FROM THE EDITOR

Let me begin by saying that it is my pleasure to return as editor of FARA Voice, a position I turned over to Joe Catanese and Bill Edwards shortly before I became President of FARA in November of 2007. In July 2009 Dennis Leighton, Secretary-Treasurer of FARA, assumed the role of Editor of FARA Voice, a position he held until February 2011. I want to thank these good folks for the fine job they have done in keeping us all informed about significant issues in intercollegiate athletics and the key roles we, as FARs, need to play.

Today, there is much going on in intercollegiate athletics, and I will do my best as editor of FARA Voice to keep you informed about recent developments, provide substantive analysis of important issues, and give you the opportunity to engage in dialogue with your fellow FARs.

Included in this month’s issue is a report on the meeting of the Coalition on Intercollegiate Athletics, held in January in Chicago, and a description of the Division I FAR Institute being inaugurated this year in late May, following the lead of the institutes already in place for FARs in Divisions II and III.

Our feature article focuses on Sickle Cell testing for student athletes. Should it be mandatory, or should it be optional? Connie Dillon of the University of Oklahoma is our guest editor for this issue, and she introduces the two articles and two responses which provide an in-depth discussion of this issue. Our thanks to Connie for performing this important task. Thanks also go to Scott Anderson, Head Trainer at the University of Oklahoma, who argues for the elimination of the waiver regarding Sickle Cell testing, and Jeffrey Anderson, Director of Sports Medicine at the University of Connecticut, who argues that the waiver should not be eliminated. FARA Voice welcomes responses from any of you who would like to join in the discussion.

I would welcome suggestions from any of you who want to propose a topic FARA Voice should take up, or who would like to present an article or editorial in FARA Voice.

Alan J. Hauser, editor  
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**Division I Transfer Policies**

At the recent meeting of the FARA Executive Committee, the group took up the review of legislative concepts on eligibility requirements for two year transfers being considered by the Division I Academic Cabinet. The concepts currently under review include an increase in the transfer gpa from 2.0 to 2.25; a limitation on the number of transferable Physical Education activity credits; the addition of a science class as a requirement; and the creation of a “year in residence” option where potential student-athletes could begin their post-secondary education at a two-year school without that initial year “counting” against their 10 semester participation period.

As you can imagine the issues associated with these concepts are quite complex. A full discussion of the concepts and the statement of the FARA Executive Committee that will be conveyed to the Academic Cabinet can be found on the FARA website, www.farawebsite.org.

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**Report: Coalition on Intercollegiate Athletics**

From January 21 through 23, I attended the meeting of the Coalition on Intercollegiate Athletics, which was held in the Big Ten office in Chicago. I was present as a representative of FARA’s Executive Committee, engaging in dialogue with this consortium of Bowl subdivision schools. COIA is a coalition of Faculty Senate chairs (current and former) and Faculty Senate members who have an interest in preserving the integrity of intercollegiate athletics and in raising issues they see to be important to the NCAA, to member institutions, and to the public in general. The sessions were productive, although it is clear that the level of knowledge about intercollegiate athletics varied considerably among those present. There was a frank exchange between President Graham Spanier of Penn State University and COIA members about presidential control of intercollegiate athletics, what it is reasonable to expect from presidential control, and what the limits are for exercising presidential control. NCAA President Mark Emmert gave his thoughts on important matters currently before the NCAA, including academic reform, responded to numerous questions about issues currently before intercollegiate athletics, and encouraged COIA to engage in constructive dialogue with the NCAA, member conferences, and member institutions. He emphasized his willingness to work with COIA in its efforts to improve intercollegiate athletics.

Amy Perko, Executive Director of the Knight Commission, spoke to the group about fiscal reform in intercollegiate athletics, a topic on which the Knight Commission last summer issued a major report. Diane Dickman of the NCAA gave a report on the review of two-year college academic standards, and their impact on transfers to NCAA institutions. Chad Hawley, Associate Commissioner of the Big 10, presented an in-depth study of the cost of compliance in today’s athletics programs. Jim Delaney, Big 10 commissioner, gave his views on academic reform and initial eligibility, and participated on a panel discussing fiscal reform in athletics.

