CHAPTER THREE

DRUG TESTING

INTRODUCTION

3.1 Drug testing is intended to ensure compliance with the regulations of the various sporting bodies. It does this by ensuring that athletes using drugs do not win competitions at the expense of those who do not. More importantly, however, drug testing can be used as a means of reducing the use of performance-enhancing drugs. An effective drug testing program requires explicit rules for selecting athletes for testing, collecting their urine samples, testing for substances and follow-up action. It also requires the development of uniform national policies and a co-ordinated approach by the Commonwealth, the States and the various sporting organisations.

3.2 Reducing the use of performance-enhancing drugs (doping) does not stop with the program of testing. This section of the report will also discuss the closely related areas of drug policy, education programs, appeal procedures and the independence of test programs.

HISTORY OF DRUG TESTING

3.3 In the 1964 Olympics, four years after cyclist Knut Jensen died as a result of drug use in his event, testing for the use of stimulants was introduced in cycling events. Stimulants, such as amphetamine, were known to increase alertness, reduce

fatigue and increase competitiveness and hostility. In the 1968 Olympics, testing of stimulants was extended to all sports and routine testing introduced.

3.4 In 1971, the IOC Medical Commission published the first list of banned substances including both stimulants and narcotic analgesics. Athletes were, as a result, routinely tested for these substances at Olympic Games. Narcotic analgesics, which include morphine and its related compounds, have a history of abuse both within and outside sport. They have the effect of reducing pain and inducing feelings of euphoria, but have significant effects on breathing and have a high risk of addiction.

3.5 Anabolic steroids were first banned in 1974 by the IOC Medical Commission when the technology to detect these substances was developed. These are chemicals closely related to the male hormone testosterone and have been used to increase muscle bulk, strength and power and to increase aggressiveness. They can have deleterious effects on health as described in Chapter Two. In contrast to the other substances banned before 1974, the greatest effect of anabolic steroids is gained during the training phase. The drug may not be present at all in the athlete's body at the time of competition, yet still enhance performance. This will be discussed further in later sections.

3.6 In the 1982 Brisbane Commonwealth Games, a test was introduced to detect the use of testosterone to enhance performance. This hormone is present in all healthy people of both sexes, but in varying amounts. When taken it has similar effects to anabolic steroids in increasing strength, power and aggression, but also has greater masculinising effects than anabolic steroids. Detection was based on comparing the level of testosterone with that of a closely associated chemical in the body (epitestosterone). If testosterone is ingested the ratio between the two will be greater than that normally found in a healthy person. In 1982 a test was also introduced for caffeine.

This set a proscribed level well above the level commensurate with everyday drinking of tea, coffee or cola drinks. Caffeine is a mild stimulant which can be abused by the use of excessive amounts to increase alertness and reduce fatigue.

3.7 Another class of medications, beta-blockers, was included on the list of banned substances in 1985. These drugs, which are used to control high blood pressure and other heart problems, can be used to reduce tremor in sports, such as archery or shooting, which require fine movements. Blood doping was also banned in 1985. This is a practice where an athlete's own blood or the blood of someone else, is transfused into the athlete before competition. This has the effect of increasing the blood's ability to carry oxygen to the muscles and increases endurance.

3.8 In 1987, the IOC Medical Commission included diuretics in the list of banned substances and these are now tested for at sporting events. Diuretics increase the production of urine and lead to dehydration. They are used in sport for two purposes. One is to reduce weight to meet weight limits for sports such as rowing or weightlifting. The second purpose is to dilute any trace of anabolic steroids in the urine at the time of competition testing, when the use of anabolic steroids had ceased some weeks previously. The IOC Medical Commission has also banned practices which alter the integrity and validity of urine samples. One named example is a drug called probenecid which inhibits the excretion into the urine of anabolic steroids.

3.9 Many of the drug tests and banned substances mentioned above will be described in greater detail in following sections of this chapter.

PURPOSE OF DRUG TESTS

3.10 The most important objective of a drug testing program is to deter athletes, and others associated with athletes, from

using performance-enhancing drugs. Drug testing can also help ensure that those using performance enhancing drugs are not able to claim sporting records or titles achieved with their assistance. The deterrence effect of a drug testing program may be produced in more than one way. Most obvious is the fear of being caught. However, Dr P Gwozdecky, Sports Medicine Director of the Australian Ice Hockey Federation, told the Committee that:

> one of the best rationales for drug testing that I have heard was from some American kids at a school being tested. They found that the enforced random testing rules helped them to combat the strong peer pressures to experiment by giving them an even stronger reason on top of their own decision not to partake. The kids found this a comfortable out that they could relate to.[1]

3.11 To be effective, a drug testing program must result in a high perceived risk of detecting drug use, have appropriate penalties, and be associated with an education program to alert athletes of the risk of detection. The testing program should provide clear and unambiguous results which should be able to stand up to the scrutiny to which they would be subject in a court of law and it should be associated with efforts to reduce the availability of drugs to athletes. Without all of these elements a drug testing program would be ineffective, and would not deter athletes from taking drugs. The existing testing program in Australia has not met all these conditions. For example, Mr Kemp commented that:

> The testing program in Australia is basically regarded as a joke by the athletes. In the case of track and field the only tested meet is usually the national championships and they know when that is on, so athletes can easily organise their schedules to avoid the testing.[2]

SELECTION FOR TESTS

Athletes at Risk

Introduction

3.12 If testing is to deter drug use it is necessary that the group from whom selection of athletes for testing will be made includes all athletes likely to use drugs. The evidence before the Inquiry indicates that virtually all sportsmen and sportswomen are at potential risk of using performance-enhancing drugs: all sports, all ages and both professional and amateur.

3.13 All athletes who compete at an international level are at risk of being tested. In major international events, including the Olympics, it is normal for the first three or four place-getters to be tested along with two others chosen at random from the list of competitors.[3] It is not certain, however, that this system has always operated fairly. Mr Kelvin Giles cast some doubt on this when he described how:

> When I toured Europe before I retired in 1986 from track and field coaching, taking Australian teams and other teams from around the world through Europe to the major meetings that go on there, I would very often be asked by the meet director or one of his aides, 'Are all the members of your group okay for drugs testing? Would you mind submitting to drug testing? Although we never had to answer 'No, we do not want anybody touched on this one', it was obvious that, if you said, We do not want to be tested; they will be found positive' they would not test you.[4]

3.14 In Australia two overlapping groups of athletes are subject to testing: those who compete in national championships and those associated with the Australian Institute of Sport (AIS) or the Australian Sports Commission (ASC). Fourteen sports in Australia have drug testing programs, either at major sporting

events or random testing at other times.[5] All athletes holding AIS scholarships or under the Sports Talent Encouragement Plan of the AIS are subject to random testing.[6] During 1988, all potential Olympians were also at risk of being tested.[7] In addition, some professional sportspeople may be subject to testing.

Banned Athletes

3.15 Given that one of the functions of a drug testing program is to discourage identified drug users from continuing to use drugs, it is clear that athletes who have been banned from their sports as a result of drug use should continue to be included in the group of athletes subject to testing. Mr Haynes from the National Program on Drugs in Sport commented that:

> there is no doubt that certain athletes in the past overseas have used the two-year proscription from sport as a great opportunity to bulk up, [use steroids] while not competing.[8]

3.16 Banned athletes have already demonstrated a propensity to use drugs and, it could be argued, should be subject to more frequent testing. Moreover, it would be appropriate that testing carried out during an athlete's suspension be carried out at the athlete's expense. Of course, athletes banned for life with no possibility of reinstatement need not be tested as they cannot compete.

3.17 For this system to work, banned athletes should be given the option one year before they are to be reinstated of paying for four tests in the next year or not applying to compete in the sport. if an athlete subsequently changes his or her mind about wishing to compete, testing paid for by the athlete should be

carried out for one year before the athlete would be allowed to compete. This would effectively prevent 'bulking-up' during a period of suspension.

Discussion

3.18 One obvious criticism of current drug testing programs in Australia is that their coverage of athletes is limited to those associated with the AIS or potential Olympic selection. This is a narrow group of between 300 and 500 athletes. Mr Haynes of the National Program on Drugs in Sport commented that:

> One of the biggest problems with the testing program is that there certainly is too great a focus from the Institute and from other government backed programs.[9]

3.19 The Committee received evidence that the use of performance enhancing drugs is not limited to international and Australian ranked athletes. While Mr Giles thought that elite athletes were 'vulnerable' because of their training environment and current ratings,[10] both Dr Millar and Dr Dawson were able to state that their overwhelming experience with anabolic steroid use was with 'ordinary run of the mill people'.[11] Dr Millar had experience with bodybuilders and footballers while Dr Dawson's experience was mostly with bodybuilders but included sports such as powerlifting, weightlifting, middle-distance running and underwater diving.[12] The range of athletes who used banned substances is described in more detail in Chapter 2. The Committee notes, however, that some major professional sports such as Australian Rules Football, which are at risk of drug abuse, do not have testing programs in place.[13]

3.20 It is clear that a testing program which concentrates only on the top 300 athletes in Australia would not address a significant drug abuse problem amongst ordinary sportspeople in sports such as bodybuilding or powerlifting. The proportion of

athletes using anabolic steroids obviously varies across different sports and at local, state and national levels of performance. The lack of testing programs in professional sports is an area of major concern. The Committee is of the opinion that the risk of being tested should extend to all potential users of drugs and that the level of risk should reflect the likely level of use. This means that high risk sports such as weightlifting would attract a high frequency of testing, while low risk sports would be included but attract a relatively low frequency of testing.

Consent

3.21 A requirement that athletes be included in a drug testing program opens up the general debate about civil liberties and rights to privacy. It is important to note that athletes in all sports voluntarily give up rights and agree to abide by arbitrary rules as part of the game. All athletes understand that abiding by the rules of the game, and accepting penalties imposed by referees and umpires, contributes to the health, safety and enjoyment of a sport. Drug testing, however, is remote from the actual event and in the case of testing for anabolic steroids, imposes conditions on the way an athlete trains for an event.

