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FALL 2008

At Issue

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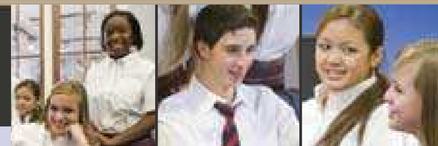

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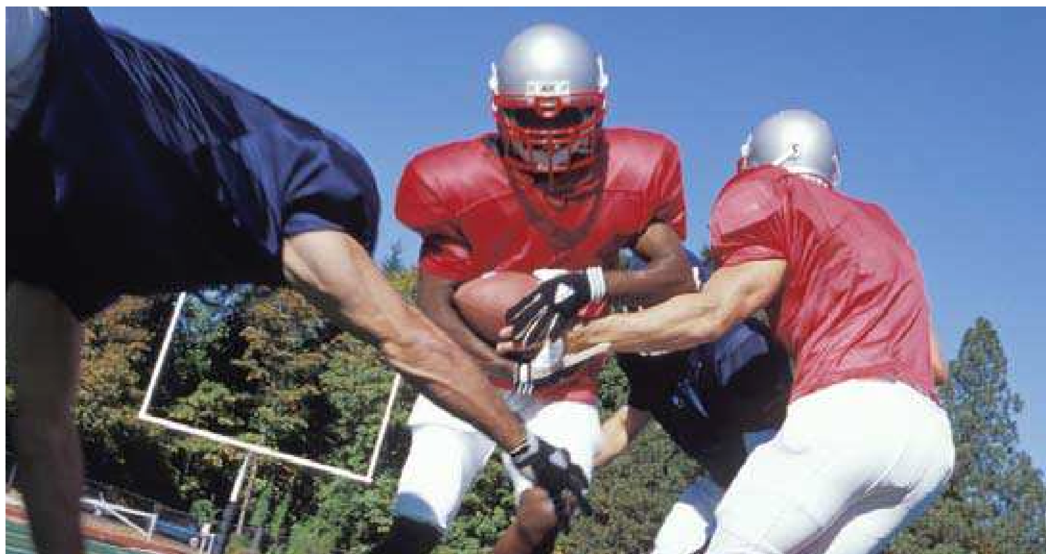
Concussion: Protecting Athletes and the Educational Institution

By Donna A. Lopiano, Ph.D., President, Sports Management Resources

At Issue: During football season, it's not unusual to read about a teenage football player collapsing several weeks after suffering a concussion. Afterwards, we may learn that he returned to competition claiming no symptoms, when in actuality he continued to experience headaches but told no one because he was afraid of missing playing time.



Another common scenario for many schools is when an athletic director walks into the principal's office with an advertisement for a coach-administered computer-based program that promotes neurocognitive testing of athletes. The athletic director makes a strong case for having baseline data available to help decide if a player can return to competition after a head injury.

How should managers of educational institutions deal with the potentially life-threatening consequences of head injury? Here are several steps to take to make sure that your coaches and staff are prepared to respond to concussions:

1. At the beginning of every season, the school's team physician should present an in-service program for coaches and athletics event staff on recognizing the observable behaviors and student-reported symptoms that are signs of concussion. Most important, the team physician is responsible for sending a clear message, "When in doubt, sit the athlete out!" Such in-service programs recognize the fact that a certified athletic trainer or team physician is not in attendance at every practice and emphasizes the school policy directing staff to err on the side of student safety.

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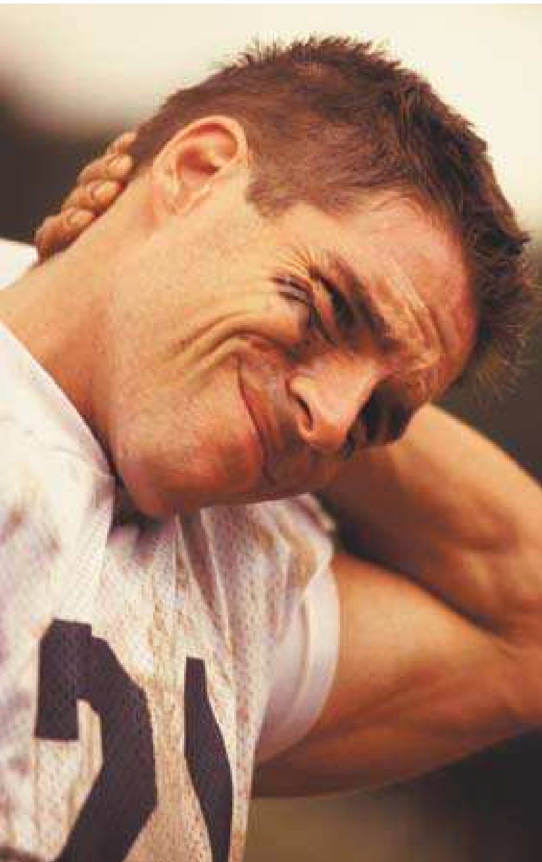