I emphasized to COIA that FARA continues to be open to dialogue with them, both in terms of providing information and discussion on particular topics, and in pursuing matters of common interest in intercollegiate athletics. I also encouraged the members of COIA to be in regular dialogue not only with FARA, but also with the FAR on their particular campus. As I noted above, I felt the meeting was very productive.

*Alan J. Hauser, editor*
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The Division I Institute

For a number of years, Division II has conducted a Division II Institute, whose purpose is to provide relatively new FARs in that division with a rigorous, comprehensive two and a half day program designed to enable them to better perform their roles as FARs. This program has been educational, interactive, and goal oriented, with each participant, by the conclusion of the institute, returning to campus with a goal oriented plan to improve their fulfillment of their responsibilities as FAR on their campus, in their conference, and in the Division II governance structure. This past fall, Division III launched its first rendition of an institute for Division III.

Now it is Division I’s turn to launch such an initiative. Through the gracious support of NCAA President Mark Emmert, late this spring a pilot Division I Institute will be launched. The goals of this institute will be essentially the same as those described above for Division II, but nuanced for the particular needs and responsibilities of Division I FARs. A selections of sessions to be held during the institute include: Defining the Role of the FAR; Relating to Student Athletes; What the FAR Needs to Know; the NCAA Academic Performance Program; NCAA Violations, Investigations, and Procedures; and Participation and Leadership at the Conference and National Levels. Each participant will leave with a set of goals for the next year.

President Emmert asked that there be a seat at the new institute for each of the 31 Division I conferences, and to that end an email went out February 8 to the commissioners of every Division I conference, asking them to submit two names as possible participants in the institute, from which the planning committee will choose one from each conference. I trust that by now Division I FARs have heard from their commissioners regarding this matter.

The Division I Institute will held in Indianapolis May 23-25. The planning committee for the institute is composed of Roger Caves, former President of FARA, Chair, Alan Hauser, former President of FARA, Co-Chair, David Clough, President Elect of FARA, Dydia Delyser, FARA Executive Committee member and FAR at Louisiana State University, and Patrick Devine, former Executive Committee member and FAR at Kennesaw State University. Mike Miranda and Jennifer Strawley of the NCAA are staff liaisons to the committee.

This new institute promises to be an exciting event, and we appreciate your interest. Roger Caves and I, or for that matter, any of those listed above, will be happy to respond to your questions or suggestions. Let me extend our thanks once again to President Emmert for his support for this institute.

Alan J. Hauser  
Co Chair, Division I Institute
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When surveyed following the 2010 FARA Annual Meeting and Symposium, 100% of respondents said they would recommend the meeting to other FARs.

Find out what you've been missing!

2011 FARA Annual Meeting and Symposium
November 10-12, San Diego, CA
Should the Sickle Cell Solubility Test Be Required?  
Arguments Supporting and Opposing 2010-110

Introduction
Connie Dillon, Faculty Athletics Representative
University of Oklahoma

As Faculty Athletic Representatives, the health and safety of our student-athletes is one of our most important responsibilities. In exercising this responsibility, our medical personnel become our greatest allies. When we face policy decisions that have ‘life and death’ implications, it becomes incumbent upon us to listen to them, even when, or perhaps ‘especially’ when they disagree. Such is the decision that is now before Division I, as Division II and III begin to discuss the role of sickle cell testing within their respective divisions.

Currently under consideration is 2010-110, a proposal that would eliminate an individual’s option to decline the sickle cell solubility test as part of the mandatory medical examination required prior to athletics participation. This proposal was brought to the membership through the governance process that included discussions by the Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS), Division I Championships/Sports Management Cabinet, Division I Legislative Cabinet, and the Board of Directors. CSMAS noted concern that the current written release option served as a blanket waiver and believed that the medical implications of such a waiver warranted further discussion.

The issue before the membership is whether or not to require sickle cell testing prior to athletic participation. This issue is significant for the NCAA and prescient for society because of the fundamental medical and ethical concerns that underlie this decision. FARs have an important voice in this debate, since our voice is largely unfettered by cost and competitive concerns. As we consider and advocate for a position, FARs will benefit by hearing from those who serve on the frontlines, our health care professionals. With this in mind, I asked two prominent voices in this debate to present their arguments to us so that we may more fully understand the implications of a blanket waiver from a medical perspective.