3.22 There is no doubt that drug testing is 'invasive of an athlete's bodily privacy' and it is necessary to ensure that testing does not unfairly compromise athletes' fundamental rights. This is perhaps especially the case with random and targeted testing, as opposed to event testing. Mr Hayden Opie, lecturer in law at the University of Melbourne, noted, however, that:

> the narrow legal point which needs to be made is that so long as athletes agree to participate in testing their legal rights to privacy are not infringed.[14]

For this reason it is widely recognised that athletes must consent to participate in drug testing programs.[15] This consent is now automatically included in scholarship agreements, entry forms and team agreements. This may raise the question of 'whether it is fair and reasonable that such a requirement be imposed'[16] and it is notable that US courts are increasingly restricting drug testing of athletes, citing rights of privacy and other civil rights.[17]

3.23 In considering whether it is reasonable that sportspeople be required to give consent to being subject to drug testing it is important to note that they are not compelled to participate in sport. If they object to drug testing they can choose not to be involved in sports. However, those who decide to participate have a right to fair competition and, especially in the professional sports, they have a right to compete against athletes who are not using performance enhancing drugs. This is not only a matter of fairness, and ensuring, a 'level playing field' to the extent that that is possible. It is also because the use of drugs can result in damage to others through loss of control or poor co-ordination. An example is provided by steroid usage. A submission to the Committee from the Canberra College of Advanced Education Sport Studies Centre, pointed out that increased aggression is considered an advantage by some, but that it can reach uncontrollable and dangerous levels. The submission gave examples, including that of a bodybuilder who reached out of his car to push away a truck he felt was too close.[18]

3.24 Given that testing is warranted, there is much that can be done to ensure that an athlete's rights are properly guarded. In particular, this involves the establishment of detailed rules and procedures for conducting the tests. This means that athletes can challenge test results with the allegation that the required rules and procedures have not been adhered to and, if there is substance to such a claim, the test result cannot be used as a basis for penalising the athletes. This is why the Committee

views with considerable concern the many cases brought to its notice in which the necessary protocols have not been followed. The is discussed later in this Chapter, and particularly in Chapter Eleven dealing with the AIS drug testing program.

3.25 Because drug testing is based on consent it is not legally permissible to compel submission to a test. Mr Opie warned that:

> Occasionally, an athlete will withdraw a prior consent and, if that occurs, it is not legally permissible to compel submission to a test. This has meant that the rules governing tests must provide for some form of penalty, usually disqualification, for a failure to submit to a test.[19]

3.26 Society accepts some infringements of civil liberties when the benefits are great. Random breath testing is a good example where drivers accept that police can interrupt their journey, without due cause, to test them for alcohol. The benefit to society is fewer drink drivers and reduced effects of road crashes. In drug testing, athletes are asked to provide urine samples and be tested for drugs for their own benefit. As a result, they are able to compete against fellow athletes who are not cheating, or in a drug-induced aggressive state. Although a drug testing program in effect becomes compulsory for sports people because the option of no longer competing is not one they are likely to consider, the Committee believes that such an infringement of rights is completely justified. In some contact sports, steroid-induced aggression may even threaten serious irreversible injuries.

Selection Basis and Timing

Introduction

3.27 There are three different types of drug tests which differ on selection basis and timing:

- Competition or event testing, which occurs during or immediately after a competition or event. The typical example would be Olympic Games testing;

- Random testing during the non-competitive times, where athletes are selected by an unbiased method at any time throughout the whole year;

- Targeted or discretionary tests where athletes are selected for a test because they are at the stage of their training when drug use is most likely. An example would be to test weightlifters for anabolic steroid use some 6-8 weeks before a major competition.

3.28 Internationally, it is rare for tests to be conducted at anytime other than at competitions, and then usually only major competitions. A common basis for selecting athletes for testing is their result in the competition (for example, first four place-getters) and an element of random selection among other competitors. Random selection means that each athlete has an equal chance of being selected using an unbiased method. In a few countries, such as Norway, athletes are subject to tests during training without prior warning.[20]

3.29 The National Program on Drugs in Sport advised the Committee that approximately 80 per cent of the 500 tests conducted in 1988 were taken 'at random during training'.[21] The Committee believes that some proportion of these tests in the AIS and AOF testing programs were not strictly random and involved

elements of targeted testing such as full squad testing at the AIS or testing AOF athletes on reports of suspicions. Nevertheless, it is important to note that only a small proportion, the remaining 20 per cent, was conducted at competitions.

3.30 At the AIS most athletes were selected for testing using what was described as a 'lotto' system of numbered balls.[22] This system developed from one using dice and random number tables.[23] This is a strictly random process. A small proportion of athletes was also tested as a group at the discretion of the AIS director.[24] The basis on which the Director chooses to exercise this discretion is unclear. A full analysis of the AIS testing program is given in Chapter Eleven.

Discussion

3.31 Testing during competition (or immediately after an event) aims to detect the use of drugs which enhance performance during competition and which have to be present in active amounts during the competition. This applies to all of the banned classes on the IOC list, except anabolic steroids. Dr Corrigan commented that:

> These days the problem with stimulants is very small and because stimulants are taken at the time of the event the ability to pick them accurately is very good.[25]

3.32 However, Dr Corrigan identified anabolic steroids as the 'major problem in the world today', and commented that:

> If you are going to control them there is no way you are going to do it, as is presently done, by measuring people after the event. The only way that it would be done is for there to be a world-wide agreement or system so that you could random test any athlete during the training season.[26]

3.33 The overwhelming weight of evidence received by the Committee supported the need for testing for anabolic steroids outside of competitions and in 1988 the World Conference on Antidoping in Sport recommended that:

> Out of competition doping controls should be introduced as soon as possible by the international federations and national sports organisations on a year-round basis.[27]

3.34 Conducting random tests for anabolic steroids during the athlete's non-competitive periods can be considered inefficient to the extent that it may be possible to concentrate testing on periods when anabolic steroids are most likely to be used. Mr Giles described how:

> Basically, in one Olympic year you would go through to phases of training that will demand that you are at destructive levels of training, and they [steroids] are taken during those destructive levels, so each should be tested at least twice, but probably four times. It should be twice in that critical cycle that you can predict, and then twice again.[28]

Mr Hurst agreed:

> It is the heavy workload phase that sets up the rest of the competitive season, so it is in the heavy workload phase that they would presumably be taking steroids or most other things.[29]

Ms Lisa Martin shared this view:

> I think Australia should set up a random body for drug testing and test athletes at random throughout the year, not just in competition, but probably also when they are doing their strength building phases of training.[30]

3.35 It was suggested to Mr Haynes that testing during peak training times would be an important component of a drug testing program. He agreed and commented that:

> one of the big problems is trying to escape this random nature because you can end up with a fairly ineffective program. You have to have something more than random. Obviously, it is no good saying, 'We are going to test you once every three months' or 'We are going to test you once on a Monday' or 'All AIS athletes will be tested on a Monday'. We have to get away from that random nature and I think we have to use the expertise that we have. If we are going to invest what will amount to hundreds of thousands of dollars of tax-payers money we have got to make it as cost-effective as possible, I believe. While there should always be some sort of random element, there has to be some other mechanism.[31]

3.36 These criticisms suggest that because of the nature of anabolic steroid use, it is virtually no use testing for them only at the time of competition. Athletes are well aware of how long before a competition they should stop using anabolic steroids so as to have no traces in urine at the competition; the so-called 'clearance time'. Only athletes unskilful in the use of anabolic steroids are likely to be caught by competition testing. Testing for anabolic steroids must be directed to the non-competition phase of an athlete's yearly schedule. Further, because the times when steroids are most effectively used in an athlete's training schedule are predictable, testing should be targeted to those periods to maximise the deterrent effect for the least number of tests.

3.37 From what has been said it is clear that an effective drug testing program should include a proportion of competition testing, random testing and targeted testing. Table 3.1 shows the advantages and disadvantages of each of these regimes. In the Committee's view it is necessary, in order to protect the integrity of a drug testing program, that 25 per cent of tests

should be random. An appropriate mix might be to have 50 per cent of the remaining tests targeted and the remaining 25 per cent used for competition testing.

TABLE 3.1
ADVANTAGES AND DISADVANTAGES OF DIFFERENT DRUG TESTING REGIMES

A. Competition Testing

- Establishes bona fides of place getters and records
- Detects abuse of drugs other than anabolic steroids

- Does not deter steroid abuse

B. Random Testing

- Ensures an element of risk for all sportspeople and has good deterrent effect
- Is effective against anabolic steroid use
- Protects tester from allegations of bias

- May waste testing funds in low risk areas

C. Targeted Testing

- Enables testers to focus on high risk sports
- Enables testers to follow up complaints to test reports about specific athletes

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- Opens testers to allegations of bias and favouritism

Australian Olympic Federation (AOF) Testing Program

3.38 The random testing program undertaken by the Australian Olympic Federation (AOF) on potential Olympic athletes from 1

January, 1988 was subject to criticism from a number of witnesses who appeared before the inquiry.

3.39 Dr Millar said that because the AOF gave prior notice of its random testing program it was bound to be ineffective. He stated that to identify athletes using performance enhancing drugs 'you would ring them up today and tell them you wanted them on Friday'.[32]

3.40 Mr Darren Clark, an Olympic athlete agreed:

> If it was up to me I would have them go out and test them straight away and get rid of them.[33]

Mr Hurst, Mr Clark's coach, went further to suggest that:

> I cannot see any reason for taking steroids after Christmas, after New Year, because the selection trials are usually in March and the State titles are in February. That is the testing period - that is the high competition phase. Presumably nobody would take drugs during the competition period, so the time to test them would be in the September to December period.[34]

3.41 Dr Millar's criticism was that athletes were given notice in November 1987 that a random testing program would begin on 1 January 1988, allowing them to cease using anabolic steroids by that date and avoid detection. Mr Hurst's criticism was that the testing program was carried out when it was too late. The period when athletes would have used steroids was in the last months of 1987. The program neither detected steroids users, nor deterred them from using steroids in their yearly cycle.

3.42 Mr John Coates, Vice-President of the Australian Olympic Federation (AOF), responded to this criticism:

> We brought in our doping policy on 6 November [1987] - and I am aware this is a criticism from Dr Millar - and we brought in a life ban for the first time. We thought it only proper that we give notice that we would start testing on 1 January. I do not think it would have been the right thing to do by the athletes to have tested the very next day, which would have then resulted in a retrospective doping policy - retrospective by two or three months. As I said, the purpose of a strong doping policy such as ours is the deterrent element. It is not to catch athletes. We want to make it quite clear to athletes that, if they had been taking drugs for sport enhancement, then they stood a very grave risk of being selected by us, and we gave them due warning. I think that was the proper thing to do.[35]

3.43 Mr Coates also said that there was a possibility that some athletes may have been subjected to a life ban if sufficient time to discontinue the drugs was not allowed.[36] He stated that:

> If they did not stop taking drugs by 1 January then they would have been very foolish.[37]

3.44 While these comments address the criticism of Dr Millar, they do not address the criticism of Mr Hurst that the testing program would have allowed steroid-using athletes to gain the full benefit of their illegal practice during the February-March- April competitive season leading to Olympic selection.

