APPENDIX 1

The following individuals and organisations made written submissions to the Committee:

Submission Number	
1.	Mr K McRae, Forestville, New South Wales
2.	Name and address withheld
3.	Mr J Sheedy, Willoughby, New South Wales
4.	Mr B Launder, Werribee, Victoria
5.	Mr M Kemp, Belconnen, Australian Capital Territory
6.	Australian Soccer Federation, Sydney, New South Wales
7.	Mr J Irwin, Everton Hills, Queensland
8.	Australian Hockey Association, South Melbourne, Victoria
9.	Dr Gavin Dawson, Launceston, Tasmania
10.	Australian Weightlifting Federation, Melbourne, Victoria
11.	Royal Brisbane Hospital Foundation, Brisbane, Queensland
12.	Mr Hayden Opie, Parkville, Victoria
13.	Australian Government Analytical Laboratories, Belconnen, Australian Capital Territory
14.	National Program on Drugs in Sport, Belconnen, Australian Capital Territory
15.	Health Department of Western Australian, Perth, Western Australia (in camera)
16.	Australian Institute of Sport, Belconnen, Australian Capital Territory
17.	Australian Sports Medicine Federation Ltd, Westmead, New South Wales

18. Australian Rowing Council Inc., Westmead, New South Wales

19. Australian Swimming Inc., Kippax, Australian Capital Territory

20. Australian Schools Sports Council, Dickson, Australian Capital Territory

21. Dr T Roberts and Mr D Hemphill, Footscray, Victoria

22. Centre for Sports Studies, Canberra College of Advanced Education, Belconnen, Australian Capital Territory

23. Australian Ice Hockey Federation, North Sydney, New South Wales

24. Australian Olympic Federation, Sydney, New South Wales

25. Mr Kelvin B Giles, Belconnen, Australian Capital Territory

26. Australian Universities Sports Association, North Ryde, New South Wales

27. Department of Community Services and Health, Canberra, Australian Capital Territory

28. Dr A P Millar, Petersham, New South Wales

29. Mr M Hurst, Sydney, New South Wales

30. Queensland Department of Health, Brisbane, Queensland

31. Mr M Stewart-Weeks, Chippendale, New South Wales

32. Ms Jane Flemming, Belconnen, Australian Capital Territory

33. Mr Glenn Jones, Queanbeyan, New South Wales and Mr Ian Childs, Caldwell, Australian Capital Territory

34. Australian Customs Service, Canberra, Australian Capital Territory

35. Australian Track and Field Coaches Association, Sydney, New South Wales

36. Dr Richard Ward, Melbourne, Victoria

37. Drug Free Powerlifting Association of NSW Inc., Rushcutters Bay, New South Wales

38. New South Wales Rugby League Limited, Sydney, New South Wales

39. 'Concerned Weightlifter'

