary Membership and Awards
Ernie Biggs, Ohio State

5. Bill Newell was re-elected as Executive Secretary. The report was moved for approval, seconded and carried.

Committee Reports

Constitution and Bylaws

Charles Medlar, Chairman, reported that there were two new committees approved by the Board of Directors this past year. The report was read as they will appear in the Bylaws:

ARTICLE VI - COMMITTEES**Section 1.**

- (m) Professional Journals.
- (n) Memorial Resolutions.

Section 2. Composition and functions of the committees.**(m) Professional Journals:**

Chairman and five members. To screen and to give titles of articles to the professional journals that deal with significant aspects of athletic training. To suggest people who might write these articles. The members of this committee should be given titles as associate editors of the N.A.T.A. Journal and should assist the Journal editor with his duties.

(n) Memorial Resolutions:

Appointed by respective district officers. Upon the death of a member of the N.A.T.A. this committee should write a memorial of approximately one page. This resolution should be presented to the secretary and handed to the active membership present at the national business meeting. The committee should then have the resolutions approved and entered in the minutes of the meeting and send a copy, along with a letter of sympathy, to the next of kin.

Twenty-five Year Award

Laurence Morgan, Chairman, presented one member for award. The recipient was Lloyd Stein, University of Minnesota.

Program

Tom Healton, Chairman, expressed his appreciation to those who participated in the program. Walter Bakke, host trainer, expressed his appreciation to the membership for coming to Madison, Wisconsin. This was received with a standing ovation.

Exhibiting

Warren Airail, Exhibits Manager, expressed deep appreciation to the companies exhibiting.

It was moved, seconded and approved that the committee reports be accepted.

It was called to the attention of the members that Professor Penneck, Springfield; McKinsey, Montreal, Canada; Doyle Alsup, Iowa University; and Mrs. Walter Bakke had passed away during the past year. One minute of silence was observed in honor of the deceased members.

A standing ovation was given to Tom Healton, Chairman, and Warren Airail, Exhibits Manager, for a job very well done.

Con Jarvis, Stanford University, made a proposal to the membership:

1. We the N.A.T.A. do unanimously endorse and wholeheartedly support the National Physical Fitness Program.

2. We the N.A.T.A. stand ready as a technically qualified body to give without limitations our specialized assistance to the physical care of men, women and children throughout this great United States of America in the event of a national emergency.

The proposal was unanimously approved and received with applause.

Tow Diehm presented the new Board of Directors:

District No. 1, Michael Linkovich, Bowdoin College

District No. 2, Joseph Abraham, Hobart College

District No. 3, William Fry, University of Maryland

District No. 4, Mel Blickenstaff, Columbus High School

District No. 5, George Sullivan, University of Nebraska

District No. 6, Weaver Jordan, Baylor University

District No. 7, Marshall Cook, Montana State College

District No. 8, Mel Moretti, College of the Pacific

District No. 9, Wesley Knight, University of Mississippi

Weaver Jordan, Baylor University, was presented as the new Chairman of the Board of Directors.

It was moved by Jack Heppinstall, Michigan State (retired), that the Board of Directors consider changing the national business meeting to a more appropriate time. This was seconded and approved.

Weaver Jordan presented an award to Tow Diehm, past Chairman of the Board of Directors, and expressed the association's appreciation for the conducting of the national business through the past year.

Tow Diehm was given permission to discuss Albuquerque as host trainer for the host district. Next year's meeting is to be held in Albuquerque, New Mexico.

Joe Blankowitsch was given a hand for his handling of the registration desk.

Having no further business before the floor, the meeting was adjourned at 4:25 P.M.

William E. Newell, Executive Secretary

Larson's

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Specific Gravity at 20° C. — 1.248
Drying Time —
approximately 30 seconds

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Dichlorophene..... 0.133
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N.A.T.A. TREASURER'S REPORT

June 1, 1961

Balance on hand June 1960.....\$2,179.98

Deposits:

Dues	\$2,105.00	
Sale of Pins and Emblems.....	55.50	
National Meeting Surplus.....	779.07	
1960 Registration Fees.....	192.00	
Journal Advertisements	626.66	
Journal Subscriptions	14.00	3,772.23

Disbursements:

Lafayette Mailing Service.....	371.42	
Journal (4 issues)		
Rosters, Envelopes, Constitution,		
Bylaws and Code of Ethics,		
Membership Report Forms.....	1,831.15	
Secretarial Expenses	1,030.60	
Office Supplies	266.00	
Dues to Affiliate Associations.....	50.00	
Miscellaneous	376.08	3,925.25

Balance on hand.....2,026.96

Checks not canceled.....	1.00
	396.50
	236.53

Certified Statement from Bank.....\$2,660.99

N.A.T.A. Membership - 1961

Active	331
Associate	175
Allied	24
Advisory	103
Honorary	6
Retired	2
Total	641

A.M.A. TO STAGE THIRD NATIONAL CONFERENCE ON MEDICAL ASPECTS OF SPORTS

The Third National Conference on the Medical Aspects of Sports sponsored by the American Medical Association, under the auspices of the A.M.A. Committee on the Medical Aspects of Sports, will be held in Denver, Colorado, at the Cosmopolitan Hotel on November 26, 1961. The Conference will be held in conjunction with the annual Clinical Meeting of the American Medical Association, November 26-30, 1961.