3.45 Dr Ken Fitch, Chairman of the Medical Commission of the AOF, indicated that 'only legal, ethical and logistic factors' necessitated a six week period to make practical arrangements before testing could begin. These arrangements included setting up the tests and requesting National Sports Federations to agree to allow the AOF to test their athletes, obtain lists of potential Olympic athletes and seek their consent to testing.[38]

3.46 Dr Fitch's evidence is contradicted by a memorandum from Mr Coles (AOF Secretary-General) to Executive Directors and Secretaries of National Sports Federation in June 1987. (Figure 3.1) The memorandum stated that:

> the AOF has determined that there will be frequent testing for potential Olympic Team members commencing in January, 1988 and continuing after selection by the AOF until the Games commence ...
>
> The AOF is concerned that practices prohibited by the IOC are prevalent and so will make the results of testing, including any positive results, public. We will do so after National Federations submit the signed Competitor's and Officials' Agreements with their proposals for Team selection to the AOF Justification Commission. In other words, while a test carried out in January may prove positive, we will delay any announcement until May, by which time we will have a contractual relationship with all Team members and thus the legal protection of the indemnity to be given by them. ...
>
> Would you please ensure that full details of this Memorandum are brought to the attention of all your potential Olympic Team members and make it a condition of entry to all State and National competitions in 1988 for competitors seeking Olympic selection, that they will be required to be available for testing by the AOF.[39]

3.47 This memorandum advised potential Olympic athletes that a drug testing program would be commenced in January of 1988. This gave athletes six months notice of when the program would begin. The memorandum was acknowledged by the meeting of the AOF Executive on 6 November 1987 when changes to the doping policy were made.[40]

FIGURE 3.1

AUSTRALIAN OLYMPIC FEDERATION
INCORPORATED

MEMORANDUM

TO: EXECUTIVE DIRECTORS/SECRETARIES OF NATIONAL FEDERATIONS

FROM: P.W. COLES - AOF SECRETARY-GENERAL

RE: AOF'S POLICY ON DOPING

DATE: 29-6-87 JDC/PWC:HMG/380/077

It is timely for me to remind you of the AOF'S attitude to doping by providing you with a copy of our policy statement on the matter.

I also particularly refer you to the provisions relating to drugs, etc. in the Competitors' and Officials' Agreements which must be signed by members of our 1988 Olympic Teams. In this regard the AOF has determined that there will be frequent testing for potential Olympic Team members commencing in January, 1988 and continuing after selection by the AOF until the Games commence.

Testing will not be random. Instead, at the direction and under the supervision of the AOF Medical Commission, testing will be carried out on athletes from sports and disciplines in which it is considered likely or reported to me that athletes may be taking or using drugs or stimulants or participating in other practices prohibited by the IOC.

The AOF is concerned that practices prohibited by the IOC are prevalent and so will make the results of testing, including any positive results, public. We will do so after National Federations submit the signed Competitors' and Officials' Agreements with their proposals for Team selection to the AOF Justification Commission. In other words, while a test carried out in January may prove positive, we will delay any announcement until May, by which time we will have a contractual relationship with all Team members and thus the legal protection of the indemnity to be given by them. Any athletes or officials involved in prohibited practices will then be dealt with in accordance with our policy and agreement with them.

.../2

LEVEL 1, SPORT HOUSE, 157 GLOUCESTER STREET, SYDNEY, NSW 2000, AUSTRALIA
TELEPHONE 251 2188. TELEX AUSOLY AA39484
CABLES AUSOLYMPIC MELBOURNE
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Australian Olympic Federation (AOF) memorandum in June 1987 advising all sports that testing would begin in January 1988.

FIGURE 3.1 (Continued) - 2 -

Would you please ensure that full details of this Memorandum are brought to the attention of all your potential Olympic Team members and make it a condition of entry to all State and National competitions in 1988 for competitors seeking Olympic selection, that they will be required to be available for testing by the AOF.

I know I can rely on your full co-operation when members of the Medical Commission or the Team Medical Section attend your athletes' training or an event for the purpose of testing.

Regards,

PHIL COLES
Secretary-General

ccs: Mr. R. Harvey, A.I.S.
Mr. S. Haynes, National Program on Drugs in Sport
Dr. K.D. Fitch, AOF Medical Commission
Seoul Olympic Team Executive
Seoul Olympic Team Section Managers
AOF Melbourne
AOF Executive Board

Distribution:

- 1988 Summer Olympic Sports
- 1988 Winter Olympic Sports (for information re Policy)

<AOF-DOPING>

3.48 It is quite clear that potential Olympic athletes were provided with an opportunity to use anabolic steroids during the non-competitive, training phase of September to December in 1987, provided they ceased the use of steroids in time to avoid detection in a random testing program beginning in January 1988. The performance-enhancing effects of steroids used in this manner would continue, to a diminishing degree, throughout the competitive season of February to April in 1988. In effect, drug-assisted athletes could be assisted to gain selection in the Olympic team over their drug-free competitors, and then perform below their previous standard at the Olympics because of the AOF testing program. Two classes of athletes were created; the drug free athletes who were disadvantaged, and the drug-assisted athletes who gained funding, prestige and selection but who performed poorly at tested international events.

3.49 It is also clear that the AOF could have begun a random program in, say, September of 1987, and withheld announcing any test results until May 1988, as indicated in the memorandum. The first of January 1988 was an arbitrary date which did not take into account the practical realities of steroids use.

3.50 There were good reasons for not applying the newly announced life bans from the day they were approved on 6 November 1987. However, this was a separate issue from the implementation of the testing program which was foreshadowed six months earlier. A life ban might only have applied from 1 January 1988, even if a random testing program had been operable since September 1987.

3.51 Considering the extensive questioning of the AOF about the six weeks notice given to athletes that testing would begin, and the defensive position adopted by the AOF, the Committee views with concern the fact that six months notice was given and that AOF officials were aware of this when giving evidence. It is absurd that the Committee only found out about the six months notice through a routine request for the minutes of a relevant

meeting. The Committee views the attitude and conflicting evidence of the AOF with scepticism, and can only conclude that the prime consideration of the program was not to prevent drug use but to allow affected athletes to pass drug tests during selection trials.

Frequency of Tests

Introduction

3.52 The more frequent the tests and the greater the probability of being tested, the greater is the deterrent effect. However, this is not an issue in testing programs carried out at competitions. As mentioned previously, the place getters and other randomly selected athletes are usually tested both internationally and at major events in Australia. For elite athletes who are using stimulants or any other drug used in the competitive phase, frequent testing is assured. However, the Committee is aware of athletes who have refused to take part in drug-tested competitions because they know that they will test positive.

3.53 In the case of anabolic steroids, however, the frequency of tests during training is crucial to the deterrent value of the testing program. Most athletes using steroids would be taking no more than two or three courses (each of six to eight weeks duration) a year. Infrequent testing would mean that they were unlikely to be tested while actually on a course.

3.54 In the AIS random testing program, one athlete and later two athletes were selected for testing each week.[41] Whole AIS squads were also tested at the Director's discretion and up to 20 July 1988 the weightlifting, track and field and cycling squads had been tested.[42]

3.55 The AOF also carried out random tests in 1988. It conducted 148 tests with little or no notice but some of these were at competition.[43] As previously discussed, none were carried out in the non-competitive training phase in late 1987. The effect of this policy was therefore to advantage users of anabolic steroids for the selection process but not for the Olympics itself, where they would have been at a disadvantage to athletes from countries with no random pre-games tests.

Discussion

3.56 The AIS agreed that the frequency of tests in its program provided 'a minimum form of deterrent'.[44] Dr Fricker estimated that to be sure all athletes in any group are clean they would need to be tested once every six weeks.[45] This is presumably because a steroid program would typically last 6-8 weeks. Mr Talbot, former Executive Director of the AIS, indicated that quarterly testing would not be frequent enough to be sure of deterring athletes.[46]

3.57 There is a difference between being certain that athletes are not using anabolic steroids, and having a testing program of such frequency that the risk of detection becomes unacceptably high to the athletes. The suggestion by Dr Fricker and the view of Mr Talbot are concerned with making detection certain. However a program designed to detect half, or even one third, of steroid-using athletes is likely to be an effective deterrent because the risk of incurring serious penalties would become unacceptable.

3.58 Mr Haynes proposed that an effective program would involve the selection of an elite pool of about 350 athletes to be tested four times each year during training and at sporting events.[47] If this program followed the suggestion of Mr Giles that two tests be targeted during the destructive level training phases,[48] this would seem to be an effective level of deterrence

for that group. In addition to this elite group, Mr Haynes suggested that all other (non-elite) athletes be subjected to 300 random and targeted tests during training, with another 300 tests at national and State competitions. Combining both proposals, the program would require about 2 000 tests per year. The cost of such a program would be $400 000 for analysis, $70 000 for two full-time drug testing officers and $50 000 for travel expenses.[49]

COLLECTING TEST SAMPLES

Introduction

3.59 Both internationally and in Australia, urine samples at competitions are meant to be obtained under IOC Medical Commission guidelines. A rigorous set of procedures for collecting samples protects the rights of an athlete and reduces challenges to the results of a test on the grounds that the sample was contaminated or substituted.

3.60 Dr Ken Donald described the collection procedures for the 1982 Brisbane Commonwealth Games in his book The Doping Game. Once athletes were selected for testing, they were accompanied by a chaperone directly to the collecting centre. The athlete was not allowed to pass urine before reaching the collection centre. On arrival, the Specimen Identification Form and Information for Laboratory Form were completed. The athlete then selected, at random from a large number, three bottles and a collection container in a sealed bag. Drinks were made readily available. When the athlete was ready to urinate, the chaperone viewed the passing of at least 50ml of urine into the collection container. The athlete and accompanying official then watched urine being poured into each bottle, which was then sealed with an identifying label, inserted into a yellow security mesh which was

in turn lead-seal crimped with a special insignia. They were then packed in transportation foam boxes to be sent to the laboratory. If the athlete and official were satisfied with the procedure, they signed accompanying forms.

3.61 These procedures, or very similar ones, should apply for all competition-based drug testing programs where the samples are to be sent to an IOC accredited laboratory.

3.62 In non-competition based programs, the initial stages are modified. For example, in the AIS program, the guidelines were that residential athletes were sent a notification to attend a test at the medical centre and had to report to the nurse no later than 5pm on the day following the selection. An athlete outside of Canberra was required to report to a nominated doctor in the relevant city within five days of the dispatch of a registered letter advising them of selection.[50] The extent to which these requirements were met is discussed in Chapter Eleven.

Discussion

3.63 Allegations have been made that urine collection procedures can be overcome in many ways and that they may not always be as carefully managed as they should. For example, the Committee has been provided with a letter written by an AIS coach to the Australian Athletic Union which states:

> At the Birmingham competition I accompanied [an athlete] for a dope test ... No attempt was made to identify the person presenting for the test. Had I tried I am sure that I could have passed myself off as [the athlete]
>
> [He] was unable to pass a specimen at the time of his first reporting to the officials. He was then allowed to leave the testing room and told to report back in one hour. During that time he was not supervised by any testing official. On reporting back ... [he] objected to being required to pass a specimen into a

> container which was not sterile and which had been used previously by other athletes ...
>
> Finally when passing the specimen, [he] was not strictly supervised. He was able to go into a cubicle on his own, a situation that could allow attempted abuses of the procedure.[51]

3.64 Mr Glenn Jones alleged that Mrs Gael Martin told him:

> a little story about how she had been sitting in the testing room at the women's world [powerlifting] championships in Belgium, with the [International Powerlifting Federation] commissioners. She indicated to them that she was finding it hard to urinate after a heavy exertion and that she had a glass of beer with her to replace fluid that she had lost ... the women's team coach ... distracted the IPF officials whilst Mrs Martin poured beer into one of her urine samples ... she believed that ... it would dilute the concentration in the sample sufficiently for her not to test positive.[52]

3.65 Ms Howland alleged that Sister Beasley, the nurse who collected the urine samples at the AIS, was involved in a cover-up of a positive test by tipping the sample down the sink.[53] This was denied by Sister Beasley,[54] and Dr Fricker pointed out that an allegation of this nature showed an 'appalling lack of understanding of dope testing procedures'.[55] A fuller discussion of AIS drug testing procedures will be found in Chapters Five and Eleven, where it will be shown that the lack of adherence to required protocols has meant that there is no reason to assume that 'sink tests' did not occur.