40. Union Internationale de Pentathalon Moderne et Biathalon, Mount Eliza, Victoria

41. Messrs J Jones and P Harrison, Belconnen, Australian Capital Territory

42. Dr Michael O'Toole, Dandenong, Victoria

43. Musashi, Bentleigh, Victoria

44. Australian Little Athletics Union, Melbourne, Victoria

45. Mr S Raskovy, Croydon, Victoria

46. New South Wales Medical Board, Railway Square, New South Wales

47. Mr T Black, Kedron, Queensland

48. Mr A Watson, Galston, New South Wales

49. Victorian Weightlifting Association Inc., Hawthorn, Victoria

50. Mrs Gael Martin, Kambah, Australian Capital Territory

51. Mr Gary Parisi, Burwood, New South Wales

52. Mr B Frew, Drouin, Victoria

53. Australian Coaching Council, Belconnen, Australian Capital Territory

54. Queensland Drug Free Powerlifting Association Inc., Scarborough, Queensland

55. Australian Commonwealth Games Association, Double Bay, New South Wales

56. Mr J Smith, Frankston, Victoria

57. Dr D Weisner, Kensington, New South Wales

58. Australian Arthritis Foundation - ACT Inc., Woden, Australian Capital Territory

59. Mr T Gathercole, AM, Belconnen, Australian Capital Territory

60. Dr Graeme Blackman, Institute of Drug Technology, Boronia, Victoria

61. Queensland Fitness Accreditation Council, Kelvin Grove, Queensland

62. Mr A Kiely, Roseville, New South Wales

63. Confederation of Australian Sport, Deakin, Australian Capital Territory

APPENDIX 2

Individuals and organisations who appeared as witnesses before the Committee

Date of Hearing	Individuals/ Organisations	Represented By
11 November 1988	Mr M Kemp Mr K Giles	
	National Program on Drugs in Sport	Dr B Corrigan, Chairman Mr S Haynes, Manager Mr D Moore, Committee Member
21 November 1988	Australian Olympic Federation, Sydney, New South Wales	Mr J Coates, Vice-President Mr P Coles, Secretary-General Dr B Corrigan, Medical Officer
	Australian Sports Medicine Federation	Dr W Webb, Chairman
	Australian Rowing Council	Dr W Webb, Principal Medical Officer
	Australian Ice Hockey Federation	Dr P Gwozdecky, Sport Medicine Director
	Mr M Hurst (coach) Mr D Clarke (athlete) Ms M Holland (athlete) Dr A Millar Mr J Sheedy	
30 November 1988	Mr A Watson Mr S Howland Mrs G Martin	

Date of Hearing	Individuals/ Organisations	Represented By
6 December 1988	Mr S Hambesis	
	Mr J Pappas	
7 December 1988	Mr G Jones	
	Mr I Childs	
12 December 1988	Mr G Parisi	
14 December 1988	Mr L Jones	
13 February 1989	Mr D Smith	
	Mr D Byrnes	
	Mr J Jones and Mr P Harrison	
	Ms J Flemming	
14 February 1989	Mr K Giles	
	Mr M Kemp	
	Mr C Hilliard	
	Mr B Batschi	
	Mr H Wardle	
15 February 1989	Dr K Donald	
	Dr G Dawson	
	Sister S Beasley	
	Dr K Maguire	
	Dr P Fricker	
16 February 1989	Mr J Scarano	
	Mr D Talbot, OBE	
	Mr R Harvey and Mr R Hobson	

Date of Hearing	Individuals/ Organisations	Represented By
17 February 1989	Mr S Haynes Ms L Martin Dr K Donald Ms R Boyle	
3 April 1989	Australian Institute of Sport	Professor J Bloomfield, OBE former Chairman of the Board Mr P Bowman, Co-ordinator of Track and Field Ms E Darlison, Board Member Mr R Harvey, Deputy Chairman Mr R Hobson, Assistant Director Corporate Services Dr J Roberts, Assistant Manager Sports Administration Dr R Smith, Acting Director
12 April 1989	Australian Institute of Sport	Sister S Beasley Mr P Bowman Dr P Fricker Mr R Harvey Mr R Hobson Dr R Smith Mr J Stanwix

AUSTRALIAN SENATE
CANBERRA A.C.T.

APPENDIX 3

PARLIAMENTARY PRIVILEGE

Procedures to be observed by Senate committees for the protection of witnesses

That, in their dealings with witnesses, all committees of the Senate shall observe the following procedures:

(1) A witness shall be invited to attend a committee meeting to give evidence. A witness shall be summoned to appear (whether or not the witness was previously invited to appear) only where the committee has made a decision that the circumstances warrant the issue of a summons.

(2) Where a committee desires that a witness produce documents relevant to the committee's inquiry, the witness shall be invited to do so, and an order that documents be produced shall be made (whether or not an invitation to produce documents has previously been made) only where the committee has made a decision that the circumstances warrant such an order.