As was true of the previous Conferences on this subject held in Dallas, Texas, and Washington, D. C., the Third Conference will cover a wide range of subjects. Included will be papers, panels, and discussions relating to training and conditioning, prevention of injuries, recognition referral and treatment of injuries, the physiology of sports participation and other subjects.

Those interested in receiving announcements concerning the Conference should address the Secretary, Committee on the Medical Aspects of Sports, American Medical Association, 535 North Dearborn Street, Chicago 10, Illinois.

NEWS RELEASE

from the American Medical Association

CHICAGO—The "dog days" of late summer offer a special hazard for high school and college football players.

This is the season of the year when sports fatalities due to heat exhaustion or heat stroke are likely to occur, two national organizations have reported.

The groups, the American Medical Association's Committee on the Medical Aspects of Sports, and the National Federation of State High School Athletic Associations sounded their warning prior to the opening of the 1961 football season.

The National Collegiate Athletic Association in a report to member institutions issued a similar statement.

Heat exhaustion and heat stroke have frequently been incriminated in football fatalities; in 1959 four such deaths were reported.

These fatalities usually occur during late summer practice sessions which are conducted in very warm and highly humid weather.

During this stage of training, athletes are not accustomed to hot weather activity. As a result, salt and water in the body are depleted due to excessive sweating which causes heat exhaustion. Heat stroke develops from overheating due to lack of sweating.

Symptoms of water and salt depletion may include headache, nausea, hallucinations, and weak and rapid pulse.

During exercise in the heat, it is essential to replace the water, hour by hour, lost by perspiration. Intake at any one time, however should be held to one-half water glass or less.

Extra salting of the athlete's food, within the bounds of taste, will help in salt replacement. Or one teaspoon of salt may be added to six quarts of the water used for drinking during practice sessions.

The three organizations offered the following suggestions to help coaches prevent heat exhaustion and heat stroke during this period:

—Require a careful medical history and check-up prior to the beginning of practice.

—Schedule workouts during cooler morning and early evening hours.

—Acclimatize athletes to hot weather activity by carefully graduated practice schedules.

—Provide rest periods of 15-30 minutes during workouts of an hour or more.

—Supply white clothing (to reflect heat), loose and comfortable (to permit heat escape), and permeable to moisture (to allow heat loss via sweat).

—Furnish extra salt and water in recommended amounts during hot weather.

—Watch athletes carefully for signs of trouble, particularly the determined athlete who may not report discomfort.

—Remember that temperature and humidity, not the sun, are the important factors. Heat exhaustion and heat stroke can occur in the shade.

PRE-SEASON TRAINING

ROSS MOORE, Athletic Trainer

Texas Western College

El Paso, Texas

Step number one in pre-season training is a thorough physical examination by a competent physician of every potential ball player. There should be a form for the doctor to fill out that will specifically show whether the boy is fit for contact sports. Player, coach, and trainer should follow the doctor's recommendation.

The preliminary training for the season should start a month before the first practice, if a game is scheduled for two or three weeks later. At least six weeks must be taken to get in good physical condition.

The factors involved in the overall training program are balanced diet, proper sleep, and graduated muscular exercises.

You, as coach or trainer, should emphasize the importance of diet and sleep. Insist that the boys eat three balanced meals a day and forget about the snacks in between. Emphasize too, that they need 8-10 hours sleep at night. The boy who gets only a few hours will be lazy and sluggish; he will loaf in practice; and he is more likely to get hurt.

The athlete inherits the potential qualities of his body, but there is still much that he must do to develop that into a strong and efficient machine. Conscientious training and right living can strengthen and bring out one's natural abilities, such as a strong heart, good wind, steady nerves, strong vital organs, speed, proper muscular strength, muscular coordination, and stamina or staying power.

A large part of the conditioning program should be running to build up stamina. There should be some charging to develop leg muscles. Gymnastics, limited weight lifting, and bar work are good to build arms and shoulders. The players, too, should include as many football skills as possible in this training—for instance, an end can develop wind and legs while practicing catching passes. Each player should try to build up his body. Extra weight is very desirable if it is in the form of muscles and not fat. And faithful practice will do much to make up for lack of natural coordination.

When you start your training program, have a definite set of exercises to give that will develop the whole body and not just a few parts. Stretching exercises are particularly beneficial. Regular and graduated exercises will cut down on your minor injuries in early training.

One of the most common minor injuries is the groin pull, which, though not serious, is enough to slow a boy down. It is my opinion that this groin muscle is pulled when a player tries to drive off the inside of his foot, causing strain on that particular muscle. To prevent this condition, explain and demonstrate to the player the proper position of the feet when executing a block or pulling out of the line. Have him turn the toe and knee of the back leg in a straight line forward, and he will see how much more drive he has and how much pressure it takes off the groin muscle.

Players who have old injuries, such as to the knee and ankle, should be given special exercises to strengthen the parts affected. *The coach or trainer should supervise*

Continued on page 8

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PRE-SEASON TRAINING

(Continued)

these exercises, which should be begun, if possible, during the summer. Exercising four times a day, for fifteen minutes at a time is more effective than once a day for an hour.

Mountain running (if you have mountains) is a good strengthening exercise for knees. We even recommend it and use it for rehabilitating knees that have been operated on. Having the boys run the stadium once a day is also beneficial.

In early practice when the weather is hot, players should be given some water (about mid-practice) to which a little salt is added—a teaspoonful to about seven gallons of water—in order to keep the salt content of the body up. A boy's muscles, mind, and nervous system must function as a whole for him to give his best performance, and this is impossible if the body fluid gets off balance.

