

Removing contact from school rugby will not turn children into couch potatoes

Allyson M Pollock, Graham Kirkwood

Background: Recently, an open letter calling for a ban on tackling in school rugby was sent to the Chief Medical Officers (CMOs) and Ministers of Sport in Education and Health in the UK and the Republic of Ireland. The Royal College of Paediatrics and Child Health (RCPCH), and the Faculty of Sports and Exercise Medicine (FSEM), have responded with statements on their respective websites.^{1 2} These statements mirror claims made in a commentary in the *BJSM* co-written by the CMO of Scotland, entitled “Turning people into couch potatoes is not the cure for sports concussion”.³

Both the RCPCH and FSEM statements take an approach of denying the evidence that exists, creating a smokescreen of new initiatives that await evaluation and finally conflating the benefits of physical activity and exercise with sport and contact sport in particular.

First, turning to the suppression and denial of evidence of harm. Writing on behalf of the FSEM, Dr Jackson claims that “There is insufficient good evidence to justify a call for tackling to be removed from school rugby”. No evidence is provided to support this statement. In contrast, there are decades of substantial and incontrovertible evidence that most injuries, including concussion and spinal injury, in rugby union and rugby league, occur during collision and tackle.⁴⁻⁶ Moreover, the risks and rates of injury are high, and injuries are serious in nature. While studies of injuries in children playing contact rugby are sporadic, and neither comprehensive in terms of coverage nor consistent in definitions of injury, the findings are consistent—collision and tackle are where most injuries occur, injuries occur frequently and prevention strategies are not evaluated.⁴⁻⁷

Second, those opposed to removing contact seek to undermine the evidence of harm by referring to a slew of new initiatives in order to claim that changes to the game have reduced the harms. Thus Professor Viner for the RCPCH writes,

“It is vital that we work to address the problems of injury to children when playing sports. We note that there have already been changes to address issues of safety in school rugby, and it is important we now give these changes time to bed in”. He gives no detail on which changes have been implemented, how they will bed in or for how long or indeed how these changes are being evaluated. Our research shows that most initiatives are not evaluated.⁷

Third, there is tendency to conceal the evidence of harms with claims of benefits. Professor Viner writes “However it is as equally vital that we appreciate the benefits gained from children playing sports in school. Currently around 1 in 3 children aged between 2 and 15 in the UK are overweight or obese, making it imperative that we make as much effort as possible to encourage more children and young people to take up regular exercise. Although there are risks attached to any sport, it is imperative that we don’t let this prevent our children from getting out and taking part in much needed physical activity.”

The risks are again suppressed while the benefits of physical activity are wrongly attributed to sport and in this case contact sport. There is no evidence of benefits unique to sport and contact sport, the conflation of the benefits of physical participation and exercise with the benefits of contact sport, and attributing the obesity epidemic to a lack of participation in contact sports appears to be designed to confuse.⁸

The FSEM statement has called for a National Sporting Injury Register. We and many others have long advocated routine injury data collection but it is difficult to know how the FSEM recommendation will work. The Royal College of Emergency Medicine (RCEM) has been working on the pilot and roll out of collection of detailed injury data in emergency departments with the Department of Health (<https://www.england.nhs.uk/ourwork/tsd/ec-data-set/>), which is a more sensible approach to begin with, while the Faculty of Public Health Medicine (FPHM) has particular expertise in routine data collection and surveillance. A

coordinated response by the FSEM with the RCEM and the FPHM would be more appropriate. Nevertheless, while we need data, there is no reason not to act and follow the precautionary principle, *namely to remove contact, including the tackle from the school game*, until the reintroduction of contact can be shown to be safe.

It is a concern that, in the absence of independent funding for research, the interests of academic and medical institutions and sports medicines research, and clinical practice and developments, could conflict with the needs of children, *especially where funding comes from corporate sporting bodies and commercial sponsors of sport*. She or he who pays the piper calls the tune.

We hope the government will draw on evidence when it responds to our letter and that the Academy of Royal Medical Colleges will ensure that the pronouncements of their member organisations are evidence based.

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