3.66 It has also been alleged that Ms Howland's urine was replaced by another athlete's urine at an athletic meeting in Belfast. This was denied by Ms Howland,[56] and is discussed in full in Chapter Seven. However, if the IOC Medical Commission procedures are followed in collecting a urine sample, it is difficult to see how a sample could be destroyed. A new sample

would have to replace the old one and this would need to be sealed with a different number which would not match the documentation signed by the athlete. Similarly, replacing one urine sample with another would be impossible without the collusion of the collecting centre and officials, or without drastic physiological measures such as injecting urine into an athletes bladder (as was admitted to the Canadian Dubin inquiry).

3.67 Dr Millar described a situation in which he envisaged that the collection procedures could be interfered with, and a positive result declared:

> What would happen is, here is, your top [to the bottle] and you [the sample collector] just happen to have some anabolic on your finger which you put in the top and you give it to him. He will just put it on and you will tip it up and down and off he goes; he is found positive.[57]

Although this scenario is possible, it relies on the complete dishonesty of a randomly assigned chaperone or an organised corruption of the testing procedures by the officials of the collection centre. Regardless of how comprehensive the procedures may be to protect the rights of the athlete, a total corruption of the system in either collecting or testing will over-ride these protections. This is an argument for the independence of the system from sporting organisations, all of which have vested interests in the performance of athletes.

3.68 So far as Australia is concerned, Mr Haynes advised the Committee that a full-time drug testing officer has been appointed to the National Program on Drugs in Sport to collect the urine samples for athletes in the lead up to the Commonwealth Games in 1990. He also indicated that two full-time testing officers would be needed for his proposed program of about 2 000

tests per year.[58] This use of independent drug testing officers having a detailed knowledge of correct procedures, and no vested interests in the athletes being tested, should be encouraged.

TESTING THE SAMPLE

Introduction

3.69 This section is concerned with the process that follows once the sealed urine sample arrives at the laboratory until the laboratory advises officials of the results of the analysis. It is important that the methods used should provide accurate and unambiguous results which, given the possibility of legal appeals, should be able to stand up to the scrutiny to which they would be subject in a court of law. Moreover, in the interests of fairness, it is important not only that positive tests indicate the presence of a banned substance, but that negative tests demonstrate the absence of such a substance.

International Situation

3.70 At the international level, the analysis of urine samples is carried out by laboratories accredited by the IOC Medical Commission. These laboratories must satisfy a stringent set of procedures before a urine sample can be declared positive.

3.71 The tests they carry out seek to establish the presence of drugs on the IOC Medical Commission list of banned drugs. These include stimulants, narcotic analgesics, anabolic steroids, beta-blockers, diuretics and chemicals which interfere with the analysis such as probenecid. Certain drugs such as alcohol, local anaesthetics and cortico-steroids are subject to certain restrictions.[59] For some substances the laboratory is required no only to detect the drug but also to show that it is above a

proscribed limit. For example, caffeine is only declared positive if the level in the urine exceeds 12 micrograms/ml. Similarly, levels for alcohol are set from time to time by individual sporting federations.[60]

3.72 Problems also exist with natural hormones, such as testosterone. In fact, because of the natural variability between individuals and over time in natural hormone levels, no proscribed limits are set for any hormone except testosterone. In other words, of all the natural hormones capable of producing performance enhancing effects, such as human chorionic gonadotrophin and human growth hormone, only testosterone is detectable with current technology. This is done by comparing the ratio in urine of testosterone to epitestosterone. A positive is declared if the ratio is greater than 6, because this is considered to be far beyond the bounds of natural variability.[61]

3.73 In almost all situations at the international level, urine samples originate from competitions and the samples are tested for the full range of banned classes of drugs. The most common methods involve radioimmunoassay, thin layer chromatography and a combination of gas chromatography and mass spectrometry.

3.74 The current cost of tests for the complete range of banned classes is about $200 and slightly more ($250) for the second test used to confirm a positive result from the first sample tested.[62] It is possible to test only for the classes of drugs that are likely to be used in training, such as anabolic steroids, diuretics and probenecid, but the reduction in cost of the analysis is minimal.

3.75 The IOC Medical Commission has developed a rigorous system of laboratory accreditation. This system requires a laboratory seeking accreditation to describe in detail how it would detect all of the list of banned classes, including minimum

concentrations detected in human urine and the maximum time required to conduct the tests. The laboratory must then analyse a series of control samples under the supervision of an expert. If the samples are correctly identified within three days, the laboratory may be accredited. In addition, every two years each laboratory is required to analyse correctly 10 samples as part of the continuing accreditation program.[63]

3.76 It was recommended at the 1988 World Conference on Antidoping in Sport that laboratories should be encouraged to undertake research into analytical biochemistry and pharmacology relevant to drug testing, in order to detect more effectively performance-enhancing drugs.[64] This is another important role of network of accredited laboratories.

Australian Situation

3.77 Between 1982 and 1987, the Royal Brisbane Sports Drug Testing laboratory was accredited by the IOC and carried out all necessary tests in Australia, particularly those associated with the Commonwealth Games in Brisbane in 1982.[65]

3.78 In January 1987, the laboratory underwent the biennial IOC reaccreditation process and was required to correctly identify eight samples. The laboratory failed to identify four of the substances in these samples and accreditation was withdrawn.[66] Dr Corrigan stated that the failure of the Brisbane laboratory to maintain accreditation was not a matter of funding alone.[67] Mr Haynes agreed and indicated that there was a 'conflict' in that the laboratory also provided a routine pathology service for the whole of Queensland.[68]

3.79 During 1987, many sports continued to send urine samples to the Brisbane laboratory for analysis, despite the loss of accreditation and the ambiguous situation in respect of action required if positive tests were identified. These sports included

rugby league, cycling, body-buildling, weightlifting, powerlifting, athletics, rowing and ice-hockey. As Dr Johnson, the drug laboratory supervisor states:

> none of the organisations for whom positive urine samples were detected followed up official IOC accredited laboratory confirmation of these samples.[69]

Positive samples detected during this period were largely for the stimulant pseudoephedrine (possibly from cold tablets). They were from New South Wales Rugby League, the Queensland Rugby League and the Queensland Cyclists Association. Three samples provided by the International Federation of Body Builders were positive for anabolic steroid metabolites and/or testosterone. The lack of follow up action is discussed in a later section of this Chapter and will be further considered in the subsequent inquiries of this Committee.

3.80 In August 1987 the Brisbane laboratory informed most major sporting organisations that the drug testing service would be discontinued. A few prior bookings were honoured until October 1987.[70] At present urine samples handled by the National Program on Drugs in Sport are sent overseas to an IOC accredited laboratory for analysis.[71]

3.81 Soon after the loss of accreditation in Brisbane, the National Program on Drugs in Sport, on behalf of the Australian Sports Commission, (ASC) called for expressions of interest from analytical laboratories in Australia to undertake procedures leading to IOC accreditation. As a result, the ASC selected the Australian Government Analytical Laboratories in Sydney to proceed to seek accreditation.[72]

3.82 It is anticipated that provided the Sydney laboratory successfully conducts the testing program for the Auckland Games in February 1990 under the supervision of Professor Donike of the Cologne laboratory, IOC accreditation could follow almost immediately.[73]

Discussion

Sensitivity of Tests

3.83 Testing for the presence of a banned drug is not always a straightforward process. As Dr Corrigan noted:

> You have a problem nowadays that the testing mechanisms, the testing methods, are so incredibly specific that you pick up parts per billion. ... Because of that this is now a biological thing and you have a problem of where you are going to set your level of confidence in your test. ... You draw a line of confidence and you can have that wherever you like. You could take it down a bit and you would be picking up 20 people or you could put it up a little bit.[74]

3.84 All laboratories are required to indicate their minimum levels of detection in the initial accreditation process,[75] and this establishes a de facto limit for each drug above which the result is determined be positive and below which the result to determined to be negative. Dr Corrigan commented that as the tests become more sensitive 'it is going to be a nightmare'.[76]

3.85 It is not known what control the IOC exerts over the detection limits of each laboratory, and it is perhaps best if this knowledge is not made public to be used by drug users. However, it appears to be a characteristic of drug users that they will attempt to find out the detectability limits of each laboratory where their urine samples will be sent. Dr Donald indicated that the Brisbane laboratory received several requests

for this type of test, called screening tests, prior to the Commonwealth Games.[77] Screening tests provide athletes with knowledge of the limits of detectability of a laboratory (including information of what drugs they cannot detect at all), and allow them to use anabolic steroids closer to the date of competition. The Committee has been told that in some circumstances athletes are not prepared to compete in events where they do not know the detection limits of particular laboratories or analytical equipment.[78]

3.86 Screening tests also enable athletes to determine the clearance time of particular drugs. Ms Sue Howland alleged that athletes known to her had screening tests conducted at the Cologne laboratory.

> They send in tests at, say, 10 days, eight days, six days. They check it all out and say 'That has got nothing in it, and that one has got this amount in it'. ... If you know that you have taken this drug and you can go right to the wire at six days, whereas normally for most people it is, say, 10 days, you will go right to the wire at six days. If you get tested you know that you are okay.[79]

3.87 Despite a belief that the testing technology is becoming more and more sensitive, this does not seem to be the case. Mr Haynes commented that:

> Over the last five years the technology and methodology involved in drug analysis have not changed. They may have become a little more sensitive. Unfortunately, there are a lot of myths around concerning what the chemist can and cannot detect and what the athlete can and cannot get away with.[80]

3.88 Dr Millar pointed to the case of Mr Linford Christie at the Seoul Olympics. Christie was found positive for the banned drug pseudoephedrine, but apparently in minute quantities. His

sample from a previous event at the Games, which had tested negative, was retested and found to be positive. Mr Christie was not disqualified.[81]

3.89 Dr Millar used the Christie case as an example of the decision-making process that is necessary with levels of drug near the limits of detectability:

> Everybody seems to feel that tests are either yes or no, but tests can vary from, say, nought to ten. Five is yes, 4.9 is probably no and 5.1 is probably yes. There are all these vagaries along the way, that is what makes it difficult.[82]

3.90 Dr Donald made it quite clear that in the operation of the Brisbane laboratory for the Commonwealth Games, there was some discretion within the laboratory in calling a result positive.[83] This is one reason why any independent drug testing commission should be required to publish not just the results of its testing program, but full details of any anomalous results and possible explanations for them.