Players should also take salt tablets each day to re-furnish the body with salt that is lost through perspiration. They will help prevent cramps in the muscles.

Blisters are common in early season. Players should be instructed to report to the coach or trainer as soon as he has a blister so that infection may be prevented. Lots

of boys think they are tough and will ignore a small thing like a blister unless it is impressed upon them that they might miss a game later on.

In early season we use Tough Skin and powder to protect the feet. Most blisters can be eliminated by having properly fitted shoes. Boys often get shoes too long in order to have them wide enough. Too much room in a shoe leads to friction which causes blisters. Shoes come in nearly every width now and should be ordered early. Our boys wear only one pair of socks for both football and basketball.

My treatment for blisters is to cut the skin away, then put athletic ointment under a sterile dressing for off-the-field wear. During practice I use Mole Skin with a hole cut out around the blister to which I apply a small amount of vaseline and a sterile dressing.

Last, but certainly as important as any other factor involved in the physical welfare of your players, is the condition of your practice field. The field needs care all year long in order to be grassy and soft and ready for play. This fact can't be stressed too much to coaches and school officials. If all your money goes to fancy equipment and you let nature take care of your practice field, you are likely to have more injuries than nature or anybody else can heal by the time you are ready to **PLAY BALL!**



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PROCTOLOGICAL PROBLEMS IN SPORTS

By DR. MAX PHILIP COWETT

Associated Bellevue and University Hospital,

Chief Proctologist of St. John's Hospital

(A copy of the talk given at the Eastern Athletic Trainers Association Meeting and Clinic held in New York on January 16 and 17, 1961.)

I have been told that this is the first time a talk on the rectal or anal conditions of athletes has ever been given. As you trainers and coaches know, it is nice to be the first one.

Before discussing the proctological conditions in athletes, I want to make it clear that athletes are not immune to any condition or any disease that the lay public or people in other groups have. They are prone to everything. What are the most common conditions in athletes? As I see it, the most common condition firstly, are hemorrhoids. What is a hemorrhoid? A hemorrhoid is nothing but a dilatation of the venous plexus in the rectum. One wants to remember they are veins, not arteria. Some of the arterioles, the smaller arteries go into the formation of hemorrhoids too. Anything that causes a stasis in the intestinal tract or a congestion can produce hemorrhoids. Athletes are more prone to this. Am not going to give a diadactic talk on the causes that produce hemorrhoids. If I did, it would take me two hours. In athletes, the main cause is constipation. Why do they develop constipation? They develop constipation because as the previous speaker said they are tense, they are anxious, they lose a lot of fluids, they develop a spasticity of their intestinal tract. The majority develop a spastic colon. So, there is a congestion in the venous plexus and a back flow as a result of this spasmus. Now if you can remember that physical fact, that they develop a spasmus, in other words a slowing of the blood stream going back into the portal circulation. That primarily is the cause. They also develop infections which causes an edema and swelling and in that way produce pain and spasm. What types of hemorrhoids are there? To the trainer, to the coach or to the physician we speak of two types, the external and the internal. The external are minor things, and you can tell today on Monday, after the storm, athletes especially who go skiing, hockey players who are out on the ice or people going to football games or football players who sit on the cold ground in the fall, people going to football games in open stadiums, like the Yale Bowl or the Columbia Stadium. Spectators and players sitting on a wet seat can develop thromboses, which are clots in an external vein and cause pain. They are simple things. Your doctor can remove those clots and they won't incapacitate the individual if the clot is removed. If they are not removed, they are painful and the individuals are out of training or out of commission. We get these in the fall season, in the winter season, once in a while in the summer, a swimmer sitting on the wet sand or on the edge of a swimming pool will develop the same thing. Jockeys and people who do horseback riding develop these as well.

The other type, which is more serious, is the internal type. They are the type that a lot of times the athletes would tell you about. They bleed a little but will not make any comment unless they have pain. They develop pain with hemorrhoids as a result of a break in the mucosa which some trainers or some coaches know, and doctors know as a fissure. It is like a cracked lip here.

These are very painful lesions and they usually occur between two hemorrhoids or as a result of straining at stool. That's what these tense young men do, they strain and push quite a lot and they develop hemorrhoids and breaks in their mucosa. If this continues, the hemorrhoids will develop first a mucosal outgoing so to speak, and they develop prolapse. I have seen a few athletes, very few, who had a real prolapse which is bad, because they have to have a major operation and probably have to be incapacitated from athletic activities for any future time. But, a fissure which is painful produces other things. The next most common thing in athletes are infections around the anus and rectum. Infections as a result of, we know, that organisms are present in the intestinal tract all the time. Some of them are not pathogenic but they become pathogenic when resistance of the individual is low and he is all petered out and some of these non-pathogenic organisms become pathogenic and develop serious infections. Starting out as a fissure initially, the infection spreads towards the posterior and they develop abscesses and then fistula.

The thing I want to warn trainers and coaches about is that when you have these individuals, these young athletes who develop infections like a fissure and a fistula don't temporize. Have them consult their doctors, for the simple reason that the longer you delay, the greater the damage. The ultimate damage will result into a fistula. If you open or treat a fissure initially you can cure it, if you open an abscess, don't rely like a lot of people do on antibiotics. To my mind they are necessary, but they have been over-rated. The only way to treat an abscess is to open them up high, wide and handsome because drainage is what counts. Get the pus out and you clear up the abscess.

