ANABOLIC DETECTION AND ENFORCEMENT

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First, let me say how much I appreciate being invited to attend this distinguished gathering of medical experts. I am sure I can speak for all sports administrators in saying how much we value the contributions of our colleagues in the field of medicine in all aspects of sport development and control. The closer our collaboration, the better and more satisfactory will be the results achieved.

I have earlier had the benefit of hearing the views of one of our present Chairmen, Sir Roger Bannister, and those of Professor Prokop, one of the Chairmen in the opening session, and a member of the I.A.A.F. Medical Committee, with whom I have had the pleasure of working on numerous occasions, and I am left in no doubt about the vital necessity of stamping out the use of anabolic steroids by our athletes, in the interests of their own health and well-being.

We must consider the problems of anabolic steroids, not in isolation, but as part of the general policy of anti-doping controls. Doping has long been outlawed by the I.A.A.F. and we first introduced an anti-doping rule in 1928. In more recent years our anti-doping rules have been strengthened by defining more closely what we mean by doping, and incorporating a list of doping substances. Anabolic steroids have been included in this list since 1970.

Furthermore the penalties for using dope have been increased. A guilty athlete is not only disqualified from the competition where the offence is detected, but also becomes ineligible to take part in competitions under I.A.A.F. Rules. He is therefore effectively banned for life.

Without doubt the main reason for introducing anti-doping rules in the I.A.A.F. was to uphold the principle of fair play. The harsh discipline imposed on offenders may be partly due to the deceitful nature of the offence, but has most certainly been reinforced by the knowledge that doping can have lasting ill-effects on athletes and must therefore not be allowed to become prevalent.

To ensure that our regulations are respected, and in fairness to the athlete, it is essential to carry out tests as frequently as possible and under conditions which allow no possibilities of error.

We have drawn up a detailed procedure, published in

booklet form, for the conduct of tests, including the collection and identification of urine samples, and the method of analysis.

We encourage our constituent bodies to hold anti-doping controls in all major international meetings, and they do in fact take place at the European Championships, European Cup competitions etc., and some other major international competitions in other parts of the world. Also many National Athletic Federations operate anti-doping controls within their own areas. It has not however so far been considered practicable to make it obligatory to have anti-doping control at all area championships or Area Games, partly due to lack of local laboratory facilities, and partly due to the cost.

It seems to us undesirable to single out anabolic steroids as a separate doping problem, and it is our policy simply to extend the existing analytical methods so as to cover the detection of steroids under the same procedures as are used for the general dope control. We hope therefore to receive the approval of the I.A.A.F. Medical Committee in the near future to a list of recommended hospitals or laboratories which have the essential technical facilities for radioimmunoassays and the experience to carry out all kinds of dope control.

I referred earlier to the need for eliminating any possibility of errors. To allay possible doubts, our Regulations provide that the athlete may challenge the findings of the Doping Committee and demand a check analysis of the corresponding reserve sample, in the presence of his own medical attendant, or may require the reserve sample to be analysed independently in an approved laboratory in another country. This of course can lead to delays, inconvenience and expense.

We have under consideration therefore proposals to withdraw the second alternative. The procedure then would be for immediate disqualification when the first series of tests proved positive, but leaving open the possibility of an appeal and a second series of tests in the same laboratory. This procedure would require full confidence in the laboratory, which highlights the importance of the accreditation to be given by the I.A.A.F.

We have received expert advice that we should designate the laboratory when requesting Organising Committees of major competitions to set-up anti-doping controls, and that these laboratories should be used to test

for steroids as well as for other doping substances. This would undoubtedly produce the most reliable results, but it would add to the problems caused by delays in announcing disqualifications, and we may feel obliged in some cases to carry out tests similar to those conducted in the past, and (once these tests are completed) to send the reserve samples away to a specially equipped laboratory for steroid tests. This is what happened for our European Championships in Rome last year.

A further problem, which appears to remain with us to some extent is that of identifying positively the particular anabolic steroid used. The I.A.A.F. rules require the actual doping substance to be identified beyond reasonable doubt. I have heard however that gas Chromatography/Mass Spectrometric techniques have

also been developed which help in this confirmatory identification.

Finally, the International Sports Federations have recently requested the I.O.C. to make the holding of anti-doping controls a condition for the grant of I.O.C. patronage to Area Games, and if this is enforced it will greatly assist us in extending fully comprehensive controls to all the major international competitions. An extension of controls will inevitably increase the need for qualified medical officers to supervise the procedure at our meetings, but I am confident that the help we shall need will be forthcoming. The interest shown by the medical profession in this meeting is evidence enough.