Writing in support of 2010-110 is Mr. Scott Anderson who is the Head Athletic Trainer at the University of Oklahoma, a position he has held since 1996. He currently directs the Education Program for the Big 12 Conference Medical Aspects of Sport Committee, serving as its Chair from 1999 to 2002. Mr. Anderson served as Co-Chair of the National Athletic Trainers’ Association (NATA) Inter-Association Task Force on Sickle Cell Trait and the Athlete. He also served on NATA’s Inter-Association Task Force on Safety in Football: Off Season Conditioning and was a member of NATA’s Inter-Association Task Force on Exertional Heat Illness.

Writing in opposition to 2010-110 is Dr. Jeffrey Anderson, who is the Director of Sports Medicine at the University of Connecticut, where he has served as a primary care physician for its student-athletes since 1994. He is a fellow of the American College of Sports Medicine and serves as a Member-At-Large in its New England chapter. He is also a member of the American Medical Society for Sports Medicine and currently serves as a member of the NCAA Competitive Safeguards and Medical Aspects Committee.

The Anderson v Anderson debate concludes as both authors offer rebuttals to the arguments presented.

In expressing their views on this topic, the authors do not represent the views of the NCAA or the NCAA Competitive Safeguards and Medical Aspects Committee.
Position in Support of 2010-110
The NCAA Should Eliminate the Waiver for Sickle Cell Testing

Scott Anderson

The NCAA was founded in 1906 to protect student-athletes from “…dangerous and exploitive athletics practices…” in response to President Theodore Roosevelt’s challenge to college Presidents that the risks of morbidity and mortality occurring in sponsored intercollegiate sport is within the control of the institution.(1) Toward that end, in its 101st year, the NCAA, for the first time, mandated the most basic of preventative sports medicine practices, a preparticipation physical evaluation (PPE). Three years later, in 2010, NCAA Division I legislated the singular required component of their PPE, a test for sickle cell trait (SCT) in the student-athlete…with a controversial cede to the student-athlete to comply or not.

SCT is a largely benign condition. Yet, for the working athlete there can be grave consequences as red blood cells ‘sickle’ with intense, sustained exertion resulting in restricted blood flow, muscle tissue death, acute renal failure, and in rare cases, death.(2) When a student-athlete in action dies a non-traumatic death the four leading causes are cardiac, exertional heat stroke, asthma, and exertional sickling.(3) Exertional sickling is the current leading cause of death in NCAA football and the latest death occurred in track. SCT is present in an estimated 3-4% of Division I football players yet is associated with 63% of nontraumatic deaths, an excess of up to 21-fold.

NCAA Division I Legislative Council, in 2010, was presented with proposed legislation for testing the student-athlete for SCT, 2009-75-B, an outcome from Dale Lloyd v Rice University and the NCAA reflecting the tenet that the institution can mitigate mortality and morbidity of its student-athletes. Council’s answer for controlling dangerous and exploitive athletics practices in a syndrome that has killed 11 NCAA student-athletes since 2000 and in light of the proposal’s rationale, “…legislation is in the best interest of student-athlete wellbeing…”, was the curious conundrum of testing that is mandatory yet voluntary. In other words, Council allowed student-athletes a unilateral option out of SCT testing by signing a waiver.

Ignoring an existing NCAA Bylaw that places administration of the PPE in the purview of a physician, Council established an onus on the student-athlete for self-determination of their medical eligibility within the PPE with respect to SCT testing. Council created a counter-precedent that control of dangerous and exploitive athletics practices ultimately resides not with the physician or the institution, but with the student-athlete.

Statements from Council explaining their action are serial and shifting suppositions from surreal (accommodate the vagary of ‘some student-athlete’s unique circumstance’, student-athlete personal comfort with testing, ill-defined ‘perceived concern’, SCT does not affect a large enough percentage of our student-athlete population) to standard (cost, appropriateness of a legislative mandate, potential discrimination against student-athletes testing positive). Cost of testing is a non-factor for the opt-out amendment as expense is borne by the institution.