What type of athletes develop abscesses? What are the factors besides the fact that there is a break in the mucosa? The type of athletes that develop infections are the wrestlers, hurdlers, broad jumpers which I have seen, and pole vaulters and people who get infections as a result of trauma, they fall on their so called sit-downs and they injure the exterior and probably have a previous fissure or large hemorrhoids that aided the infection. There is also the question of clothing that either baseball players or football players use, the jock straps are a little tight or their running pants are tight and infections occur due to trauma. They sweat a lot in this region and that produces infection. Also, I should say, their bowel function is not good, they are constipated, and as a result they can't combat infection like the ordinary individual. That occurs in other groups of individuals, but in athletes who are tense, they develop more frequently.

There is another type of infection besides the so-called fistula, there is a condition that trainers, coaches and doctors know in which there is a congenital defect at the base of the spine. You probably know it as a pilonidal cyst. Many of these are asymptomatic until they are injured in this region, getting kicked at a football game in the posterior or falling and as a result of traumatization they develop infections and these require operations.

What are the other conditions that develop in athletes? So-called irritation around the anal orifice, a result as I said of poor rectal hygiene. A lot of athletes, whether you come from Princeton, Yale or Harvard, don't know how to clean themselves, it is true. I see it more than the GP or the medical man. It can occur in individuals on Wall Street, or a President of a corporation. They come in and you look at their underwear and it is dirty. That causes

PROCTOLOGICAL PROBLEMS (Continued)

an irritation and it starts itching. There may be other factors besides the mucous discharge from hemorrhoids that causes this irritation. I don't know whether you people require new jock straps every day, some of them are rarely washed. The only way you can clean these up is by autoclaving and I don't know whether your training table is equipped with an autoclave but I would suggest it if you get many of these perianal infections. Any skin condition that occurs in other parts of the body such as eczema, psoriasis and many others are irritating. I have seen several cases in athletes of inflammation of nerve ends. You probably refer to it as shingles if this condition is seen on the chest. I have seen it around the anus and it is the most painful condition in the world. You can get fungus infections, especially athletes develop athlete's foot or feet. They start scratching, don't clean themselves and then they scratch about the anus. This condition is frequent and if detected early can be cleared up. In young athletes I have seen two cases of pinworms which caused perianal irritations. In prep schools it may occur, and also in the older group. Have seen irritations in swimmers around the anal region and also in the axilla as a result of chlorine irritation and they are nasty things to treat. There are certain people who develop allergies, some people can't eat strawberries or tomatoes, or fish, or whatnot, and those individuals whether they be athletes or other groups may develop an irritation.

Young people can develop polyps or have polyps I should say, and are rarely diagnosed by the doctor at college or prep school or the club. They are found usually on proctoscopic or x-ray examinations. I tell you this story. About fifteen years ago, I had a young man referred to me from a prep school in Connecticut who was in a hurdle race or a dash, I forget which, and he collapsed. They had found blood on his shorts and the doctor up there sent him to New York. He sent him to a friend of mine who said "I can't find out what's wrong with this boy." I examined the boy and found he had a polyp about five or six inches from the anal orifice. It was non-malignant and we removed it and he never had any more trouble. These polyps can only be detected by x-ray or by proctoscopic examination.

Another condition which can be detected by proctoscopic or sigmoidoscopic examinations is the colitides. You people who send teams down across the border to Mexico, to South America, etc., and I have had one athlete that came back from South America and I've had a ball player too, came back with amoebic colitis. If he hadn't got back early, he would have been a sick boy. So, you want to be on guard if you send them abroad or down south, be on guard for colitis whether it be amoebic or other types.

Now in closing, and more serious, our greatest threat in medicine and surgery is cancer. I am going to tell you a story of a second year medical student who was a basketball player in Michigan. He came down to our school, and was the nicest boy I have ever seen, handsome and stocky. Our Chief Surgeon Dr. Wright said "this boy is bleeding, I think he has hemorrhoids, will you see him?" I said, "Sure I'll see him." The man came into my examining room and I examined him. Within reach of my examining finger I felt one of the biggest masses I have ever felt. This boy was only 24 years old. I walked back to Dr. Wright and I said, "Arthur this boy has a cancer." He said, "Get out of here, you're crazy." The end of that story was the boy was operated on within two weeks and it was proven cancer, he died within six

months. The point I want to make is this. In these younger groups, if you spot a cancer early, you may do him some good but if you don't, they are dead "ducks." So, the lesson I want to tell you trainers, doctors and coaches is, that you know specialists can become very narrow. They think their specialty is the only one that is important. If we are going to save people from developing cancer, there is no reason why they can't have a good rectal examination by a competent man.

I should have been the last one on the program because that's my specialty. I may have given you trainers and coaches a pain in your "sit-down" that you sometimes get when you're being pushed around by the alumnae or whatnot for not having winning teams but, if I can get this message to you, don't allow these minor rectal conditions to go too far in athletes. If you get them early, you can clear them up but if you don't you get into trouble.

Thank you ever so much.

Question: I am not a trainer, but here as a newspaperman, but something occurred to me doctor. Is it possible for a fellow to develop any rectal disorders from sitting on the bench too much?

Dr. Cowett: If it is a cold day and it is wet—yes, that is possible.

Question: We have problems with professional athletes doctor, we play in cold weather frequently, we haven't had a chance of warming up, would you say a warm up is necessary as a preventative against any anal conditions such as hemorrhoids, before they go out to play the game?