2. On the issue of whether a school should have a protocol for neurocognitive evaluation, the answer is "yes". However, such a testing program should be administered by a certified athletic trainer, a physician or other qualified personnel and never by a coach. The coach will always be in a conflict of interest position and should not be put in a position to be involved in the decision to return an athlete to play after a concussion, nor should she or he be the one to interpret comparisons to baseline data. While the coach plays an important role in recognizing behavioral symptoms or listening to an athlete describe his or her symptoms, assessments of physical condition and decisions to return from injury rightfully belong to trained certified personnel.

3. The decision to return to competition should not be solely dependent on athlete-reported symptoms because the athlete also has a conflict of interest. Research demonstrates that athletes underreport their conditions due to a desire to return to competition. (Van Campen, et. al, 2006) While information from the athlete plays a role, ultimately neurocognitive testing must guide any such decision.

4. Following a concussion, the athlete should be referred to a physician for medical evaluation on the same day as the injury if there was loss of consciousness; amnesia lasting longer than 15 minutes; vomiting; motor, sensory or balance deficits, or symptoms that worsen. Immediate transport to the hospital emergency room should occur in the case of pulse or respiration irregularity or decreases, unequal, dilated or unreactive pupils, lethargy, confusion, seizures and other symptoms. All of these operating rules should be covered in the physician education program at the beginning of the season and be given to coaches and staff in writing. There are clear protocols for responses to concussion that must be communicated to coaches and staff.

5. The school should have conservative policies in place to deal with athletes who suffer repeated concussions, from removal for the rest of the game to disqualification from participation for the rest of the season to complete disqualification from participation in contact sports. These policies should be established in consultation with a physician and be based on continuation of symptoms, repeated concussions and other physician determined factors.

6. Policies should exist which require a physician or certified trainer to give oral and written instructions to parents regarding home care following an athlete suffering a concussion, especially with regard to ingesting alcohol, drugs or other substances affecting cognitive functioning.

One of the best resources for the athletics director and school administrator is the National Athletic Trainers' Association *Position Statement on the Management of Sport-Related Concussion*.

In summary, four steps are necessary for responsible handling of concussions:

(1) assessment of neurocognitive baseline data by qualified personnel;

(2) adequate preparation of on-the-field staff in symptom recognition and conditions for emergency treatment versus physician referral;

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(3) oral and written communication with parents and caregivers regarding home care of the athlete following a concussion; and

(4) conservative return to play decisions only after qualified medical personnel are sure the athlete is symptom-free.

Resources:

Guskiewicz, K.M., S.L. Bruce, R.C. Cantu, M.S. Ferrara, J.P. Kelly, M. McCrea, M. Putukian, T.C. Valovich McLeod. (2004) National Athletic Trainers' Association Position Statement: Management of Sport–Related Concussion

Journal of Athletic Training, 2004; 39(3):280–297. http://www.csmfoundation.org/NATA_Position_Statement.pdf.

Van Kampen, D.A., M.R. Lovell, J.E. Pardina, M.W. Collins, and F.H. Fu. (2006) The "Value Added" of Neurocognitive Testing After Sports–Related Concussion. *The American Journal of Sports Medicine* 34:1630–1635 (2006)

Hazing

By Donald McPherson, President of Don McPherson Enterprises, LLC

The hazing I experienced 20 years ago in professional football came from a long history of "rites of passage" rituals that have passed through generations of military, sports teams and other organizations. Hazing is often carried out without an understanding of function or purpose, and in cases such as mine, is perpetrated on willing, even expectant targets.

When I reached the National Football League and became a player for the Philadelphia Eagles, I was 22 years old and confident in my abilities. I had worked hard and proven myself in high school and at Syracuse University. Like all professional athletes, I felt that I had earned my opportunity to make a professional football team. My older brother had played in the League and told me what to expect. My hazing experience was designed for humiliation, not physical abuse. My teammates' rote behavior was a leftover tradition from the days when the NFL was populated with players who had served in the armed forces and who had used such rituals to "fast track" unity, trust and hierarchal respect – respect for the veteran players and coaches who had proven their mettle in the League.