(3) A witness shall be given reasonable notice of a meeting at which the witness is to appear, and shall be supplied with a copy of the committee's order of reference, a statement of the matters expected to be dealt with during the witness's appearance, and a copy of these procedures. Where appropriate a witness shall be supplied with a transcript of relevant evidence already taken.

(4) A witness shall be given opportunity to make a submission in writing before appearing to give oral evidence.

(5) Where appropriate, reasonable opportunity shall be given for a witness to raise any matters of concern to the witness relating to the witness's submission or the evidence the witness is to give before the witness appears at a meeting.

(6) A witness shall be given reasonable access to any documents that the witness has produced to a committee.

(7) A witness shall be offered, before giving evidence, the opportunity to make application, before or during the hearing of the witness's evidence, for any or all of the witness's evidence to be heard in private session,

and shall be invited to give reasons for any such application. If the application is not granted, the witness shall be notified of reasons for that decision.

(8) Before giving any evidence in private session a witness shall be informed whether it is the intention of the committee to publish or present to the Senate all or part of that evidence, that it is within the power of the committee to do so, and that the Senate has the authority to order the production and publication of undisclosed evidence.

(9) A chairman of a committee shall take care to ensure that all questions put to witnesses are relevant to the committee's inquiry and that the information sought by those questions is necessary for the purpose of that inquiry. Where a member of a committee requests discussion of a ruling of the chairman on this matter, the committee shall deliberate in private session and determine whether any question which is the subject of the ruling is to be permitted.

(10) Where a witness objects to answering any question put to the witness on any ground, including the ground that the question is not relevant or that the answer may incriminate the witness, the witness shall be invited to state the ground upon which objection to answering the question is taken. Unless the committee determines immediately that the question should not be pressed, the committee shall then consider in private session whether it will insist upon an answer to the question, having regard to the relevance of the question to the committee's inquiry and the importance to the inquiry of the information sought by the question. If the committee determines that it requires an answer to the question, the witness shall be informed of that determination and the reasons for the determination, and shall be required to answer the question only in private session unless the committee determines that it is essential to the committee's inquiry that the question be answered in public session. Where a witness declines to answer a question to which a committee has required an answer, the committee shall report the facts to the Senate.

(11) Where a committee has reason to believe that evidence about to be given may reflect adversely on a person, the committee shall give consideration to hearing that evidence in private session.

(12) Where a witness gives evidence reflecting adversely on a person and the committee is not satisfied that that evidence is relevant to the committee's inquiry, the committee shall give consideration to expunging that evidence from the transcript of evidence, and to forbidding the publication of that evidence.

(13) Where evidence is given which reflects adversely on a person and action of the kind referred to in paragraph (12) is not taken in respect of the evidence, the committee shall provide reasonable opportunity for that person to have access to that evidence and to respond to that evidence by written submission and appearance before the committee.

(14) A witness may make application to be accompanied by counsel and to consult counsel in the course of a meeting at which the witness appears. In considering such an application, a committee shall have regard to the need for the witness to be accompanied by counsel to ensure the proper protection of the witness. If an application is not granted, the witness shall be notified of reasons for that decision.

(15) A witness accompanied by counsel shall be given reasonable opportunity to consult counsel during a meeting at which the witness appears.

(16) An officer of a department of the Commonwealth or of a State shall not be asked to give opinions on matters of policy, and shall be given reasonable opportunity to refer questions asked of the officer to superior officers or to a Minister.

(17) Reasonable opportunity shall be afforded to witnesses to make corrections of errors of transcription in the transcript of their evidence and to put before a committee additional material supplementary to their evidence.

(18) Where a committee has any reason to believe that any person has been improperly influenced in respect of evidence which may be given before the committee, or has been subjected to or threatened with any penalty or injury in respect of any evidence given, the committee shall take all reasonable steps to ascertain the facts of the matter. Where the committee considers that the facts disclose that a person may have been improperly influenced or subjected to or threatened with penalty or injury in respect of evidence which may be or has been given before the committee, the committee shall report the facts and its conclusions to the Senate.