Cost, whether nominal or phenomenal, is always a consideration of significance. The NCAA offsets expense for repeat testing in the presence of documented results of a previous SCT test as all 50 states and the District of Columbia screen for SCT at birth. Testing at the NCAA Division I level becomes necessary given natal screening is too far removed from sports participation. Unfortunately, databases have not been established for retrieval of natal testing results at a later date and in some cases the records are destroyed prior to availability to the student-athlete as a young adult. Until such time that those responsible for natal screening and counseling impart efficiency and practicality into their systems, repetitive testing and associated costs become imperative if SCT status is to be known.
Opt-out is a deliberate choice not to test and rarely articulated are the costs of not testing: student-athletes with SCT carrying a risk of serious or fatal sickling crisis go undetected; student-athletes experiencing a sickling crisis go untreated; the incalculable cost of a human life lost to exertional sickling; the financial fallout in gaining closure in fatal and non-fatal exertional sickling; and, the potential impact upon careers.

Safe to say that as one is unaware of SCT status one is, too, unaware of any risk. At the University of Oklahoma, in the time we have tested our incoming football players, 21 have tested positive for SCT yet only two of those were aware of their status prior to our screen. None of the 21 was aware of any risk for SCT and exertion. Additional complication, and threat, for the unknowing student-athlete with SCT experiencing a sickling crisis is going untreated by an unknowing medical provider. Ryan Clark, an NFL football player with SCT, experienced splenic infarct at altitude, a complication of SCT, and languished with misdiagnosis and mistreatment prior to a correct differential diagnosis and management plan.(4) Splenic infarct case reports exist for college basketball where, again, sickling symptoms presented but ignorance by student-athlete and providers delayed appropriate care.(5)

Student-athletes in the throes of fulminant rhabdomyolysis from exertional sickling have arrived in the Emergency Room and SCT status is either not known or not communicated and the student-athlete died, untreated for the specificity that is the metabolic cascade of exertional sickling. This cost is the student-athlete’s alone.

Whereas the cost of a human life is incalculable in relative terms, it does become calculable in financial terms as institution after institution is forced to reconcile with the survivors of a dead student-athlete. One case was recently settled for $2 million, plus $250,000 for an endowed scholarship in the name of the deceased student-athlete, plus $10,333.95 in plaintiff’s taxable court costs, in addition to the institution’s $375,000 legal defense costs.(6) Not quantifiable is the inevitable public relations ‘damage control’ and the untenable position of shifting ‘blame’ from the institution to the student-athlete in litigation defense tactic.

Any institution feigning a sense of separation from these costs based on a ‘waiver’ is simply playing a chance-game against the odds. That the risks of morbidity and mortality occurring in sponsored intercollegiate sport is within the control of the institution has become tangible of late as Grambling University fired its men’s basketball staff and North Carolina A&T University fired its Athletics Director, Senior Associate Athletics Director, Compliance Director, ‘retired’ the Coach, and suspended the Athletic Trainer – actions subsequent to failure to appropriately manage ‘dangerous and exploitive athletics practices.’(7) Although loss of career cannot equate to loss of life, all human toll is regrettable. Herein resides an immutable institution cost, student-athlete-option notwithstanding.

The opt-out amendment is established upon idealist assumption that given education and opportunity student-athletes will always act in their best personal interests regarding testing for SCT in the PPE and who better to make the determination than the individual. NCAA, in settling the Lloyd lawsuit, agreed to develop educational material for coaches and student-athletes, a tacit admission that student-athletes lack sufficient information to make an informed decision on their own. Current reports from the field reflect that, given a choice, student-athletes are opting out of the test. Student-athletes are opting out in the face of strident physician directive to pursue, as a point of personal health information (PHI), knowledge of SCT status.
Council’s conclusions as to why student-athletes should not or would not test have not manifested as ignorance is endorsed while the risks remain.

