Editorial

Doping taboos

Hidden behind the procedural and chemical technicalities of dope control in sport are questions which have somehow become taboo, but which should now be openly discussed, especially if the controls are to command the full support of sportsmen and women and their attendants.

Firstly, there is little evidence that any of the long list of chemicals covered by control regulations improve sporting performance. This reflects the virtual monopolisation of dope control by chemists acting on theoretical grounds rather than the involvement of experienced team doctors familiar with clinical responsibility and using the pharmacopoeia. What, for instance, is the dose of any listed drug which causes the alleged benefit to performance which makes it forbidden and what is the degree of benefit available? How would the drug's side-effects prove counter-productive?

Is it true, as we were quietly told earlier, that codeine was originally prescribed solely because of its nuisance value in the detection of other opiate derivatives by older analytical methods? If so, is this a valid reason to brand an athlete who uses codeine as a cheat? It is said that the major aim of dope control is to protect the athlete. While the use of diuretics in 'making weight' is dangerous for the dehydration it produces, is this a reason to forbid all diuretic use, including the innocent control of premenstrual oedema or as first-line orthodox treatment of hypertension? Who decides these issues? Are they experienced physicians reflecting the broader responsibilities of medicine to the population? Have they considered the consequences of ill-considered bans?

Who is responsible for the consequences of an 'amateur' athlete losing high earnings as a result of the use of a legitimate prescription of an orthodox medicine, legally, if sport's dope controllers don't approve? Who has the right to demand that a subset of our patients should have their legitimate medical treatments altered, especially when there is no published evidence of either the benefits or dangers of that therapy in the individual's context (for example, a shooter could be banned for taking diuretics for hypertension because shot putters take the same drugs to mask their anabolic steroids!)

If, truly, dope controls are to protect the athlete as much as to ensure fair competition (whatever that is!), then should we not be looking at athletes living on prolonged enormous daily doses of non-steroidal anti-inflammatory drugs, where the risks of such dosages are well documented; or perhaps the real health risks such as competing while ill? Or is that too difficult?

Professionalisation of sport and the increasing tendency of governing bodies to regard themselves as above merely national laws makes the whole logic of dope control increasingly difficult to question, let alone criticise. There are other legal matters which sit uncomfortably in this agenda, including the autonomy of governing bodies and civil rights issues (including the right to deprive athletes of their livelihood) which have simply been ignored by those who seek to impose their scientifically unproven views of what constitutes fair sport upon the wider community. Team doctors have an immediate interest in this issue and the broader sports medicine community owes itself an open-minded review of the issues at stake.

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Announcement

The *Journal* will be changing its publishing arrangements at the end of Volume 29 (December 1995). Please note the changes in address for all communications, with immediate effect, as follows: All manuscripts should be submitted to:

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