Resolutions of the Senate - 25 February 1988

APPENDIX 4

IN CAMERA EVIDENCE

A Senate Committee may agree to take evidence in camera. This means that the evidence will be taken in private, with the public and press excluded. In agreeing to take evidence in camera the Committee will inform a witness whether it is the intention of the Committee to publish or present to the Senate all or part of the evidence. For example, where a matter is either before a court of law or pending legal proceedings (sub judice), the Committee might wish to hear evidence in camera in order to avoid influencing or prejudicing the outcome of court proceedings. In these circumstances the Committee may indicate that it will authorise the publication of the in camera evidence once the legal proceedings have been completed.

When receiving in camera evidence for other than sub judice reasons it will generally be the intention of the Committee that the evidence will not be published. However, it should be noted that the Committee is unable to give a binding assurance that evidence taken in camera will not be disclosed. This is because disclosure can be authorised by three mechanisms:

- a resolution of the Committee concerned can result in the publication or the presentation to the Senate of evidence taken in camera;
- the production and publication of undisclosed evidence can be authorised by the Senate;
- an individual member of the Committee preparing a dissenting report may, without reference to the Committee or the witness, disclose in camera evidence which the member claims is clearly relevant to the matter on which the Senator dissents and which forms a necessary part of the reasoning of the dissent.

Clearly, the first of these mechanisms is under the control of the Committee and is unlikely to be applied if the Committee has indicated it does not intend to disclose in camera evidence. However, the membership of the Committee may change or the Committee may decide at some later stage that the reasons for confidentiality may no longer exist. In this case the Committee would normally notify the witness and seek his or her up-to-date preference about the matter. The other two mechanisms through which disclosure can be authorised are outside the direct control of the Committee. However, it should be noted their use has been rare.

In giving in camera evidence it should be noted that the resolutions adopted by the Senate on 25 February 1988 concerning procedures to be observed by Senate committees for the protection of witnesses state that:

> [w]here evidence is given which reflects adversely on a person ... the committee shall provide reasonable opportunity for that person to have access to that evidence and to respond to that evidence by written submission and appearance before the committee. (paragraph 13)

When a Committee has taken evidence in camera involving allegations made against an individual, the Committee will normally try to raise these allegations with the individual concerned in such a way that the identity of the witness making the allegations is not disclosed. This would be done during the course of an in camera hearing.

Distribution of the Hansard transcript of in camera evidence is limited to the witness, the Committee members, the Committee secretariat and to Hansard. Extra security, such as double enveloping is used in the distribution of such evidence.

Unauthorised disclosure of in camera evidence is both a contempt of the Senate and a criminal offence. The Parliamentary Privileges Act 1987 sets out the penalties for unauthorised disclosure of in camera evidence as:

- in the case of a natural person, $5 000 or imprisonment for 6 months;
- in the case of a corporation $25 000

It should be noted that disclosure can be authorised only by the three methods described. Disclosure cannot be authorised by the witness providing the evidence. If a witness later changes his or her mind about the need for secrecy, the Committee should be advised as, in this case, the Committee might wish to consider the possibility of disclosure.

If a witness wishes to keep confidential the fact that he or she has appeared to give evidence before the Committee, as well as the evidence given, this should be made clear to the Committee secretary as soon as possible.

Note:

Where there is an absolute need to ensure confidentiality a Committee may agree to hold private discussions with a prospective witness rather than take formal evidence.

APPENDIX 5

INTERNATIONAL OLYMPIC COMMITTEE

LIST OF DOPING CLASSES AND METHODS

I. **DOPING CLASSES**

A. Stimulants
B. Narcotics
C. Anabolic Steriods
D. Beta-blockers
E. Diuretics

II. **DOPING METHODS**

A. Blood doping
B. Pharmacological, chemical and physical manipulation

III. **CLASSES OF DRUGS SUBJECT TO CERTAIN RESTRICTIONS**

A. Alcohol
B. Local anaesthetics
C. Corticosteroids

NOTE:

The doping definition of the IOC Medical Commission is based on the banning of pharmacological classes of agents.