Discrimination is easily debunked. Knowledge of the risk of death for an NCAA student-athlete with SCT dates to 1962 and was established in 1974 when Polie Portier died an exertional sickling death at the University of Colorado.(8) Despite 17 similar sickling deaths in college athletes since Polie Portier, no evidence exists that any SCT student-athlete has been denied participation in sport. Subsequent to Portier’s death the NCAA recommended screening for SCT in 1975, rescinded the recommendation in 1992, and reversed field again in 2001 to no longer recommend not testing. Nonetheless, testing has continued in NCAA institutions, at a variable rate. In 35 years of testing there is no known case of any student-athlete being denied participation due to testing positive for SCT. In a 2006 survey of Division I institutions one could estimate that 50% of the institutions were testing for SCT in their PPE(9); yet again, no evidence that any student-athlete has been denied opportunity to participate in sport. The specter of reduced playing time, stigmatization, or loss of scholarship for a student-athlete upon identification of SCT in the PPE is unfounded. (10) Compromised career opportunity as a professional athlete is another common criticism of collegiate sickle cell screening; truth is the NBA and NFL test for SCT and the incidence of SCT in NFL players mirrors that of the general public. (11) Discrimination, undeniable in other failed screening programs and a basis for the opt-out amendment, is a pseudo-scare and has not manifested in the society of sport.

While the PPE, historically, has had little impact on the mortality of athletes in sport, for the Division I student-athlete, the NCAA’s lone requisite PPE component, testing for SCT, is the singular PPE point of information that can save lives. Knowledge beats ignorance and knowledge of SCT status begets targeted education and tailored precaution that can expand the margin of safety for student-athletes with SCT in sport. Safe participation – protection from dangerous and exploitive athletics practices – is the end-game for all Division I student-athletes…and, as President Roosevelt charged, the reserved role and responsibility of the institution and so said the NCAA...until August 1, 2010.

Reference List

1. http://ncaa.org/wps/wcm/connect/public/ncaa/about+ncaa/who+we+are/about+ncaa+history
   NCAA, 2010-2011 NCAA Division I Manual, July 2010

Position in Opposition to 2010-110
The NCAA Should Not Eliminate the Waiver for Sickle Cell Testing

Jeffrey Anderson

For the past year, those of us at Division I institutions have been requiring documentation of sickle cell status from all of our student-athletes under an NCAA requirement that became active on August 1, 2010. This was done either by receiving written documentation of the student-athlete’s status from their primary care physician or by testing the student-athletes when they arrived on campus. Prior to this past year, many institutions were already testing student-athletes for sickle cell trait and educating student-athletes, sport coaches, and strength and conditioning coaches about the risks associated with sickle cell trait in college student-athletes. The potential risks of sickle cell trait have been documented in military recruits and athletes working under conditions of physiologic duress (1-4), and the goal of the mandatory screening program has been to better identify those who may be at risk of life-threatening complications in order to diminish their risk. Along with this mandatory screening program has been an opportunity for the individual student-athlete to refuse testing via the signing of a waiver form after they have been educated regarding the potential risks of sickle cell trait and exertion. Currently, we are faced with a proposal to eliminate this right of the student-athlete to refuse testing, and we should not permit that right to be taken away for the following reasons:

1) There is not uniform support in the medical community for the current testing policy. In fact, some leading experts and patient advocacy groups in the area of sickle cell disease oppose the mandatory screening for the sickle cell carrier state amongst student-athletes.
The information gleaned from sickle cell testing is genetic information about the student-athlete. The level of responsibility in dealing with this information appropriately is substantial. The potential risk of mishandling or misinterpreting this information needs to be accepted by the student-athlete if they choose to undergo testing.

The risks for suffering severe consequences from sickle cell trait are not homogeneous throughout all of our student-athletes. There needs to remain a process by which those who face minimal risk can forego testing, if desired.

Currently, the blood draw associated with sickle cell testing is the only invasive procedure required of our student-athletes. While of minimal risk, the blood draw still holds potential for complication. The risk of complication from this procedure is clearly acceptable if the individual participates in the procedure voluntarily. The risk becomes substantially less acceptable if the student-athlete is compelled to participate with their ability to participate in intercollegiate athletics tied to it.

The precautions to protect student-athletes with sickle cell trait can and should be applied to all of our student-athletes. Serious attention needs to be paid to the manner in which some of our student-athletes are being asked to train.