Each day in our schools, students engage in hazing with the same disconnect to purpose and function as my former teammates. And, since there is no real connection to the sport or activity, the behaviors and expectations are whimsical and less defined. What makes this climate more dangerous is that it takes place for young people at a time of personal, emotional and psychological growth. School-aged students experience hazing at a time of discovering "self" as well as identifying their place in the world. They accept hazing as part of that same "rite of

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passage." And, they consider it part of the game. After all, they continue to see their heroes in the world of sports carry out the (silly) behavior in the media.

A few years ago, a local newspaper reported that a group of high school football players had hazed their teammates by sexually assaulting them. A few months later, the same newspaper published photos of young professional male athletes being forced to wear women's clothing as part of a hazing—and all in good fun. The message was clear in both cases: attacks based on gender and sexual identification are powerfully humiliating.

For some, men wearing skirts is harmless fun, unless you deconstruct the message and understand the inherent sexism in the behavior—that to be compared to a woman is a humiliating act for a man. Still, many will argue it is no more harmful than being assigned the task of carrying the water bucket for the team. So how is it that such behavior can be lumped categorically with sexual assault and sodomy? Where do we draw the line on hazing? And, do we really know it when we see it?

In September 2008, I addressed administrators, coaches and student-athletes at Alfred University and Alfred State College alongside legal scholar and hazing expert Janet Judge. Norm Pollard of Alfred University in 1999 released a comprehensive study on hazing in higher education. In the study, Norm Pollard asked that we help students understand and identify what hazing "looks like." Nine years later we are still grappling with how to define hazing. Further, while students have trouble identifying the problem, schools, administrators and coaches have become more vulnerable to the decisions made by students during social activities. In fact, the high profile cases that have increased the volatility of the issue and have captured our attention, do little to help define the overall problem. While we may argue that carrying the water bucket should not be considered hazing (since it is a necessary chore for any team), technically it is. But, it is difficult to place hazing activities like sexual assault and coerced intoxication of minors in the same category.

All throughout our society we find blurring, arbitrary interpretations of the rules. We all know the acceptable speed above posted limits on the highway. And for all the talk about underage drinking, young people especially know how little those laws are enforced. Hazing is no different. In fact, when you add the (seeming) "voluntary" nature of the behavior, it becomes more difficult to discern.

Unlike the high profile incidents involving professional athletes whose lives are more likely self-defined by a proven track record, their family or overall endeavors, young people's lives are heavily influenced by peer group belonging and behavior. Very often their teammates or peers dramatically shape their sense of self. The pressure to "belong" is great. Such relationships between the individual and group are hierarchal and the group often sets the arbitrary rules. And, just as I wanted to "get it over with," when I was hazed as a 22-year-old professional athlete, so too will young people endure the absurd, to fit in with the group to which they want affiliation.

With a broad definition from the benign to the horrifically criminal, how can schools, administrators and coaches best guide students and help them identify inappropriate hazing behavior? How do we get them to "buy into" the need for reformative thinking around "rites of passage?" Can we see "carrying the water bucket" as being on the slippery slope to mean and unacceptable behavior?

We need continued education, awareness and action that help people identify and define hazing, while providing alternative activities that help build unity, team and a healthy educational environment. ■

What About Bullying?

By Robert Bambino, CPCU, ARM, Vice President - Risk Management

Often called the "younger cousin" to harassment, bullying may be a precursor to illegal harassment. In 2001, the American Association of University Women Education Foundation (AAUW) released the report *Hostile Hallways: Bullying, Teasing and Sexual Harassment in Schools*. This report followed an earlier study released in 1993.

The 2001 report contains similar findings and conclusions; in both 2001 and 1993 eight in ten students experienced some form of harassment during their school career. The percentage of boys who reported being harassed "often" or "occasionally" increased from 49 percent in 1993 to 56 percent in 2001. Incidents of anti-gay sexual harassment also increased. Sixty-one percent of students reported knowing someone who was called gay or lesbian; 36 percent say they have been called gay or lesbian – up from 17 percent in 1993.

Personality Characteristics of Bullies

- Are aggressive
- Lack Empathy
- Lack Guilt
- May lack confidence
- Need to dominate others
- Have authoritarian personalities
- Use force as a way to solve problems
- Are quick to anger
- Identify with aggressive role models

The U.S. Department of Education – Office for Civil Rights, produced a document that can assist headmasters and other school administrators to address harassing and bullying behavior. The *Checklist for a Comprehensive Approach to Addressing Harassment* can be found at the U.S. Department of Education – Office for Civil Rights Web site – http://www.ed.gov/about/offices/list/ocr/checklist.html.