3.91 It is clear that de facto limits exist for all banned drugs. These are determined mostly by the limits of detectability of the analysis. There may also be a tendency to not report positives just above the detection limit for substances which may have been taken inadvertently and for which the levels identified are not high enough to enhance performance. Pseudoephedrine is an example which is commonly found in cold medications. Perhaps a more effective approach would be to set very low proscribed limits, near to the limits of detectability, for drugs such as anabolic steroids which are unlikely to be used inadvertently, but to set higher limits for more common drugs which are unlikely to enhance performance unless taken in greater amounts. This would remove any element of discretion in the laboratory, leaving it to an appeal processes. If reasonable limits are set, it would also be unlikely that positive results would be overturned

on the grounds of inadvertent use. The Committee believes setting appropriate limits is an important requirement. It is clearly inappropriate for laboratory technicians to decide an athlete's future without some unambiguous guidance.

Proscribed Levels

3.92 The reasonableness of proscribed levels is a major issue in the case of caffeine. Dr Donald states that:

> The Commonwealth Games in 1982 was the first sporting event in which a quantitative level for caffeine had been set, and as a laboratory we were very nervous about that.[84]

The level recommended for the Commonwealth Games was 15 micrograms/ml of caffeine in urine. This was based on an informal experiment conducted by the Brisbane laboratory which gave 500 milligrams of caffeine (the equivalent of 5-10 cups of coffee) to 20 volunteers. Over the eight hours following, levels of caffeine in the urine varied between 4 micrograms and 18 micrograms/ml.[85] The fluid intake was not measured. Dr Donald comments:

> All we have set out to demonstrate ourselves in that study was that given an average person under average circumstances, and given the equivalent of 5 to 10 cups of coffee what would happen to his or her urinary caffeine? What is the sort of limit that could happen to ordinary people's urinary caffeine? The answer is that they can go as high as 18 or as low as 4.5.[86]

3.93 The level of 15 micrograms/ml of urinary caffeine was agreed to by the Brisbane laboratory on the basis that it was 10 times the normal dietary level of caffeine of 1.5 micrograms/ml. This normal dietary level was established in the study of 20 volunteers and in a study of the urines of 130 athletes participating in the SGIO Mini Games in 1981.[87]

3.94 The Brisbane laboratory was aware that the proscribed limit of caffeine could be reached by a competitor drinking 5 to 10 cups of coffee in the two hours before the event, but an assumption was made that athletes would not do this and would only compete with normal dietary level of caffeine. Ten times that normal level was set as the proscribed limit.

3.95 The New Zealand Commonwealth Games Association gave the following advice to its athletes competing in Brisbane in 1982:

> CAFFEINE
>
> A mild stimulant found in tea, coffee and cola drinks. Roughly, a dose of 600mg of caffeine (equivalent to 6-12 cups of tea or coffee) would be required to produce a urine level of 15[micrograms/ml] in a 4hr urine sample. Antimigraine drugs, Cafergot, Ergodryl and migril each contain 100mg.[88]

3.96 At the Seoul Olympics, the proscribed level of urinary caffeine was 12 micrograms/ml. Despite the lowering of the caffeine level, Mr Alex Watson alleged that when the Australian Olympic Team was gathered in Canberra prior to the Games, Dr Sando, an Olympic Federation doctor, advised that 'an athlete would have to consume 20 cups of strong coffee in an hour to go over the Olympic limit'.[89] Clearly, this advice was contrary to the rationale for setting the proscribed level well above the normal dietary level achieved before competition. The level is set on the assumption that the athlete does not consume caffeine during the event. However, this information was available to Olympic athletes, including Mr Alex Watson, prior to the Games. The National Program on Drugs in Sport booklet Over the Counter Preparations, produced in March 1986 stated:

> the social use of caffeine prior to a competition, e.g. a cup of coffee, cola drink, bar of chocolate, will not produce a positive result unless excessive amounts are consumed in approximately a four hour period, e.g.

about 8 cups of coffee, or 10 cans of cola, or 3 family bars of chocolate, etc.[90]

3.97 Evidence was received by the Committee arguing that the caffeine level recorded by Mr Alex Watson at the Seoul Games of 14.25 micrograms/ml could have been reached by the regular consumption of coffee during the day's competition.[91] However, this is not the issue. The IOC Medical Commission set a proscribed level for all competitors, and they should know how to avoid passing that level. The issue is that Mr Watson and his manager were allegedly misinformed about the number of cups of coffee required to reach the proscribed level, or even the aim of tests to deter athletes from consuming caffeine during competition.

3.98 In the light of information Dr Donald provided on the rationale behind the proscribed level of caffeine at the Brisbane Commonwealth Games in 1982, the level set by the IOC appears reasonable. An athlete is unlikely to be found positive through the social use of caffeine preparations before competition. However, the IOC Medical Commission, in the pursuit of rigour, stated only that caffeine levels should not exceed 12 micrograms/ml in urine, and did not indicate that the intent of that level is to restrict consumption during competition while allowing social consumption before competition.[92]

3.99 The Committee has noted that, at the time of writing, the matter of Mr Watson's ban as a result of caffeine use is being considered by the AOF appeals committee. It is possible that this issue may require further investigation in later deliberations of the Committee.

Natural Hormones

3.100 It is clear from the discussion of drugs used to enhance performance that the natural hormones of the body can be injected into the body to enhance the strength or endurance of an athlete.

These hormones include testosterone, human chorionic gonadotrophin, human growth hormone and erythropoietin.

3.101 The IOC Medical Commission guidelines state:

> Testosterone: the definition of a positive depends upon the following - the administration of testosterone or the use of any other manipulation having the result of increasing the ratio in urine of testosterone/ epitestosterone to above 6.[93]

It is not sufficient to demonstrate the presence of testosterone, which is a natural hormone in both males and females. Further, it is not acceptable to set a high level of testosterone, well above the normal level in the population, as the proscribed limit indicating doping. A certain percentage of people will always be over that limit and elite athletes are a select group outside the normal range on most indicators.[94]

3.102 The approach adopted by the IOC Medical Commission is to compare the level of testosterone in urine with another similar hormone, epitestosterone. The ratio between the two is said to be constant and any additional testosterone will upset the balance.[95]

3.103 Dr Donald was critical of the science underlying this approach to detecting testosterone doping:

> with epitestosterone, to my knowledge, nobody is aware of the pathways at this point in time of that control. I am also not aware that the range of functions of epitestosterone in the body - what it does, why it is there - has been elucidated. There are theories, but the question is far from resolved. In my view, to use a hormone when you are not sure what it is doing there and how it is controlled as the baseline for a ratio with something else, is scientifically very suspect. I think it is an absolute hallmark of the sorts of problems we have with doping control in sport, where not

> enough research has been funded and done to even allow the rules, as they stand in some cases, to be scientifically justified.[96]

3.104 Dr Donald found that the ratio of testosterone to epitestosterone varied between 12:1 to 1:30 in the urine samples tested at the 1982 Commonwealth Games. The normal ratio is 6:1. He believed that this great variation was probably due to variations in the level of epitestosterone, although manipulations using probenecid were also suspected once the use of this substance became known.[97] Dr Donald commented that:

> I took the view that if we obtained a result which we considered to be methodologically sound, within the ratio proscribed, then that would have been called positive. But the results we obtained in my view, and in the view of the scientists at the laboratory were not methodologically sound.[98]

3.105 Dr Donald also pointed out that the test would be easy to circumvent by an injection of epitestosterone to balance up the ratio.[99] Dr Millar similarly commented that:

> If you knock off the injectable [anabolic steroid] three months before and you change over then to testosterone, you will be able to go right up to the Games with that, provided that the day before the event you have an injection of epitestosterone, which interferes with the level between the two of them.[100]

3.106 Despite the difficulties with the testosterone doping test, testosterone represents the only natural hormone which is both detectable and banned. Doping with human chorionic gonadotrophin is banned but not detectable. Doping with human growth hormone, erythropoietin and any other enhancing hormone is not yet banned by the IOC.[101] Human growth hormone is, however, banned by the US Olympic Committee.

3.107 Blood doping, the injection of the athlete's own blood back into the athlete before competition, is also banned, but no reliable tests have yet been developed to detect this illegal practice. Ms Lisa Martin indicated that she had never been to any event where there was a test for blood doping, although she believed that a blood-based test was under development and could be in place by 1992.[102] A report in the December issue of The Olympian[103] stated that Dr Tapio Videman of Finland and Dr Inggar Leireim of Norway have developed a test for blood doping which involves comparing the amount of haemoglobin in the blood with the amount of substance that would create the haemoglobin naturally. The test was said to be able to prove beyond doubt when an athlete had received a transfusion of someone else's blood, but was less than 50 per cent effective in detecting when athletes had received a transfusion of their own blood. The Federation Internationale de Ski had agreed to introduce blood doping tests on a trial basis for two years.

3.108 One delegate to the World Conference on Antidoping in Sport is reported to have said there 'wasn't a rat's chance in hell' that doping with human growth hormone, a natural substance in the body, could be detected.[104] Presumably, this also applies the other natural hormones while the present technology is based on urine analysis.

3.109 Dr Donald suggested that although urine analysis will remain the 'best broad medium for carrying out tests', blood tests may be needed to examine doping with natural hormones. He commented that:

> We will need to measure blood levels and some hormones and we will need to measure ratios of hormones in the blood before we can put together a profile which would satisfy me that we are not going to set up a system which will convict innocent people.[105]

3.110 Dr Donald also suggested that doping practices will move into the area of natural brain hormones (endorphins) in the future.[106]

3.111 Because some currently known and practised drug usage involving natural hormones is neither banned nor detectable, it is possible for well-informed athletes to use performance-enhancing drugs right up to the day of competition without fear of detection.[107] They do this by using the relatively inexpensive anabolic steroids during the untested training phase. They then change-over to the undetectable but more expensive natural hormones nearer to the days of competition. In effect, athletes with better medical advisers have a significant advantage over other athletes.

3.112 Although the IOC Medical Commission has stated that its policy is to ban only those drugs which are detectable in urine, events have overtaken this approach and the IOC banned list now includes undetectable substances (human chorionic gonadotrophin) and practices (blood doping).[108] Perhaps the approach should also be extended to include acceptance of evidence other than a positive drug test, of athletes engaging in illegal practices. For example, witness statements, substances in the possession of an athlete and other evidence normally acceptable in a court of law. Of course, safeguards to natural justice must also be in place, and this will be discussed in a later section. There may also be a need to encourage athletes to supply voluntarily blood samples for experimental purposes when they supply urine samples for testing. This would enable research on means of detecting the natural hormones. The collection of blood samples would, in many cases, be faster and certainly less embarrassing for the athlete, than the provision of urine samples.