Dr. Cowett: No, I don't think so. Let me tell you something about concentration. This is probably going to hit the newspapermen, but the public has been brain-washed by newspapers, TV and radio on constipation. Constipation is really a relative thing. We did a piece of work several years ago or maybe ten years ago. We took four hundred students, did x-ray studies on them with markers and in only about 40% of those 400 had bowel movements in other words, every day. Normal individuals, the rest of them had bowel movements every two days, every three days. There are some normal individuals who have bowel movements twice a day, three times a day, so the thing that causes hemorrhoids, constipation is a relative thing. In some individuals I say they move normally once a day, in some people twice a day. We had one group, one student once every five days without developing any toxic symptoms, headache or anything else or spasms, and he had no hemorrhoids. Does that answer your question?

Question: I was just wondering about strain?

Dr. Cowett: There is no question that straining a stool is a factor.

Question: Well, I was wondering about strain when they are cold and they have to compete, and the strain on their intestinal tract?

Dr. Cowett: I don't think that is a factor. You have a good man down in Philadelphia, Ted Bacon, if you ever get in trouble about hemorrhoids.

Question: How effective is a sitz bath after a cold day on the bench?

Dr. Cowett: Very good. It reduces the—if you have hemorrhoids that's what they use. If you have a fissure that's what we tell you to do.

Question: Doctor, we've had problems rectally with professional basketball players, quite a few of them through the years. How much of a problem would it be in the pre-season physical for a GP to do say a series of



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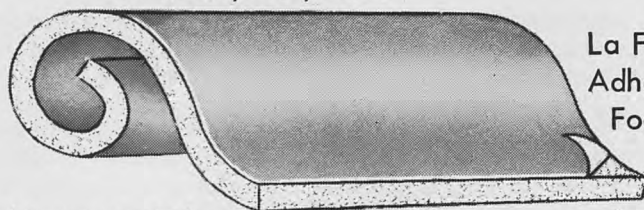
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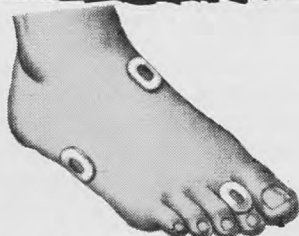


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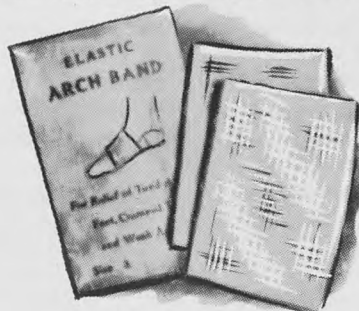
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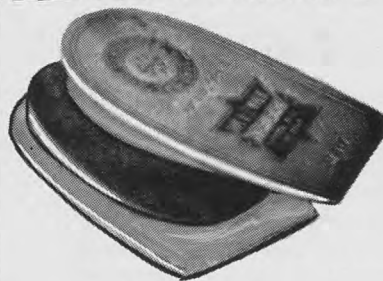
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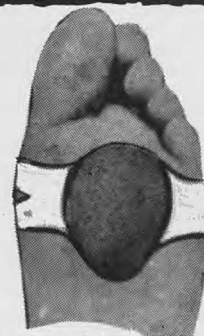
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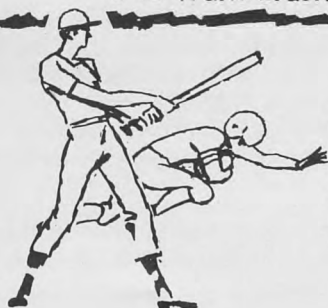
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PROCTOLOGICAL PROBLEMS (Continued)

20 of them at a time—you would have to have 20 proctoscopes, is it practical in a physical?

Dr. Cowett: If he is competent, I'd say yes, and some of them are. It all depends, we have some poor doctors, I hate to say this, and we have just as you have, some poor trainers and some poor coaches. I think preventative measures and good public health measures is an excellent idea.

Question: In other words, just going further than just with the light and a routine look for just external hemorrhoids would be a good policy but is it practical in say just a school situation or where there are a lot of men going through—it wouldn't take too much time would it?

Dr. Cowett: Let me tell you something. I'm consultant in a few of the commercial firms and they require every one in their company to be protoscoped, why can't athletes?

Question: But, it is something that is not done in most instances with routine physicals.

Dr. Cowett: It should be done. I told you I am narrow. Specialists are narrow, they can only see their own specialty. We think it should be done because if you can prevent cancer and polyps which are the precursors of cancer you are going to be better doctors and more helpful in helping mankind.

Question: Doctor, is there a particular body type more prone to rectal difficulties?

Dr. Cowett: That is a good question. These short stocky individuals probably are more prone. It is not true though, I mean completely true. I see them more frequently, they strain at stool, they have shorter venous channels, there is also a generic factor too, that some people have a weakness in their venous system. I have operated on mothers and subsequently their daughters or sons have had hemorrhoids. As I get older I get the sons and daughters of parents who I have operated on for hemorrhoids. It is a congenital thing as well. Does that answer your question?

CONCUSSIONS

By DR. ROBERT E. MORGAN

To me, the concussion is the most serious injury that an athlete can receive. Of 117 football deaths occurring in colleges and schools between 1931 and 1934, 78 were caused by injuries to the head and neck. These figures are according to Lloyd, Deaver, and Eastwood. Eastwood, however, reports in The Fourteenth Annual Survey of Football Fatalities that in 1945 only six deaths were reported: only three in high school and three in sandlots were reported to have died of head injuries. This is about one fatality for every 200,000 players.