The definition has the advantage that also new drugs, some of which may be especially designed for doping purposes, are banned.

The following list represents examples of the different dope classes to illustrate the doping definition. Unless indicated all substances belonging to the banned classes may not be used for medical treatment, even if they are not listed as examples. If substances of the banned classes are detected in the laboratory the IOC Medical Commission will act. It should be noted that the presence of the drug in the urine constitutes an offence, irrespective of the route of administration.

EXAMPLES AND EXPLANATIONS

I. **DOPING CLASSES**

A. Stimulants e.g.

amfepramone
amfetaminil
amiphenazole
amphetamine
benzphetamine
caffeine*
cathine
chlorphentermine
clobenzorex
clorprenaline
cocaine
cropropamide (component of "micoren")
crothetamide (component of "micoren")
dimetamfetamine
ephedrine
etafedrine
ethamivan
etilamfetamine
fencamfamin
fenetylline
fenproporex
furfenorex
mefenorex
methamphetamine
methoxyphenamine
methylephedrine
methylphenidate
morazone
nikethamide
pemoline
pentetrazol
phendimetrazine
phenmetrazine
phentermine
phenylpropanolamine
pipradol
prolintane
propylhexedrine
pyrovalerone
strychnine and related compounds

* For caffeine the definition of a positive depends upon the following: - if the concentration in urine exceeds 12 micrograms/ml.

Stimulants comprise various types of drugs which increase alertness, reduce fatigue and may increase competitiveness and hostility. Their use can also produce loss of judgement, which may lead to accidents to others in some sports. Amphetamine and related compounds have the most notorious reputation in producing problems in sport. Some deaths of sportsmen have resulted even when normal doses have been used under conditions of maximum physical activity. There is no medical justification for the use of 'amphetamines' in sport.

One group of stimulants is the sympathomimetic amines of which ephedrine is an example. In high doses, this type of compound produces mental stimulation and increased blood flow. Adverse effects include elevated blood pressure and headache, increased and irregular heart beat, anxiety and tremor. In lower doses, they e.g. ephedrine, pseudoephedrine, phenylpropanolamine, norpseudoephedrine, are often present in cold and hay fever preparations which can be purchased in pharmacies and sometimes from other retail outlets without the need of a medical prescription.

THUS NO PRODUCT FOR USE IN COLDS, FLU OR HAY FEVER PURCHASED BY A COMPETITOR OR GIVEN TO HIM SHOULD BE USED WITHOUT FIRST CHECKING WITH A DOCTOR OR PHARMACIST THAT THE PRODUCT DOES NOT CONTAIN A DRUG OF THE BANNED STIMULANTS CLASS.

-Beta2 agonists

The choice of medication in the treatment of asthma and respiratory ailments has posed many problems. Some years ago, ephedrine and related substances were administered quite frequently. However, these substances are prohibited because they are classed in the category of "sympathomimetic amines" and therefore considered as stimulants.

The use of only the following beta2 agonists is permitted in the aerosol form:
bitolterol
orciprenaline
rimiterol
salbutamol
terbutaline

B. <u>Narcotic analgesics</u> e.g.

alphaprodine
anileridine
buprenorphine
codeine
dextromoramide
dextropropoxyphen
diamorphine (heroin)
dihydrocodeine
dipipanone
ethoheptazine
ethylmorphine
levorphanol
methadone
morphine
nalbuphine
pentazocine
pethidine
phenazocine
trimeperidine and related compounds

The drugs belonging to this class, which are represented by morphine and its chemical and pharmacological analogs, act fairly specifically as analgesics for the management of moderate to severe pain. This description however by no means implies that their clinical effect is limited to the relief of trivial disabilities. Most of these drugs have major side effects, including dose-related respiratory depression, and carry a high risk of physical and psychological dependence. There exists evidence indicating that narcotic analgesics have been and are abused in sports, and therefore the IOC Medical Commission has issued and maintained a ban on their use during the Olympic Games. The ban is also justified by international restrictions affecting the movement of these compounds and is in line with the regulations and recommendations of the World Health Organisation regarding narcotics.