Second Sample Testing

3.113 The IOC requires that both of the urine samples collected are tested and found positive before any action can be taken. This further protects the rights of athletes. Confirmation tests are usually more thorough and more expensive.[109]

3.114 Mrs Gael Martin was critical of the procedures involving the testing of her second sample by the International Powerlifting Federation. Evidence was received that a second sample can only be tested if the first is positive and the athlete gives permission. Mrs Martin alleged that her first sample was negative and that, without her permission, the second sample was tested and found positive. She was subsequently banned for three years on the basis of this result.[110]

3.115 Ms Howland was able to describe the more acceptable procedure:

> You get your first test analysed and then if it has come up positive they talk to your manager; they talk to you; they ask you if there is any reason that this has been found in your system and then they go ahead with your manager and/or you present to watch the second test opened.[111]

Ms Howland alleged that this procedure was not followed in her banning:

> With me last year the IAAF people did the first test without anybody at all knowing. Then they said, 'You have come up positive; that is it. I was given no say. I do not even know, still, the quantities. There was nobody there to prove that it was my test. It could have easily been rigged.[112]

3.116 The IOC policy is that an athlete should be present when the second sample is opened. This allows the athlete to check the seals, numbers and matching signature to establish that the sample is his or her own urine. The AIS amended its policy in March 1988 to accord its athletes these same protections.[113]

INVESTIGATIONS AND RESEARCH

Post-test Investigations

3.117 At the international level, each individual positive result in the IOC system would be considered by an international or national committee and the athlete involved would be given an opportunity to explain the circumstances surrounding the result.[114] The previous section, however, provided evidence that this ideal process does not occur in every case.

3.118 The case of Mr Linford Christie, a British athlete at the Seoul Olympics, provided an example of this procedure. He or his representatives were able to explain to the IOC Medical Commission that the small amount of pseudoephedrine found in his urine was due to the inadvertent use of a ginseng tablet some days before his events. Mr Alex Watson stated that:

> he [Mr Christie] was able to establish, because he had the strong backing of his Olympic Federation and it obviously put forward a good case, that he had taken ginseng tablets containing a banned substance, pseudoephedrine, not for deliberate reasons, to get an unfair advantage, but merely to counteract a throat infection that he had and I think they made the right decision in not disqualifying him.[115]

3.119 Mr Watson, however, was critical of the support and assistance he received from the AOF in presenting his case when his urine sample was found to be positive for caffeine.[116]

3.120 The Australian Olympic Federation (AOF) confirmed that they would conduct a hearing if a positive result may have been inadvertent.[117] Importantly, the AOF also indicated that its doping policy is:

> targeted at any coach, official, medical officer or other person who aids, abets, counsels, procures or is knowingly involved in an athlete's breach of any of those doping policies.[118]

3.121 Despite the position indicated by the AOF, it appears there is little, if any, investigation of the circumstances surrounding positive drug use by an athlete in Australia. The involvement of coaches and officials is not investigated, nor the source of the banned substance. Athletes have been banned, but there is no mention of action taken against coaches, managers or doctors.

3.122 The World Conference in Anti-doping in Sport concluded:

> Doping infractions should be investigated to determine the possible involvement of others beyond the athlete him/herself (e.g. coaches, sports body staff, medical staff etc.).[119]

Research

3.123 Dr Donald provided examples of a laboratory identifying unusual results in the urine sample, which were not positives according to IOC guidelines. Urine samples from the 1982 Commonwealth Games showed extremely low testosterone to epitestosterone ratios which could not be called positive doping, even though there was a high probability that the testosterone physiology had been manipulated.[120] These unusual results were not followed-up and investigated.

3.124 It would be appropriate for a drug testing laboratory to attempt to investigate all questionable urine analysis results. This is not to suggest that an athlete should be found guilty of using a performance-enhancing drug which has not been banned, but only that information from such research could be crucial in fighting the development of new methods of doping. All IOC accredited laboratories should exchange this type of information and continue to develop policies which reflect improved detection techniques. Moreover, athletes who produce anomalous results which suggest the use of blocking agents or masking agents could be subjected to additional targeted testing.

3.125 Laboratories should also adopt a structured approach to researching new doping substances and testing techniques. The 1988 World Conference on Antidoping in Sport recommended that:

> Research and development into analytical biochemistry and pharmacology should be encouraged in doping control laboratories. New data should be circulated and results published quickly in order to speed the adoption of techniques and policies shown to be necessary.[121]

The National Program on Drugs in Sport has already indicated an intention to establish a research program along these lines.[122]

Non-Test Investigations

3.126 It is reportedly well-known that certain cycling teams and marathon runners are using blood-doping in the knowledge that it is undetectable using present techniques. This throws into disrepute the credibility of testing policies and procedures.

3.127 No evidence has been presented to the Committee that an antidoping policy should involve more than a physical test of drugs present in the body. However, in cases where there is clear evidence of doping practices which would normally be accepted by

a court of law, it would seem reasonable to impose sanctions without the need for a positive test. As an extension of this it would be reasonable to allow officials from the drug testing program to seek evidence of drug abuse other than that coming from a test. This would at least reduce the incidence of athletes flouting the intent of anti-doping policies by the use of blood-doping and natural hormones, such as human growth hormone, to the open knowledge of their competitors.

OUTCOMES OF TESTS

Advice of Results

Introduction

3.128 A positive result from competition-based testing programs is generally reported to a committee representing the organisers of the competition. In the case of the Olympic Games this is the IOC Medical Commission, a reputable and expert body. In Seoul, it was reported that there were 20 positive results advised to the Medical Commission for which no further action was taken.

3.129 Ms Lisa Martin provided evidence that even when positive results are reported to a national body at a national competition, further action does not necessarily follow. She stated that:

> When the TAC, [The Athletic Congress] of the United States of America tested 17 athletes positive at its 1988 US Olympic trials, one newspaper announced that 17 people were tested positive and that it would start revealing the names, but they were never revealed - that was squelched. My agent, Brad Hunt, was present at this meeting that was held immediately after the trials, when the Olympic team for the United States was named. Those athletes were told of the meeting, 'Please be aware that

> when you go to Seoul the testing will count', which as far as I am concerned, implies that testing at the US Olympic trials did not count.[123]

3.130 Mr Kelvin Giles said that in the European track and field circuit, there is corruption, and that this corruption extends to the drug testing programs.[124] As a general rule, IOC accredited laboratories are supplied only with a numerically identified sample and it is the body requesting the results which controls any action as a result of positive tests. The laboratories analysing the samples do not know the athletes involved.

3.131 In Australia the same general rule applies, that the body who orders the tests controls any action as a result of a positive test. Dr Les Johnson, the Drug Laboratory Supervisor in Brisbane, reported that even though positive tests were identified in 1987, and notified to the relevant sports bodies, none were followed-up for confirmation at an IOC accredited laboratory.[125] This follow up would have been necessary if any action was to have been taken.

3.132 The results of the AIS random testing program were provided to the AIS administrators and the Australian Sports Commission before action could be taken. Chapter Five discusses some aspects of this procedure when the athletes concerned were taking steroids for allegedly legitimate medical purposes.

Discussion

3.133 The most obvious criticism of these procedures is that sporting bodies, by controlling the tests and being responsible for taking action on positive results, have a conflict of interest. It can be argued that a major concern would be to protect the sport from any bad publicity accompanying a positive result. Mr Glenn Jones, for example, gave evidence that six

positive tests in powerlifting were found 'technically faulty', not only protecting the image of the sport, but also saving some of the executives of the sport from a ban that would have been imposed if the positive result had been confirmed.[126]

3.134 Dr Millar was critical of the formation of 'cartels' within the international organisations such as the IOC Medical Commission. He believed that blocks of countries could agree to support each other in agreeing to vote against a positive test for their own athletes, regardless of the circumstances. He argued that only athletes from the small countries outside these 'cartels' were found positive at the Olympics.[127]

3.135 Even if a rigorous and effective testing program is in place, the deterrent value of the program can be undermined if the sports body with the vested interests of the sports image has complete control of the results. Only when a testing authority has complete independence from the sporting federation will this be the case.

Penalties

3.136 Dr Ken Donald observed in 1983 that athletes were 'outed for periods as short as 9 months - a far cry from Sebastian Coe's request for a life ban'.[128] At the other end of the scale, the Australian Olympic Federation, the Australian Institute of Sport and the Australian Sports Commission are prepared to impose life bans on athletes found guilty of using performance enhancing drugs.[129] About 10 other nations out of the 160 national Olympic Committees impose the life ban penalty.[130] Dr Donald noted that:

> A life ban for an athlete in modern society is a very major penalty: it can be the equivalent of a fine of many millions of dollars; it is also an accusation and a conviction to be carried for the rest of the person's life ... It is a very severe penalty.[131]

3.137 Dr Corrigan and the National Program on Drugs in Sport advocate a two year penalty for a first offence.[132] In Ms Sue Howland's case, the IAAF imposed a two year ban for her positive drug test and she was reinstated after 18 months in February 1989.

3.138 The size of the penalty plays an important role in the effectiveness of a drug testing program. However, the most effective penalty is not always the largest. An effective penalty must be commensurate with the size of the offence in both the athlete's and community's eyes. A penalty that is too small encourages an athlete to take the risk and commit the offence. In contrast, a penalty that is larger than community expectations is unlikely to be imposed in all but the most obvious cases, just as the death penalty for murder can lead to the acquittal of guilty persons. The Australian Olympic Federation admitted that this is a problem.[133] When there is the slightest doubt concerning inadvertent use, possible tampering with tests or the underlying science, few committees would be prepared to impose such a severe penalty. As a result, a drug testing program would lose credibility with few penalties being imposed as a result of positive tests. On the other hand the procedures could degenerate into long, drawn-out processes of litigation and appeals.

3.139 A more positive approach would be to impose a penalty of two years suspension for a first offence, with all positive tests resulting from deliberate use attracting the penalty. For high-income international athletes, a two year ban is a relatively severe penalty. Any subsequent offences would then be subject of a life ban.

3.140 No penalty is presently associated with inadvertent use of banned substances and the Committee believes this is justified for the first occurrence. Persistent inadvertent use, particularly with the same drug, is another matter. Inadvertent use should not be an automatic defence even when the substance

involved is at a low level and is common in medications. Penalties shorter than two years should be considered for cases of repeated inadvertent doping. Other actions recommended by the Committee in setting proscribed levels and wider drug education will also address the problem of inadvertent use.

3.141 Mr Don Talbot pointed out that the same penalty should be imposed on those who assist an athlete to use drugs, the coach or others.[134] The same penalties should also apply to anyone trying to interfere in any way with the testing procedures, whether by providing clean urine samples for substitution or in any other way.

3.142 It has already been pointed out that banned athletes should be tested for a year before being reinstated to ensure their suspension is not used to 'build-up' on steroids. Athletes should nominate that they wish to re-join competition a year before reinstatement and pay for their own tests during that period. The 1988 World Conference on Antidoping in Sport also raised the issue of banned athletes competing in sports other than the one in which they tested positive.[135] It would seem that consistent antidoping policy would require a banned athlete to be ineligible for competition in any sports while banned. This is a matter that should be addressed in the development of a national antidoping policy, as discussed later.