The NCAA’s decision to require the documentation of sickle cell trait status in all of its Division I student-athletes has not been met with universal acclaim. Although the National Athletic Trainers Association (NATA) and the College of American Pathologists have recommended universal screening of student-athletes, other prominent groups have opposed it. The Sickle Cell Disease Association of America (SCDAA) has publicly criticized the NCAA’s decision for several reasons. Firstly, the testing policy is potentially discriminatory in that the gene prevalence is 8% in African Americans in the United States, but only 0.012% of Caucasians in the United States. Secondly, there are no provisions inherent in the policy regarding the assurance of privacy of this genetic information nor protection from discriminatory use of this information. The SCDAA also properly asserts that testing for sickle cell trait has yet been documented to reduce the rate of training-related deaths. In the absence of empiric evidence, anecdote must suffice, and anecdotally, deaths associated with sickle cell trait have recently occurred at institutions where the student-athletes’ sickle cell status was already known.

Recently, the opposition to universal sickle cell trait testing amongst student-athletes has also been voiced by the Secretary of the U.S. Department of Health and Human Service’s Advisory Committee on Heritable Disorders in Newborns and Children (SACHDNC). This advisory committee points out the paucity of empirical scientific evidence in support of universal testing of athletes. This committee also makes note of the concerns regarding genetic privacy and discrimination. They also state that universal application of training modifications in the military have met with success in diminishing the rate of sudden death in individuals with sickle cell trait. Their recommendation to the Secretary of Health and Human Services in October of this past year was that mandatory universal screening of all college student-athletes was inadvisable.
Proponents of sickle cell screening have been careful to note that the carriage of the sickle cell gene is not a racial characteristic, which is certainly true. However, because of the natural selection process, where the presence of sickle hemoglobin providing protection from malaria, the prevalence of the gene has a clear predilection for people of color. Any screening program, whether targeting people of color, or not, will inevitably have an unequal effect on different races. Also, different races will also have disproportionate risk of complications. The risk of sudden death associated with sickle cell trait is also not evenly divided across all sports. The risk falls predominantly with football. While it is certainly possible that student-athletes in other sports can experience sudden death in association with sickle cell trait, the fact remains that at the NCAA Division I level, those deaths have occurred in football. The causes for this disparity have not been fully elucidated, but the timing of many of the deaths point towards the possibility of flaws in the manner in which we currently train our football student-athletes. Currently, the NCAA’s screening requirements require identical treatment of all student-athletes in all sports. This violates one of the most basic principles of a screening program. For disease screening to be effective, it needs to target those at risk. Mandatory screening for sickle cell trait that targets the golf and the football programs equally is not medically sound. The NCAA is adverse to establishing health care legislation that differentiates between sports or individual student-athletes. However, a policy such as the one currently in place, that allows all student-athletes the opportunity for testing, while still permitting individual risk assessment and decision-making by the student-athlete, along with their health care providers, is medically sound and allows the student-athlete to be an active participant in their own care.