In most states, when a boxer is knocked down three times in one round, the fight is stopped. In some states, a boxer cannot participate in a contest for six weeks after he has been knocked out.

The term "brain concussion" describes absolutely nothing as far as medical diagnosis is concerned. It actually refers to an abnormality of behavior following a blow to the individual's head. All do not agree on what happens in the skull frame after trauma. However, most agree

that there is a loss of blood to the brain because of compression of the ends of blood capillaries, causing loss of nourishment. The period of unconsciousness following a brain blow is usually short-lived.

Three types of concussion in athletes are recognized.

1. Mild type in which the patient is momentarily knocked out. He regains all his intellectual functions immediately.
2. Mild type in which the person is what we call "out on his feet." He never loses consciousness and retains some of his intellectual and all of his vegetative consciousness.
3. The more severe type, in which the period of unconsciousness is obvious and exists for a minute or longer and the patient suffers residual symptoms of headache, dizziness, and the complete or incomplete loss of intellect.

Most of these concussions clear up fairly rapidly. Some patients have headaches for as long as one or two days. When a boy is knocked out repeatedly, I believe he should give up the type of sport in which he is being injured.

The first symptom to look for after a blow on the head is amnesia. Memory is the most reliable test (what happened, when it happened, dates, numbers, names).

Eye signs: dilated, fixed pupils in both eyes indicate serious brain damage; double vision (diplopia); lack of eye control (strabismus).

Other signs of concussion are seen in the patient who is dazed, drowsy, belligerent, irritable, irrational, or delirious.

If a boy is knocked out in a game, he should not be returned until his blood pressure and all signs have been checked and have cleared up.

If a boy is unconscious for any length of time, even though he returns fairly well to normal, he should be watched carefully for at least 24 hours for what is called *delayed concussion*. In this violent concussion, the patient is placed in a prone condition, with a cold pack on his head; smelling salts or ammonia is used. Check for any abnormality of the head, and if the patient does not recover rapidly, he should be hospitalized. If in your judgment the concussion has been severe, an electroencephalogram should be made, with lumbar puncture and hourly check on blood pressure and pulse. All this should be done under direction of a neurosurgeon. X-ray studies should be made of all these cases.

Very seldom does an athlete who has regained consciousness after being knocked out become unconscious again.

I want to remind you again that, according to Dr. Thorndyke of Harvard University, 44.7 per cent of all football fatalities recorded from 1931 to 1945 were the results of cerebral hemorrhages; 22.5 per cent resulted from spinal injuries; and 29.8 per cent were caused by abdominal or visceral injuries (this suggests inadequate medical attention).

Since I have been in sports, I have had to ask that three participants not be allowed to participate in sports because of recurrent head injuries.

CONTROVERSIAL CALISTHENICS

Comment by the National Federation of State High School Athletic Associations and the Committee on the Medical Aspects of Sports of the American Medical Association.

The deep knee bend and "duck waddle," which have been used traditionally as training activities for football and some other sports are now generally disapproved by medical authorities, according to the Committee on the Medical Aspects of Sports of the American Medical Association. Both exercises have a potential for serious injury to the internal and supporting structures of the knee joint, one of the most vulnerable parts of the athlete's body.

In the deep knee bend, the athlete moves alternately from a standing position to a full squat; in the duck waddle, he travels about while trying to maintain the full squat position. Both exercises involve complete flexion and often twisting of the knee which can result in cumulative deterioration or immediate injury to the meniscus (cushioning cartilage) of the joint. The incidence of such meniscal injury following the use of these exercises is sufficient to warrant dropping them from the training program, the A.M.A. Committee noted.

In addition to their injury hazard, the deep knee bend and duck waddle have questionable values as conditioning exercises. Few, if any, of the football player's activities involve complete flexion of the knee and thus neither exercise relates directly to the game. The best conditioning activities, except for those to increase general power and endurance, it is universally agreed, are exercises specifically designed to strengthen those body parts most used and most subject to injury in a particular sport.

Many other exercises, not carrying the same injury hazard as the duck waddle and deep knee bend, are available for athletic conditioning, according to the Committee. These can be found in standard references on fundamental conditioning exercises and athletic training procedures. For best results, regular practice of the prescribed exercises should begin well before the start of organized practice. Faithful adherence to preseason conditioning can be an aid to performance as well as a means of preventing injuries.

SHOCK

By DR. ROBERT E. MORGAN, M.D.

Southern Methodist University, Dallas, Texas

Shock is caused by many different things, but the kind which primarily concerns us is the shock caused by dehydration or by traumatic injuries. Shock is a condition of acute peripheral circulatory failure due to the arrangement of circulatory control or the loss of circulatory fluid and brought about by injury. It is marked by pallor, clamminess of skin, decrease in blood pressure, feeble rapid pulse, decreased respiration, restlessness, anxiety, and sometimes unconsciousness.

Most cases of shock which we see are mild and do not require too drastic treatment. You can usually have a patient stretch out and elevate his feet and keep him warm. Then if you think he may be a little dehydrated, give him a little water, but not too much.

In traumatic shock, the cause is usually evident. In treating traumatic shock, the treatment varies according to the severity of the shock and the amount of treatment required to restore the circulation. The length of time elapsing between the incident and treatment will decide

the amount of treatment necessary. Constant check on the level of arterial blood pressure still is the best index to the degree of shock.