Co-ordination

3.143 It is important that test results are communicated to all those who need to know them. Within the sports themselves are the international, national, state and local bodies, all of whom need to be informed if the penalty is to be effectively applied. The Committee is aware of one incident in which a local body and international body in powerlifting were aware of a ban, but the national body was not.[136]

3.144 In Australia, there are mechanisms to ensure a reasonably good flow of information from sport to sport, at least for the sports coming under the Australian Olympic Federation or the Australian Institute of Sport umbrella. The emerging role of the National Program on Drugs in Sport also provides a focus for the cross flow of information and co-ordination.

3.145 One area that needs to be improved is the co-ordination of testing authorities with police, customs and health authorities. The National Program on Drugs in Sport admitted that this was an area requiring further development,[137] but there was mention of co-operating with customs or police in removing the source of supply of illegal drugs.

3.146 The Australian Olympic Federation also drew attention to the need for customs, police and health authorities to be more active in reducing the sources of performance enhancing drugs, including more thorough search of athletes entering or re-entering Australia.[138] Providing relevant information on positive drug tests to these authorities would expedite their work in this area. Questions relating to the supply of drugs are discussed more fully in the next chapter.

EDUCATION

Introduction

3.147 The National Program on Drugs in Sport told the Committee that education is 'one of its most successful areas of activity'. The program involves:

> the preparation and dissemination of resource materials designed to increase awareness about the drug issue in sport and of the dangers of drug abuse.[139]

3.148 To support their claim of success, the National Program on Drugs in Sport provided details of the production and circulation of educational materials. Seven hundred resource kits have been provided to schools, colleges, health and sporting groups, and a wide-range of publications has been distributed. There have been over 700 requests for information of a general nature and some 150 counselling sessions with athletes coaches and medical practitioners. Other qualitative comments were offered to support the success of the education program.[140]

3.149 The 1988 World Conference on Antidoping in Sport also identified educational initiatives as an important element in the fight against drug abuse in sport.[141]

Discussion

3.150 The aim of the national Program on Drugs in Sport education initiative is to assist athletes to make informed decisions on the use of performance-enhancing drugs. This is important. However, the success of the program is better measured by its effect on the knowledge and attitudes of athletes, coaches and medical practitioners, rather than by the number of publications produced or distributed. The survey proposed in Recommendation Three will provide a measure of the program's effectiveness. Each sporting body should be encouraged to carry out an educational program specific to their sport. This would be a more effective use of the National Program on Drugs in Sport's educational resources, rather than the more remote attempts to influence school and college students generally. The efforts of the AIS in drug education will be considered later in Chapter Ten.

3.151 The Committee notes that there is a more immediate educational need closely associated with the drug testing program. It would be of no use to conduct an effective drug testing program if the athletes who were at high risk of using

drugs were unaware of the program. Only those caught and punished would be affected, and the deterrent effect would be lost.

3.152 Athletes will be deterred from using drugs if it is made known to them that there is a high risk of being caught and that a severe penalty is almost certain to result. Those responsible for drug testing must also be responsible for educating athletes about the 'threat' of the program. Athletes should be aware of the frequency of tests, both in competition and in training, the techniques being used to detect new drugs and the penalties actually imposed on other athletes who are caught. If this information is convincing and frequent, a high perceived risk of detection can be developed resulting in a lower level of drug abuse.

3.153 A further aspect of the education program should be to reduce the defence of 'inadvertent use', by making all athletes aware of the common medications that contain banned substances. This has already been discussed in Chapter Two.

APPEAL PROCEDURES

3.154 At an international level, the 1988 World Conference on Antidoping in Sport recommended that fundamental elements of doping policies are:

> procedures giving effect to the principles of natural justice, the conduct of a fair hearing by judges who are independent; recognition of the rights of athletes including the provision for appeals; protection of confidentiality until a decision is reached.[142]

3.155 Dr Ken Donald also supported the need for avenues of appeal for athletes found positive[143] as did Ms Raelene Boyle who said:

> There has to be more of an appeal. The athlete cannot be just a lump of pulp that bashes his body around to make a team and gets in there, and then when something like that goes wrong he has no avenue of appeal whatsoever. He is a human being and it is his career that is being made or broke.[144]

Mr Steve Haynes also supported the need for appeal procedures in Australia.[145]

3.156 The Australian Institute of Sport introduced a form of appeal to the Executive Committee in November 1988, for any positive tests in its random testing program.[146] Similarly, the Australian Olympic Federation (AOF) advised the Committee that it had also instituted appeal procedures to the Executive Board of the Federation from 3 February 1989 for anyone breaching its doping policy.[147] However, it should be noted that in both these cases, the appeals are directed to virtually the same bodies who rule on the original test results and impose the penalty. Dr Donald was critical of this type of appeal process and emphasised that:

> My preferred system would be to have a specific appeals system in sport, which is independent of the rest of sporting administration, but then appeal from that body to the normal court system.[148]

3.157 Mr Haynes also agreed that the appeal procedures should be independent and commented that:

> I do not believe the law enforcement agency should be judge and jury as well ... I think the appropriate type of organisation would be some semi- or quasi- judicial independent group.[149]

INDEPENDENCE OF TEST PROGRAMS

Introduction

3.158 At the Olympic level, the IOC Medical Commission controls all phases of the drug testing program. These include selecting athletes, collecting urine samples according to IOC procedures, testing at IOC accredited laboratories, investigating and deciding on outcomes and penalties of positive tests and even hearing the appeals. Although the IOC Medical Commission is separate from the IOC itself, it must still operate to ensure the continuing support of the Olympic ideal.

3.159 Dr Millar suggested that the decision-making process of the IOC Medical Commission is not independent of national influences.[150] Similarly, it has been suggested that national considerations over-rode justice in the hearing of Mrs Gael Martin's appeal against her suspension in the sport of powerlifting.[151] Mr Kelvin Giles also drew attention to the corruption of drug testing programs under the control of those who run the European track and field circuit.[152]

3.160 In Australia, sports outside the two major testing programs have complete control over their own testing program. Evidence has previously been discussed indicating that a number of positive tests found by the Brisbane laboratory were not acted on and remained internal to the sport.

3.161 The two major programs in 1988 by the Australian Olympic Federation (AOF) and the Australian Institute of Sport (AIS) have moved towards independent testing by the National Program on Drugs in Sport. However, in both cases the results were still advised to the AOF and AIS, which then decided penalties and heard appeals. Moreover, the National Program on Drugs in Sport

reports to the Australian Sports Commission which is also responsible for the operations of the AIS and includes members of the AOF.

Discussion

3.162 Mr Kevin McRae, a concerned member of the public took the attitude that:

> drugs will never be extirpated from sport if surveillance is left to the various sporting authorities themselves ... The public interest is best served by the formation of an independent authority with a hand-picked staff of dedicated, genuine anti-drug campaigners with little or no particular interest in the sports concerned and which may be above the ignoble practice of accepting bribes.[153]

3.163 Dr Donald was strongly in favour of an independent commission being established to oversee all of the testing program. He also believed that the commission should publish some sort of annual report, available to the public, so that there could be no cover-up of results. He stated this should be mandatory.[154]

3.164 Mr Steve Haynes commented that:

> there has to be some independent agency to carry out drug testing because that conflict of interest [involving in-house testing] will always exist.[155]

3.165 He further commented that:

> there has to be a totally independent system for domestic programs before an international program could possibly take off ...
>
> I do not believe any sport should run its own testing program - perhaps I could qualify that. I think any sport that has its own

testing program should open the whole procedures to an independent agency.[156]

3.166 Mr Haynes suggested that an independent commission should be outside the bureaucracy and independent in terms of policy and resources, in order to remove any conflict of interest with sport administration.[157] He also suggested that an annual report should be published and there should be 'direct liaison through the Chairman of an independent agency with a Minister or parliament'.[158]

A MODEL FOR DRUG TESTING IN AUSTRALIA

3.167 The discussion in this chapter will have made it clear that a fair and effective drug testing program requires the establishment of an independent drug testing commission to be responsible for all testing. The commission would need to be responsible for testing all sportspeople - elite or non-elite, amateur and professional. Its testing program would need to include competition, random, and targeted testing, directed towards all at-risk groups. Because it is important that Australian athletes are not disadvantaged in international events because of less stringent sports drugs policies and programs in overseas countries, the Commission would need to adopt a high international profile. Together with the Australian Olympic Federation, it should be required to work towards the international acceptance and implementation of strict anti-doping policies and programs.

3.168 An appropriate model would be for the Commission to have full and total responsibility for selecting the athletes to be tested, arranging the collection of samples and their dispatch to the IOC accredited laboratory, and receiving the results. The Commission would also be responsible for keeping all the necessary records relating to these procedures. The Commission

should report directly to the relevant Minister and prepare an annual report, to be tabled in parliament, listing all athletes tested and the result of the tests.

3.169 The Commission would not itself impose penalties but would send test results to the appropriate sporting federation for the imposition of a penalty. The sporting federation should be required to consider the test report and determine a penalty at the earliest opportunity, and in any event no later than three months after the result had been received from the Commission. In imposing a penalty the federations would be empowered to consider matters such as intent and inadvertent use, but would be required to report their decision, and the reasons for it, to the Commission.

3.170 An independent appeal tribunal should be set up to adjudicate as appropriate on positive drug tests. Appeals could be referred to the tribunal by:

- the Commission e.g. if it considered the penalties imposed by the sporting federation were insufficient;
- the sporting federation e.g. if it thought that the positive result should be invalid on technical grounds; or
- the athlete, who might wish to appeal against the severity of the sentence imposed by the sporting federation.

Appeals against the decision of the appeals would still be possible through the normal court system.

3.171 A major complicating factor in this area at present is the lack of co-ordination between the various sporting bodies, particularly in terms of their own list of banned substances and different appeal procedures. The introduction of a national drugs in sport commission would require all sporting bodies to adopt a

unified set of regulations and procedures, which would be carried out by an independent authority. Penalties should be standardised, with a two year penalty for a first offence, a life ban for any subsequent offence. In the case of persistent inadvertent doping a penalty of less than a two years suspension and a life ban for any subsequent offence. An athlete banned from one sport for drug abuse should be banned from all other sports for the same period. Penalties applied to athletes should also apply to any other person involved in the supply or administration of drugs to the athlete.

3.172 It should be a condition of any sporting organisation receiving Government funding that it come under the control of the Commission. The Committee believes that a meeting of Commonwealth and State Sports Ministers should be held to ensure that a uniform policy is developed on this matter.

3.173 It is important that relevant professional national sporting bodies such as rugby league football, Australian rules football, soccer and basketball, be brought under the umbrella of the Commission. The Committee believes that, at least in the first instance, this should be done on a voluntary basis. However, if necessary the Committee would recommend that appropriate legislation be introduced to ensure that this happens. This is a further matter that could be considered by the proposed meeting of sports and health ministers. Professional sporting bodies should be required wherever possible to pay for the tests conducted on their behalf and such tests would be in addition to the minimum of 2000 mentioned in Recommendation Four below.