If a student-athlete is unable to provide their sickle cell status to the Sports Medicine staff at their university, the only manner to ascertain that status is via a blood test. While the risks associated with phlebotomy are minimal and generally without significant clinical consequence, the fact remains that phlebotomy is an invasive procedure. It currently stands as the only physically invasive procedure that the NCAA requires its student-athletes to undergo. Risks associated with phlebotomy include syncope, hematoma formation, superficial thrombophlebitis, infection, and peripheral nerve injury. The rates of these complications are poorly described in the literature, and what is present typically addresses blood donation(7). We know that the complication rates are quite low, and the complications are typically self-limited and minor. However, they do exist. In medicine, we are required to have the patient’s permission to perform any testing on them. Specifically, with any invasive procedure, the patient maintains the right to decline that procedure, whether we think it is in their best interests, or not. In intercollegiate sports medicine we infringe on some of our student-athletes rights with the requirement of participating in the drug testing program or in the sharing of their basic injury information with their coaching staff. The student-athletes consent to these stipulations to their participation, just as they would if it were required that they undergo sickle cell screening in order to participate. However, the act of drawing blood from a student-athlete for the purpose of determining genetic information is a significantly greater infringement on their rights as a patient.
The knowledge of a student-athlete’s sickle cell carrier status can be a valuable tool in their medical care. Knowledge of any of our student-athletes’ medical risk factors can serve to improve their care, and it is information that many of our student-athletes should be counseled to provide. However, the value of having this information does not supersede the individual’s right to decline testing for it. It is my recommendation that the NCAA maintain its policy requiring its institutions to provide the opportunity for testing for sickle cell trait for their student-athletes. Athletic departments should also continue to be required to provide annual education for its student-athletes, sport coaches, and especially its strength and conditioning coaches, regarding the risks associated with extreme workouts and workouts in extreme conditions, with the realization that the risks are much greater for an individual with sickle cell trait. All sports medicine and coaching personnel should be well-versed in the symptoms associated with a pending crisis for a sickle cell trait student-athlete and the proper interventions to make before symptoms progress. All sports medicine personnel should also be adept at identifying and emergently managing an episode of sickle cell related collapse, should it occur. Additionally, institutions need to readdress their training and conditioning programs. The guidelines recommended by the NATA for the training and conditioning of student-athletes with sickle cell trait should be applied universally in the strength and conditioning realm. We make the claim with sickle cell testing that the training modifications made for an individual with sickle cell trait will have no detrimental effect on the performance development of the student-athlete. If this is the case, why can’t we apply these modifications to all student-athletes? This has been done in the United States military with success, and it should be adequate for our student-athletes. More attention also needs to be focused on the risks of extreme training early during training periods. In the sport of football, these periods are at the beginning of winter workouts, at the beginning of summer conditioning, and at the beginning of training camps. Many, but not all, of the sickle cell trait casualties have occurred during these periods, but in a larger sense, these periods of time are of high risk for all manners of training-related morbidity.

It is also my recommendation that we do not eliminate the individual student-athlete’s right to refuse testing for sickle cell trait. While the knowledge of a student-athlete’s sickle cell status may help us in intercollegiate athletics provide a safer training environment, that benefit does not outweigh the student-athlete’s right to decline testing. The absolute risks associated with intercollegiate sports participation with sickle cell trait have not been fully delineated, and these risks are not the same for all student-athletes. A “one size fits all” compulsory testing program is not in our student-athletes’ best interests.

Reference List


Response to the Affirmative

Scott Anderson

Dr. Anderson has salient points rendering much of a rebuttal to “majoring in the minors”. I’ll address antagonists, ‘choice’, and risk.

SCDAA has, in multiple public statements as late as the death of Dale Lloyd, denied that any student-athlete has ever died an exertional sickling death.(1) Current SCDAA comments, though, now echo the excess of SCT in student-athlete deaths. Further, SCDAA summarily rejected the Inter-Association Task Force on Sickle Cell Trait in the Athlete (Task Force) “Consensus Statement: SCT and the Athlete” but now posts its “Precautions and Treatments”.(2) SCDAA has consistently come late to SCT and the student-athlete and holds fast to the ‘military’ model. The Army experienced transient success with respect to exertional heat stroke death and exertional sickling death but so-called ‘universal precautions’ have not eliminated exertional sickling deaths in the Army nor will they in collegiate athletics.(3)

In 2007, given lack of knowledge let alone consensus, the Task Force convened for the purpose of raising awareness and reducing risk. The Task Force sought solutions with a primary statement that despite no evidence-based proof that screening saves lives, the case for screening is strong. “Knowledge of sickle cell trait status can be a gateway to education and simple precautions that may prevent sickling collapse and enable athletes with sickle cell trait to thrive in sport.”(4) Witness, no exertional sickling death has yet occurred in a college that screened and took proper precautions.

Dr. Anderson avers the student-athlete’s right to refuse testing for sickle cell trait with a tandem tenet “…knowledge of a student-athlete’s sickle cell carrier status can be a valuable tool in their medical care. Knowledge of any of our student-athletes’ medical risk factors can serve to improve their care.” I say, even with safe, science-based training and conditioning, the modifying factors of environmental heat, altitude, acute illness, etc., that exacerbate sickling remain and so shall our ‘need to know.’ As much as I might believe ‘need to know’ supersedes the student-athletes right to choice, it does not. The student-athlete has choice.
The choice not to test for SCT in the PPE for the Division I student-athlete, however, demands a declination and signed release wherein, by exercising the right to choose, the student-athlete gives up their right. Release is, by definition, forfeiture of ‘right’ and the student-athlete has absolved the institution of its duty of care. Provision herein is a purposeful shift of protection against dangerous and exploitive athletics practices from the institution to the student-athlete subsequent to tacit admission that student-athletes, on their own, lack sufficient information to make an informed decision in the PPE.