Persons in shock are in danger of sudden death and must be closely and continuously watched until circulation is restored. When head or chest injuries are causing shock, the head or chest might have to be elevated; otherwise, the feet. Keep the body warm. The patient should be kept quiet. As a rule, about $\frac{1}{4}$ grain of morphine will quiet him. If the patient complains of thirst, he may be given water or, preferably, saline solution. In severe shock, water is allowed only in sips, and sometimes not at all. Adrenalin chloride solution, epinephrin, caffeine, or other stimulants may be used if necessary. The definitive treatment of traumatic shock is by fluid replacement given immediately to restore circulating blood and tissue fluid volume. Whole blood is the fluid of choice.

In deep shock, vomiting often occurs and is a grave danger to the patient. The patient should lie with his head turned to one side, and if he vomits, the oral air passages must be quickly cleared. A suction apparatus should be kept constantly available.

In cases of even mild shock, we send the boys to the infirmary, where they can be watched and checked for at least 24 hours.

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- Baggett, Ray, Athletic Department, Assistant Trainer, Indiana University, Bloomington, Indiana — 4
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- Barker, Dick, 1423 Illinois Avenue, Lansing, Michigan; Assistant Trainer, Michigan State University, East Lansing, Michigan — 4
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- Beeten, Bob, Box 61, Trainer, Idaho State College, Pocatello, Idaho — 8
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**LEGAL RAMIFICATIONS OF
ATHLETIC INJURIES**

By WILLIAM N. HARSHA

Oklahoma City

The physician has been an integral part of athletic competition throughout history, both in the preparation of athletes for these functions and in the care of injuries. As athletics become more highly organized and as younger age groups are included, he is called on more and more to supervise and care for these youths. Paralleling the increased participation in athletic endeavors is the apparent rise in the number of litigious persons in this country, and thus it behooves all persons interested in sports to be apprised of the possible legal ramifications of athletic training and athletic injuries.

I have had the opportunity and the distinct honor of being the team doctor for a high school for several years and have become well acquainted with the problems of athletes as well as those of their coaches. Although lawsuits involving school districts and coaches are quite rare, all persons interested in school athletics need to be well informed concerning the possibility of such lawsuits and how to cope with the problem intelligently.

Students in high school, college, junior high school and even grammar school who engage in bona fide school athletics usually are required by the school board to sign a release for bodily injury that might result from such participation. This release, signed by parent or guardian, is a legally binding document. It protects the school board, coaches and teachers from personal liability for the usual activities of engaging in sports. The definition of "usual activities" and of what constitutes unusual activities is ex-

tremely important. Athletic endeavors that are directly controlled and supervised by the school board, coaches and teachers may be the basis for personal involvement in litigation if there is negligence on the part of these groups. Releases given by parents for the usual athletic endeavors do not include negligence or failure to recognize an injury, or direct instruction by a coach or teacher or school to play in an injured state or with inadequate equipment. For example, a high school which equips its football players with worn-out shoulders pads is not protected by the bodily-injury release, nor is the coach who instructs a player who sprains his ankle during a game to get up and run it off and returns him to the game, only to find later a fracture with serious damage to the ankle has occurred.

A great need in our school system at present in regard to protective gear for athletes is a system of sharing the responsibility with groups competent to judge the adequacy of equipment. The average football coach is more than competent to evaluate the equipment provided for his team, but frequently the school board insists that he use worn-out, lightweight or inadequate gear. The school district, of course, incurs a very real risk if an injury of a player is due to inadequate equipment. A case in point is *Govel versus Board of Education*, New York, in 1944 (citation, 267 App. Div. 621). The coach, training students for a track meet, did not place mats under a set of cross-bars, and one of the players fell and was injured. The mats were available, but through the coach's oversight or negligence they were not used. A judgment was returned against the board of education.

Most school districts insist on general physical examinations for athletes. Although there is no legal insistence on this practice, it offers a higher degree of protection both to the school district and to the athletes. The parent releases the child to athletic endeavors in the physical condition in which he enters the school. The school then does not have a duty to ascertain whether or not the student has a disabling medical disease. Once it does have information that he has a disabling medical disease, however, if the school or coach obliges the athlete to play, to the latter's detriment, a release by the parents of any liability for the injury becomes invalid and the school board or coaching staff assumes the risk.

ADEQUATE CONDITIONING AND TRAINING

It has been demonstrated repeatedly that the most effective way to prevent major athletic injuries is by adequate conditioning and training. High schools and colleges have active training programs for their athletes prior to competition, but in junior high and grammar schools young athletes frequently enter competitive sports with little or no conditioning. All professional people are familiar with the concept of malpractice or negligent practice, and all athletic coaches as part of their training are made keenly aware of the necessity of adequate conditioning and training. Thus the coach who assumes the responsibility of sending an unconditioned or untrained athlete into active contact competition reasonably incurs a liability for any injuries which might result. The parent who signs a release and allows his child to engage in such athletics jointly shares this liability, and it would be difficult to decide whether the coach or the parent was legally responsible if any injury based on inadequate conditioning occurred. In the case of *Medsker versus Etchison* in 1936 (101 Ind. App. 369) it was argued that the athletic coach was unskilled and untrained and as a result the players were not conditioned adequately and the athlete Medsker was injured. It was held that parents accept the

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LEGAL RAMIFICATIONS

(Continued)

athletic department at face value for the caliber of its coaching staff. A small school, such as the one concerned in this case, could not expect to have the expert coaching staff that a major university might have. Nonetheless this example does point up an avenue of thinking, and certainly aside from any legal ramifications it is a sound medical concept to insist on adequate training. Most high schools allow a two week training period before the first scheduled football or basketball game. This perhaps is not a long enough period, but certainly it is far better than no training period at all.