Furthermore, it is felt that the treatment of slight to moderate pain can be effective using drugs - other than the narcotics - which have analgesic, anti-inflammatory and antipyretic actions. Such alternatives, which have been successfully used for the treatment of sports injuries, include Anthranilic acid derivatives (such as Mefenamic acid, Floctafenine, Glafenine, etc.), Phenylalkanoic acid derivatives (such as Diclofenac, Ibuprofen, Ketoprofen, Naproxen, etc.) and compounds such as Indomethacin and Sulindac. The Medical Commission also reminds athletes and team doctors that Aspirin and its newer derivatives (such as Diflunisal) are not banned but cautions against some pharmaceutical preparations where Aspirin is often associated to a banned drug such as Codeine. The same precautions hold for cough and cold preparations which often contain drugs of the banned classes.

NOTE: DEXTROMETHORPHAN IS NOT BANNED AND MAY BE USED AS AN ANTI-TUSSIVE.
DIPHENOXYLATE IS ALSO PERMITTED.

C. Anabolic steroids e.g.

bolasterone
boldenone
clostebol
dehydrochlormethyltestosterone
fluoxymesterone
mesterolone
metandienone
metenolone
methyltestosterone
nandrolone
norethandrolone
oxandrolone
oxymesterone
oxymetholone
stanozolol
testosterone** and related compounds

** 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.
It is well known that the administration to males of Human Chorionic Gonadotrophin (HCG) and other compounds with related activity leads to an increased rate of production of androgenic steroids. The use of these substances is therefore banned.

This class of drugs includes chemicals which are related in structure and activity to the male hormone testosterone, which is also included in this banned class. They have been misused in sport, not only to attempt to increase muscle bulk, strength and power when used with increased food intake, but also in lower doses and normal food intake to attempt to improve competitiveness.

Their use in teenagers who have not fully developed can result in stunting growth by affecting growth at the ends of the long bones. Their use can produce psychological changes, liver damage and adversely affect the cardio-vascular system. In males, their use can reduce testicular size and sperm production; in females, their use can produce masculinisation, acne, development of male pattern hair growth and suppression of ovarian function and menstruation.

D. <u>Beta-blockers</u> e.g.

acebutolol
alprenolol
atenolol
labetalol
metoprolol
nadolol
oxprenolol
propranolol
sotalol and related compounds

The IOC Medical Commission has reviewed the therapeutic indications for the use of beta-blocking drugs and noted that there is now a wide range of effective alternative preparations available in order to control hypertension, cardiac, arrythmias, angina pectoris and migraine. Due to the continued misuse of beta-blockers in some sports where physical activity is of no or little importance, the IOC Medical Commission reserves the right to test those sports which it deems appropriate. These are unlikely to include endurance events which necessitate prolonged periods of high cardiac output and large stores of metabolic substrates in which beta-blockers would severely decrease performance capacity.

E. <u>Diuretics</u> e.g.

acetazolamide
amiloride
bendroflumethiazide
benzthiazide
bumetanide
canrenone
chlormerodrin
chlortalidone
diclofenamide
ethacrynic acid
furosemide
hydrochlorothiazide
mersalyl
spironolactone
triamterene and related compounds

Diuretics have important therapeutic indications for the elimination of fluids from the tissues in certain pathological conditions. However, strict medical control is required.

Diuretics are sometimes misused by competitors for two main reasons, namely: to reduce weight quickly in sports where weight categories are involved and to reduce the concentration of drugs in urine by producing a more rapid excretion of urine to attempt to minimise detection of drug misuse. Rapid reduction of weight in sport cannot be justified medically. Health risks are involved in such misuse because of serious side-effects which might occur.