3.174 The Committee has noted that a model similar to the one suggested here has been established by the Anti-Drugs Campaign on behalf of the Australian Commonwealth Games Association. A Commission of three (Dr Brian Corrigan, Dr Ken Fitch and Mr Steve Haynes) has been established to select athletes to undergo

testing during training in the period leading up to the Auckland Games in 1990. Collection procedures are carried out by a full-time drug testing officer of the Campaign. An Independent Tribunal has also been established to adjudicate on any appeals amounting from the testing program. Membership of the tribunal is Dr Ken Donald, Mr Hayden Opie, Ms Elaine Canty and Ms Julie Draper. [159]

3.175 It seems to the Committee that these arrangements for the Commonwealth Games present a nucleus around which the proposed Australian Sports Drugs Commission could be established, and that this existing body could, pending the formal establishment of an independent Commission, be given wider responsibilities relating to Australian sport generally.

Recommendation Four

The Committee recommends that the Commonwealth Government:

(i) establish an independent Australian Sports Drug Commission to carry out all sports drug testing in Australia. The Commission should be responsible for developing sports drug policies, conducting relevant research, selecting sportspeople for drug testing, collecting samples, dispatching samples to an IOC accredited laboratory, receiving results, conducting necessary investigations and carrying out the necessary liaison activities with law enforcement agencies, customs officials and health departments. The Commission should report the results of drug tests to the appropriate sporting federations for the imposition of penalties on athletes, coaches, doctors or officials who use or encourage performance enhancing drugs. The Commission should be required to use protocols at least as stringent as those recommended by the IOC Medical Commission. The Commission should report directly to the

Minister responsible for sport and should be required to table an annual report listing all tests carried out, providing comment on any anomalous results and identifying significant developments in Australia and overseas. The Commission should be established to carry out a minimum of 2000 tests a year under the following restrictions;

- 350 of Australia's best athletes to be tested four time per year using targeted, random and competition testing,

- 300 tests to be carried out on a wide selection of athletes not in the above group during non-competition periods,

- 300 tests to be carried out at competition events, and

- overall, 25 per cent of tests are to be on a strictly random basis of selection;

Additional tests would be carried out for professional sports on a full cost recovery formula to be developed as indicated in Recommendation Five below;

(ii) establish an independent tribunal to adjudicate on disputed drug tests and the penalties imposed by sporting federations on athletes testing positive for banned substances. The tribunal should hear appeals from the Australian Sports Drug Commission, the sporting federations and individual athletes in relation to decisions made in Australia as a result of tests carried out in Australia or internationally. The appeal tribunal should be appointed by the minister responsible for

sport and should be completely autonomous, although it could be serviced by the Australian Sports Drug Commission and publish its findings in the annual report of the Commission;

(iii) request the Australian Sports Drug Commission, and the Australian Olympic Federation, to adopt a strong international role in order to take steps to ensure that the Committee's views are presented to major international forums (e.g. Second World Anti- doping Conference in Moscow and the Dubin inquiry) and to promote the world-wide acceptance of mandatory random and targeted drug testing regimes and the development of uniform policies. This is necessary in order to ensure that Australian athletes are not penalised because of Australia's strong stance on this issue;

(iv) require the Australian Sports Drug Commission to closely examine policies relating to the inadvertent use of drugs and particularly the minimum level at which a positive result is recorded for those drugs which need to be taken on the day of competition to have a performance-enhancing effect and which have a legitimate use in medicine;

(v) as an interim measure, and until a fully independent Australian Sports Drug Commission and separate appeals body can be established, increase the funding and administrative independence of the Australian Sports Commission Anti-drug Campaign through immediate incorporation in order to use the organisation established to carry out the testing and appeals for the Australian Commonwealth Games Organisation to take on responsibility for all sports drug testing in Australia. The Australian Commonwealth Games Association selection panel and appeals tribunal should form the basis of the

Australian Sports Drug Commission and the appeals body respectively, and should play a major role in their establishment. The membership is as follows:

Commission

Dr Brian Corrigan, Chairman - (Chairman, Committee of the National Program on Drugs in Sport)

Dr Ken Fitch, Deputy Chairman - (Chairman, Australian Olympic Federation Medical Commission)

Mr Steve Haynes, Manager - (Manager, National Program on Drugs in Sport)

Appeals Tribunal

Dr Ken Donald, Chairman - (Deputy Director General of Health and Medical Services, Queensland Department of Health, Chairman of Doping Control Committee for 1982 Commonwealth Games)

Mr Hayden Opie - (Lecturer in Law, University of Melbourne)

Ms Elaine Canty - (Sports broadcaster and lawyer)

Ms Julie Draper - (Co-ordinator, National Sports Research Program)

Recommendation Five

The Committee recommends that the meeting of Commonwealth and State Ministers responsible for sport and health matters proposed in Recommendation One of this report:

(i) develop in consultation with relevant sporting organisations appropriate funding and charging policies for the Australian Sports Drug Commission, particularly in regard to professional sports and international competitions in Australia;

(ii) agree that a fixed proportion of all public monies allocated for sports funding be directed to the proposed Australian Sports Drug Commission for testing and other programs;

(iii) investigate mechanisms through which professional sporting organisations can be encouraged to adopt drug testing programs designed by the Australian Sports Drugs Commission and be subject to the decision of the appeals tribunal;

(iv) agree that it be a precondition of any sporting organisation receiving government funding that it adopt standard penalties of a two year suspension from competition for a first offence and a life ban for any subsequent offence; and

(v) as an interim measure, and until the completion of research directed towards setting the maximum levels beyond which inadvertent use of a drug cannot be claimed, the Commission be given discretionary power to recommend to the sporting federations a penalty of less than a two years ban for persistent inadvertent use.

1. Evidence p. 436
2. Evidence p. 29k
3. Evidence p. 32
4. Evidence p. 23
5. Evidence p. 77
6. Evidence p. 78
7. Evidence p. 78
8. Evidence p. 154
9. Evidence p. 154
10. Evidence p. 35
11. Evidence p. 218
12. Evidence p. 1353
13. Evidence p. 122
14. Submission No. 12 p. 1
15. Submission No. 12 Attachment A
16. Submission No. 12 p. 1
17. Richard H Strauss, 'Drug Abuse in Sports', Sports Coach, Vol. 12, No. 1, p. 23.
18. Submission No. 22 pp. 43-4
19. Submission No. 12 Attachment A
20. The Fight Against Doping in Sport, Sports Information Bulletin November 7, 1986, p. 316
21. Evidence p. 78
22. Evidence p. 1393
23. Evidence p. 1923
24. Evidence p. 1836
25. Evidence p. 144
26. Ibid.
27. Evidence p. 319
28. Evidence p. 35
29. Evidence p. 468
30. Evidence p. 1667
31. Evidence p. 1654
32. Evidence p. 212
33. Evidence p. 471
34. Evidence pp. 468-9
35. Evidence p. 348
36. Ibid.
37. Evidence p. 361
38. Submission No, 24C
39. Submission No. 24B, Section 3
40. Submission No. 24B Section 5, p. 10.
41. Evidence pp. 1835-6
42. Evidence pp. 1827-9
43. Evidence p. 347
44. Evidence p. 1825
45. Evidence p. 1484
46. Evidence p. 1617
47. Letter Mr Steve Haynes to Secretary, 7 March 1989.
48. Evidence p. 35
49. Op. cit.
50. Evidence pp. 1809-11
51. Letter Mr Merv Kemp to Mr Rick Pannell, Australian Athletic Union, 16 February 1987
52. Evidence p. 742
53. In Camera Evidence p. 136
54. Evidence p. 1394
55. Evidence p. 1473

56. Letter Ms Sue Howland to Secretary, 1 March 1989
57. Evidence p. 210
58. Letter Mr Steve Haynes to Secretary 7 March 1989
59. Appendix 1
60. Ibid.
61. Ken Donald, The Doping Game, Boolarong Publications, Brisbane, 1983, p. 68.
62. Evidence p. 88
63. Evidence p. 80
64. Evidence p. 321
65. Evidence p. 81
66. Ibid.
67. Evidence p. 116
68. Ibid.
69. Letter Dr Johnson to Secretary, 10 March 1989
70. Ibid.
71. Evidence p. 117
72. Evidence p. 84
73. Letter Mr Coates to Secretary, 13 January 1989
74. Evidence p. 373
75. Evidence p. 79
76. Evidence p. 383
77. Evidence p. 1282
78. In Camera Evidence p. 10
79. Evidence p. 534
80. Evidence p. 130
81. Evidence p. 204
82. Evidence p. 223
83. Evidence p. 1292
84. Evidence p. 1677
85. Evidence p. 1675
86. Evidence p. 1676
87. Evidence p. 1684A
88. Ken Donald, The Doping Game, Boolarong Publications, Brisbane, 1983, p. 53
89. Evidence p. 498
90. National Program on Drugs in Sport, Over the Counter Preparations, Canberra, 1986, p. 16
91. Evidence pp. 497-500
92. Evidence p. 103
93. Appendix 1
94. Ken Donald, The Doping Game, Boolarong Publications, Brisbane, 1983, p. 67.
95. Ibid. p. 68.
96. Evidence p. 1706
97. Evidence pp. 1290-1
98. Evidence p. 1292
99. Ken Donald, The Doping Game, Boolarong Publications, Brisbane, 1983, p. 68.
100. Evidence p. 213
101. Evidence p. 106
102. Evidence pp. 1665-6
103. Evidence p. 46
104. Evidence p. 303
105. Evidence p. 1703
106. Evidence p. 1703
107. Evidence p. 213
108. Evidence p. 132

109. Submission No. 14 p. 30
110. In Camera Evidence p. 143
111. Evidence p. 553
112. Ibid.
113. Evidence p. 1836
114. Op. cit.
115. Evidence p. 506
116. Evidence p. 507
117. Evidence p. 348
118. Ibid.
119. Evidence p. 325
120. Evidence pp. 1290-1
121. Evidence p. 321
122. Review and Evaluation, Final Report MWP Management Consultants. Strategic Plan, p. 15
123. Evidence p. 1668
124. Evidence pp. 1105-6
125. Letter Dr Johnson to Secretary 10 March 1989
126. Evidence pp. 738-9
127. Evidence p. 204
128. Ken Donald, The Doping Game, Boolarong Publications, Brisbane, 1983, p. 15.
129. Evidence p. 368
130. Ibid.
131. Evidence p. 1688
132. Evidence p. 144
133. Evidence p. 375
134. Evidence p. 1617
135. Evidence p. 319
136. Evidence p. 741
137. Evidence p. 150
138. Evidence p. 294
139. Evidence p. 74
140. Evidence p. 75
141. Evidence p. 326
142. Evidence p. 318
143. Evidence p. 1687
144. Evidence p. 1734
145. Evidence p. 1638
146. Evidence p. 1837
147. Evidence p. 1697
148. Evidence p. 1688
149. Evidence p. 1638
150. Evidence p. 204
151. In Camera Evidence p. 143
152. Evidence pp. 1102-6
153. Submission No. 1
154. Evidence p. 1713
155. Evidence p. 1637
156. Ibid.
157. Evidence p. 1638
158. Evidence p. 1639
159. Letter Mr Steve Haynes, Australian Sports Commission Anti-drugs Campaign to Secretary, 7 March 1989