THE RISK IN EVALUATING ATHLETIC INJURIES

The athletic coach is the key person in regard to possible negligence. Although he is automatically protected by the school board and school district, if he acts in a manner contrary to the board's instruction, he incurs total liability. In most jurisdictions the school board has to agree to a lawsuit before it can be sued. However, if a real cause for action is present, it is difficult for a governmental agency to refuse testing the case in court.

The evaluation of athletic injuries, particularly in football or basketball players injured during a game, constitutes a real risk to the coaching and teaching staff. Many times the coach or trainer examines such a player and, assuming the injury to be a minor sprain, returns the athlete to the game without a period of observation. In *Duda versus Gains* (12 N. J. Super. 326) a young athlete dislocated his right shoulder during a game. The coach examined him and told him medical treatment was unnecessary. He was returned to the game, thereby worsening his injury. A verdict against the coach was substantiated. In *LaVelley versus Stanford* (272, App. Div. 183) a young athlete appeared fatigued and did not perform as well as the coach felt he should. He was obliged by scholastic threats to drive himself harder, and as a result had a nervous relapse. Medical testimony was sufficient to show that the unusual energies of the coach aggravated the student's condition. A verdict was awarded against the coach. This is an extreme verdict.

Most significant injuries to the extremities are manifested by pain, swelling and deformity either immediately or within 5 to 10 minutes, and it probably is wise to remove an injured player from a game for that period of time. Another problem that arises is a player's insistence that he is not injured. The coach, perhaps against his better judgment, may return such a player to the game because the player is afraid he will lose face among his colleagues if he admits to the possibility of a disabling injury. In *Sayer versus Roger* (16 N. J. Super. 22) in 1951 a student deliberately acted against the coach's request and refused to submit to medical examination, continuing in the game. The decision in this case was a difficult one, because the coach did have direct supervision of the player and allowed him to play, but it was also pointed out that the coach did attempt to provide medical attention, which was refused. The verdict at first was awarded against the coach, but later was reversed; in many jurisdictions it could have been held against the coach. The coach does, of course, have absolute control of the game. It takes an astute coach to ferret out these facets of the problem.

There have been situations in which a coach has insisted that an injured player hobble off the field or in which he has examined an injured athlete in such a way as to cause further damage; the latter problem has arisen particularly in cases of injuries of the neck and low back.

In one lawsuit, \$200,000 was awarded to a football player whose injured neck was sharply manipulated by a member of the coaching staff on the field during examination, resulting in severe injury of the spinal cord. It is therefore imperative that the coach and the training staff be well acquainted with the types of injury that carry very real risks of permanent damage, and that they insist that players with these types of injury be carried from the field properly and that medical attention be sought promptly. Because of the possibility of such an injury in any athletic endeavor, I believe it is quite important to have a physician available at all games and promptly available during practice sessions. Most medical societies are more than ready to furnish this coverage, and it is a rare physician who is unwilling to cooperate.

Occasionally a coach is accused of conducting an unusually rough athletic contest or a disciplinary type of game. There have been several lawsuits in which families have charged that coaches have been unduly forceful with athletes. In certain situations this approaches negligent behavior. *Pirkle versus The Oakdale Union Grammar District* in 1953 (253 P2d) was a case in which the players on a football team ranged in weight from 90 to 190 lb. In a practice session one of the larger boys tackled a much smaller boy and injured his kidney and right knee. The court held that this constituted negligence on the part of the supervising coach. A further illustration of the close degree of control a coach must exercise is the case of *Lee versus Board of Education* (263 App. Div. 23). A baseball player in a school game was running for a high fly and stepped out into a street and was struck by a car, receiving severe injuries. It was held that the coach needed to exercise that degree of supervision to reasonably expect a fly ball to be hit into the street and to recognize the possibility that a player might be injured.

SUMMARY

It is the duty of the school board, the athletic coach, the trainer and the teaching staff to offer athletes competent and supervised coaching and adequate protective equipment and facilities. The release which the parent or guardian signs for the participation of a child in athletics assumes that these are to be made available or, to be legally binding, must specifically exclude one of these items (and, of course, this is facetious thinking). Any member of the teaching or coaching staff can incur personal liability by acting in a fashion which a jury may consider unreasonable under the circumstances for a person trained in coaching or athletics. Avenues for incurring personal liability on the part of the person supervising the athletes are returning an injured player to the game, improper physical care of the injured player, and yielding to personal whims.

Some of the more progressive school systems recently have furnished liability insurance plans which protect school board and coaching staff. The rule in injury cases in such districts with insurance coverage has been that the insurance company can be directly held in suit without the school board's permission. This is one avenue of solving the litigation problem, but, of course, it increases the expense of athletic endeavors, which already is a problem in schools operating on low budgets.

An intelligent approach to the problem is to have available at all times competent medical personnel during athletic encounters, either on call for practice sessions or in the stadium or on the bench during games. All physicians should be willing to give of their time for this purpose, and most of us frankly look forward to doing it.

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