While all of the recommendations are helpful, three of the suggestions stress the need to use curriculum to teach respect; use activities to prevent unwanted behavior; evaluate and monitor the school environment; try to identify the frequency and types of harassment that may exist, and to respond promptly and appropriately when needed.

Reference:

American Association of University Women Educational Foundation http://www.aauw.org/research/hostile.cfm

Community-Associated MRSA

By Robert Bambino, CPCU, ARM, Vice President - Risk Management

Methicillin-Resistant Staphylococcus Aureus or MRSA is a bacterial infection that is resistant to the broad-spectrum antibiotics commonly used to treat Staph. Although treatable, MRSA can be fatal. The most common type of MRSA is health-care associated MRSA, which occurs in health care settings, such as hospitals, nursing homes and dialysis centers. However, Community-Associated MRSA (CA MRSA) occurs outside of a health care setting - such as in schools, colleges, public pools or other recreational facilities. A person can get MRSA through direct contact with an infected person or by sharing personal items, such as towels, clothing or razors that have touched infected skin. The Centers for Disease Control (CDC) reports the estimated number of people developing a serious MRSA infection (i.e., invasive) in 2005 was about 94,360.

According to the Mayo Clinic and the Centers for Disease Control (CDC), there are six risk factors for CA MRSA. Three of the six are related to school settings. They are:

- Participation in contact sports, such as wrestling and football. CA MRSA can spread through openings in the skin.
- Sharing towels or athletic equipment. CA MRSA can spread through razor sharing between athletes, drying-off with towels previously used by another athlete, and sharing uniforms or equipment.
- Young age. CA MRSA can be dangerous in children, who do not have a fully developed immune system, or sufficient antibodies to common germs.

The other factors cited by the Mayo Clinic include a weakened immune system, living in a crowded or unsanitary environment, and associating with health care workers who may have the infection.

MRSA presents itself as a bump or infected area on the skin that may be red, swollen and painful or warm to the touch. The infected area may be draining, or have pus in the site. People suffering from MRSA may have a fever. The Mayo Clinic and the CDC offer recommendations to prevent CA MRSA in a community setting, which are also applicable to the school environment.

- Wash your hands or use a hand sanitizer, with at least 62-percent alcohol.
- Keep personal items personal - avoid sharing personal items such as towels, sheets, razors, clothing and athletic equipment.
- Keep wounds covered with sterile, dry bandages until they heal.
- Shower after athletic games or practices.

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- Keep student-athletes out of athletic games and practices if they have an infection.
- Make sure laundries sanitize towels.
- Have medical professionals test students with skin infections that require treatment.
- Use antibiotics appropriately - follow the medical professional's instructions and take the prescribed dosage until it is completely gone.
- Maintain a clean school environment by developing and implementing cleaning procedures for frequently touched surfaces and surfaces that come into direct contact with people's skin, such as desks and tables. Athletic equipment, particularly helmets and protective gear, needs special attention. Shared equipment should be cleaned every time it is used.
- Include a discussion about MRSA with student-athletes at the start of each new athletic program.
- Consider sending a letter home to parents and guardians about MRSA, with information about the disease, including what the disease looks like, how to prevent it and what to do if a parent or guardian suspects their child has MRSA.

MRSA is most likely to be spread in high-contact sports, such as wrestling, football and rugby, as well as basketball and soccer.

Stories in the media concerning MRSA outbreaks in schools are common. In 2007, reports concerning students infected with the disease in California, New York, Michigan, Oklahoma, Ohio, Virginia, Washington, and New Jersey were used to raise the public's awareness of MRSA. This past September, schools across Long Island reported cases of MRSA primarily among students.

The CDC has two excellent fact sheets on its Web site that are helpful to school health officials, nurses and school physicians: MRSA in Schools: Fact Sheet and MRSA Among Athletes: Fact Sheet. The CDC does not recommend removing a student-athlete with MRSA from competition unless the wound cannot be properly covered during competition, or there is increased risk of additional injury to the infected area because of the competition. Local or state athletic rules may address this condition differently, however.

References

Mayo Clinic Web site. http://www.mayoclinic.com/health/mrsa/DS00735/DSECTION=risk-factors

Centers for Disease Control - Information about MRSA. http://www.cdc.gov/mrsa/

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