The Task Force has charged ‘choice’ in the PPE to the institution - each institution should carefully weigh the decision to screen in the absence of documented newborn screen results. Nowhere is authority or responsibility granted to anyone in the PPE other than a physician.(5) Therefore, with regard to SCT and every other medical matter, final authority in the PPE rests with the physician. As an agent of the institution, with determination based on medical standards of practice and the best available science, the physician is charged with acting in the best interests of their patient/student-athlete. In short, the physician should decide which teams to screen for SCT.

The Task Force sought to illuminate risk. All NCAA exertional sickling deaths have occurred in so-called conditioning/tryout ‘testing’ or conditioning workouts. There have been no exertional sickling deaths in practice or competition! I wholeheartedly endorse Dr. Anderson in that “...serious attention needs to be paid to the manner in which some of our student-athletes are being asked to train...”

Reference List


**IMPORTANT DATES**

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<td>Regional Rules Seminar</td>
<td>May 16-20, 2011</td>
<td>Tucson</td>
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<td>Regional Rules Seminar</td>
<td>June 6-10, 2011</td>
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<td>NCAA Convention</td>
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<td>NCAA Convention</td>
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Response to the Negative

Jeffrey Anderson

In his essay, Mr. Anderson does a fine job of expressing the value of awareness of the potential risks of extreme exertion with sickle cell trait (SCT). Mr. Anderson and Dr. Randy Eichner, with whom he has worked at the University of Oklahoma, have done an exceptional job of educating those of us in the sports medicine profession, and the athletic community at large, about the risks associated with SCT. Because of their work we are better poised to protect our student-athletes as they train.

One of our tools in protecting our student-athletes is knowing their sickle cell gene carrier status. With this knowledge, we can give our student-athletes with known SCT added attention, which we hope will provide them protection. However, the knowledge of a student-athlete’s sickle cell gene carrier status has not universally protected them from sudden death, and while we believe it should help, we’ll likely never have the statistical power to prove that it does. Even with the logical, though unproven, assumption that this knowledge is beneficial, neither the potential for us to do good, nor the potential for litigation in case of a bad outcome, give us the right to coerce our student-athletes into testing.

Mr. Anderson makes some specific comments in his essay with which I must disagree. He notes, “Safe to say that as one is unaware of SCT status one is, too, unaware of any risk.” This statement implies that our student-athletes cannot be protected from the conditions that are most related with deaths associated with SCT. In fact, the alteration of our training practices to match the NATA recommendations for athletes with SCT should not be detrimental to any of our student-athletes’ training. It would also offer some protection from other complications associated with overly zealous training practices. Mr. Anderson uses the phrase “protection from dangerous and exploitive athletics practices” in several areas. It is attention to these practices that will serve our student-athletes best.

Additionally, one need not know whether someone has a condition to be vigilant regarding its signs and symptoms and to recognize them should they arise. This is how most of medicine is carried out. While it is certainly helpful to know a patient’s coronary artery anatomy, one need not know it to recognize the symptoms of an impending heart attack. It is through the education of sports medicine professionals, coaches, and student-athletes about the symptoms of a sickling crisis that Mr. Anderson and others have already provided a tremendous service.

Mr. Anderson also states, “The opt-out amendment is established upon idealist assumption that given education and opportunity student-athletes will always act in their best personal interests regarding testing for SCT in the PPE and who better to make the determination than the individual.” In this, he is also incorrect. The opt-out amendment recognizes that individuals retain the right to make their own health decisions, whether they may be in their own self-interest, or not. Opting out of testing for sickle cell gene carrier status is a bad idea for many of our student-athletes. It makes our job of protecting them more difficult. However, it does not make it impossible, and our ease in protecting them does not supersede their right to refuse an invasive test of their genetic information.