Furthermore, deliberate attempts to reduce weight artificially in order to compete in lower weight classes or to dilute urine constitute clear manipulations which are unacceptable on ethical grounds. Therefore, the IOC Medical Commission has decided to include diuretics on its list of banned classes of drugs.

N.B. For sports involving weight classes, the IOC Medical Commission reserves the right to obtain urine samples from the competitor at the time of the weigh-in.

II. METHODS

A. Blood doping

Blood transfusion is the intravenous administration of red blood cells or related blood products that contain red blood cells. Such products can be obtained from blood drawn from the same (autologous) or from a different (non-autologous) individual. The most common indications for red blood transfusion in conventional medical practice are acute blood loss and severe anaemia.

Blood doping is the administration of blood or related red blood products to an athlete other than for legitimate medical treatment. This procedure may be preceded by withdrawal of blood from the athlete who continues to train in this blood depleted state.

These procedures contravene the ethics of medicine and of sport. There are also risks involved in the transfusion of blood and related blood products. These include the development of allergic reactions (rash, fever etc.) and acute haemolytic reaction with kidney damage if incorrectly typed blood is used, as well as delayed transfusion reaction resulting in fever and jaundice, transmission of infectious diseases (viral hepatitis and AIDS), overload of the circulation and metabolic shock.

Therefore the practice of blood doping in sport is banned by the IOC Medical Commission.

B. Pharmacological, chemical and physical manipulation

The IOC Medical Commission bans the use of substances and of methods which alter the integrity and validity of urine samples used in doping controls. Examples of banned methods are catheterisation, urine substitution and/or tampering, inhibition of renal excretion, e.g. by probenecid and related compounds.

III. CLASSES OF DRUGS SUBJECT TO CERTAIN RESTRICTIONS

A. Alcohol

Alcohol is not prohibited. However breath or blood alcohol levels may be determined at the request of an International Federation.

B. Local anaesthetics

Injectable local anaesthetics are permitted under the following conditions:

a) that procaine, xylocaine, carbocaine, etc. are used but not cocaine;
b) only local or intra-articular injections may be administered;
c) only when medically justified (i.e. the details including diagnosis; dose and route of administration must be submitted immediately in writing to the IOC Medical Commission).

C. Corticosteroids

The naturally occurring and synthetic corticosteroids are mainly used as anti-inflammatory drugs which also relieve pain. They influence circulating concentrations of natural corticosteroids in the body. They produce euphoria and side-effects such that their medical use, except when used topically, require medical control.

Since 1975, the IOC Medical Commission has attempted to restrict their use during the Olympic Games by requiring a declaration by the team doctors, because it was known that corticosteroids were being used non-therapeutically by the oral, intramuscular and even the intravenous route in some sports. However, the problem was not solved by these restrictions and therefore stronger measures designed not to interfere with the appropriate medical use of these compounds became necessary.

The use of corticosteroids is banned except for topical use (aural, opthalmological and dermatological), inhalational therapy (asthma, allergic rhinitis) and local or intra-articular injections.

ANY TEAM DOCTOR WISHING TO ADMINISTER CORTICOSTEROIDS INTRA-ARTICULARLY OR LOCALLY TO A COMPETITOR MUST GIVE WRITTEN NOTIFICATION TO THE IOC MEDICAL COMMISSION.

APPENDIX 6

Drugs Proscribed by the IOC Medical Commission which are available through the Pharmaceutical Benefits Scheme

Dexamphetamine

Adrenaline

Fenoterol

Phenylephrine

Caffeine

Codeine

Methadone

Morphine

Oxocodone

Pethidine

Papaveretum

Ethyloestrenol

Fluoxymesterone

Methenolone

Methyl Testosterone

Nandrolone

Oxymetholone

Testosterone

Alprenolol

Atenolol

Metoprolol

Oxprenolol

Pindolol

Propranolol